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TOOLS AND METHODS

Development of a disability-inclusive healthcare service: review of the Healthcare Accreditation Programme in Thailand

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Despite decades of global agendas on disability inclusive development, persons with disabilities continue to experience many barriers to quality health care. The Healthcare Accreditation Programme is one instrument facilitating healthcare quality development. As the standard manual is the core component of the programme, this study explores the disability-inclusiveness of the standard against an inclusive framework developed by synthesizing key elements of the UN Convention on the Rights of Person with Disabilities (UNCRPD) and the International Classification of Functioning, Disability and Health (ICF). The general healthcare standards and rehabilitation facilities standards were searched purposively to evaluate those used in Thailand and to compare them with those in other countries where rehabilitation accreditation programmes are widely implemented, such as the USA, the UK, and Australia. The rehabilitation specific standards appear more concerned with mainstreaming disability. The general healthcare standards are less disability inclusive. Although rehabilitation services are mentioned in the standards but functional evaluations are not always indicated. Both rehabilitation and general standards appear to neglect barriers to general health care and the human rights of persons with disabilities. The accreditation programme can facilitate the disability-inclusive healthcare if its standards are revised to address concerns over client's rights, especially by avoiding substituted decision making and embracing accessibility evaluation and removal of barriers. In addition, it needs to emphasize a participatory approach in care processes, the functional evaluation and the focus on personal independence and social re-integration.

Keywords: disability inclusive development; rehabilitation; accreditation; healthcare; quality development; mainstreaming; tools; Thailand

Introduction

The equalization of opportunities and full participation of persons with disabilities has been encouraged since 2005, in the 58th World Health Assembly resolution, after the issuing of the United Nations Standard Rules on Equalization of Opportunities for Persons with Disabilities (WHO 2005). Disability inclusive development was re-emphasized when the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD) was adopted in 2006 (The Office of the United Nations High Commissioner for Human Rights 2006). The UNCRPD mandates state parties to develop 'disability inclusive health', a commitment that is also reiterated by the WHO Global Disability Action Plan 2014-2021 (WHO 2013). To advance disability inclusive health for persons with disabilities, the WHO also supports use of the International Classification of Functioning, Disability and Health (ICF) (WHO 2001), the Community-Based Rehabilitation (CBR) Guidelines and Matrix (WHO 2010), and the development of Global Cooperation on Assistive Technologies (GATE) (WHO 2014). According to the ICF, disability is not only a matter of body structure or function, but also relates to activity levels of a person as well as their participation in society. In this sense, disability is no longer considered a consequence of disease, but is rather an umbrella term for impairments, activity limitations and participation restrictions which result from the interaction between health conditions and environmental factors; thus the ICF has widened the scope and interpretation of disability.

To date, debates continue over the appropriate tools or measures to evaluate disability inclusive health development (Goujon et al 2014). However, there is extensive evidence regarding the inability of persons with disabilities in accessing healthcare services (Lawthers et al. 2003, Veltman et al. 2001). Several papers discuss barriers in accessing rehabilitation, such as the perception and attitudes of health professionals, the unavailability of information about disability-related health conditions and services, and the stigmatization of being so-called disabled (Helland et al 2015, Mlenzana et al 2013, Southall & Wittich 2008). Some also mention gaps in the health system, for example: fragmentation and uncoordinated healthcare services, healthcare providers' insufficient skills and knowledge on disability, barriers related to attitudes, communication and physical, as well as environmental barriers and financial hardship (Lawthers et al. 2003, Iezzoni et al. 2002, Krahn et al. Abdi et al 2015).

In Thailand, health services, for persons with disabilities, are managed by the mainstream health system. For example, rehabilitation services and assistive devices for persons with disabilities are provided in general provincial and district hospitals (Kheawcharoen et al 2009). Disease prevention and health promotion programmes are generally performed by the district and sub-

district healthcare facilities for everyone living in the catchment area. Healthcare financing is under the universal health coverage policy which deploys through three national public health insurance schemes for all the citizens where services are provided, literally free, at the point of care. There are, however, some discrepancies in benefit packages and reimbursement methods across the three schemes which create problems for persons with disabilities in accessing healthcare (Pilasant et al 2015).

The Ministry of Public Health, as a health policy implementer and regulator, has a set of key performance indicators for annual monitoring of implementation (Ministry of Public Health 2015). Unfortunately, of the 21 compulsory indicators, none relate to monitoring performance on healthcare of persons with disabilities.

Another independent and influential public body in Thai healthcare system is the Healthcare Accreditation Institute (HAI). It plays an important role in facilitating the quality development of the healthcare delivery system since its inception in 1996. To date, 88.7% of all public and private hospitals in the country (1,161 hospitals out of the total 1,323) voluntarily participate in the quality management system convened by the HAI, of which approximately 54% are accredited (HAI 2016). Some private hospitals and a few public hospitals are also accredited by the Joint Commission International (JCI) which is an international healthcare accreditation institute. Both Thailand HAI and JCI have been recognized and accredited by the International Society for Quality in Health Care (ISQua).

There are four main components of HAI's hospital and health care accreditation process (HAI 2008):
1) the existence of hospital and health care standards;
2) the application of a standard for self-assessment and self-improvement by hospital staff;
3) external assessment by surveyors from the HAI to verify self-assessment findings, identify blind spots unnoticed by hospital staff; and
4) the recognition, through provision of accreditation certification, by the HAI of a three-year term after which re-accreditation processes are required. A similar process is applied by JCI for international healthcare accreditation.

The Thailand Hospital and Health Care Standard is used by HAI as the guide for assessment, planning and conducting the quality improvement and accreditation process. The first version of the Thailand Hospital and Healthcare Standard was launched in 1996 by HAI. The Standard has been reviewed and improved continuously since its inception to ensure appropriateness and gain international acceptance (HAI 2008). In 2003, the concept of Malcolm Baldrige National Quality

Award (MBNQA) and the concept of health promotion were integrated into The Standard. The current version was named 'The Hospital and Health Care Standard, Sixtieth Anniversary Celebrations of His Majesty's Accession to the Throne Edition' which was announced for official use in 2006.

Although hospital and health care accreditation is voluntary in Thailand, more than 80% of all hospitals in the country comply with the HAI programme (HAI 2016). This number is quite remarkable. The core argument of this paper is that the Standard, used as a guide for healthcare quality development, might be a fundamental change agent for disability inclusive health development through the hospital accreditation process, if it is developed in careful consideration of persons with disabilities. This paper reviews general hospital and healthcare standards being used by the HAI and the JCI in Thailand and the rehabilitation-specific healthcare standards used for quality development of rehabilitation facilities in Australia, the UK and the USA; and proposes a disability inclusive framework for Thailand HAI's hospital and health care standard revision.

Methods

A conceptual framework for the study was formulated drawing on disability inclusive concepts based on the UNCRPD and the World Health Organization's ICF with the aim of understanding of disability, and barriers and rights to health, by persons with disabilities, when exploring hospital and healthcare standards.

The general hospital and health care standard currently used by Thailand HAI, and the international one used by the JCI were purposively selected for analysis against the disability-inclusive conceptual framework. The international rehabilitation-specific standards were also purposively retrieved and reviewed against the conceptual framework from three countries where hospital accreditation programmes are widely implemented: The United States, the United Kingdom and Australia. The disability inclusiveness and functional dimensions of the standards were analysed.

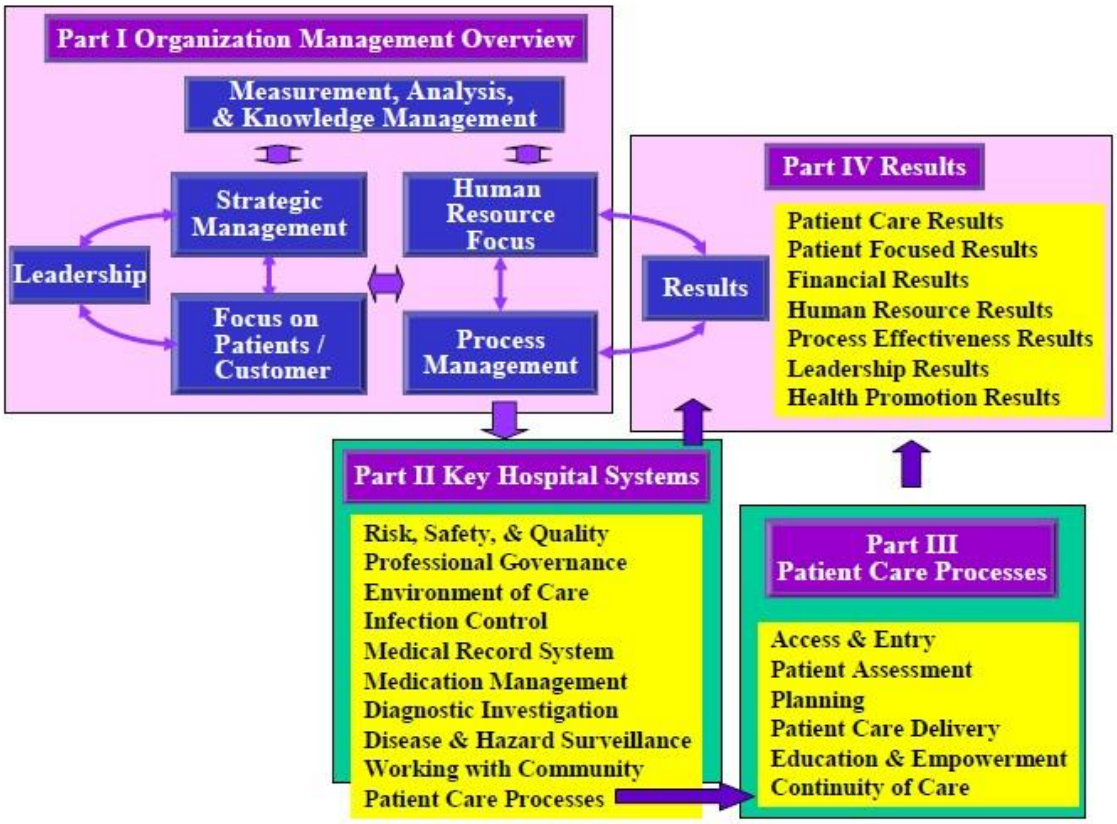

Figure 1: The Hospital and Health Care Standard (HAI 2006) as representative of general healthcare standard framework

Results

Formulating the conceptual framework

To develop the conceptual framework, we drew on disability inclusive concepts from the UNCRPD and the ICF. The UNCRPD is a global legislative framework with the perspective of human rights including rights to health protection, while the ICF is a technical framework which widens interpretation of disability to cover both individual health conditions and environmental context as mentioned earlier. The general principles of the UNCRPD compose of eight subjects which are; 1) Respect for inherent dignity, individual autonomy including the freedom to make one's own choices, and independence of persons; 2) Non-discrimination; 3) Full and effective participation and inclusion in society; 4) Respect for difference and acceptance of persons with disabilities as part of human diversity and humanity; 5) Equality of opportunity; 6) Accessibility;

7) Equality between men and women; and 8) Respect for the evolving capacities of children with disabilities and respect for the right of children with disabilities to preserve their identities. We also explored the structure of general hospital and health care standards which commonly categorize requirements into 2-4 main parts; the most important of which are organization-related and patient-related parts. Using Thailand HAI's healthcare standard as an example, there are 4 main parts; 1) organization management overview, 2) hospital systems, 3) patient care process and 4) results. Each part is divided into categories, with 28 categories in total (Fig.1).
By matching the UNCRPD and ICF concepts to the hospital and health care standard, it is evident that many disability inclusive concepts are relevant to and should be elaborated in the 'Patient's Rights' category in Part 1 of the standard, 'Environment of care' category in Part 2 or Hospital Systems part of the standard, 'Patient care processes' part which include sub-categories on Access & Entry, Patient Assessment, Planning, Patient Care Delivery, and Continuity of Care, and lastly 'Patient Care Results' part as shown in Table 1. Most of the core concepts of the UNCRPD and ICF appeared to be relevant to 'Patient Care Processes' part while the remaining categories of 'Environment of Care' and 'Patient's Rights' are essential in supporting the care process.

The contents of the UNCRPD and ICF were then grouped and correlated with their possible presentation in the hospital and healthcare standard to develop the conceptual framework presented in Fig 2. The framework shows that full and effective participation and inclusion by persons with disabilities should be facilitated across the patient care process with the focus on person's independence and social inclusion in the health outcome. Concern for 'Patient's Rights' should include respect to person's dignity, autonomy, differences, freedom of choices, rights of children, and provision of equal service without discrimination. In the 'Access & Entry' category, concern should be made to assure equality in service provision and accessibility, especially of the physical environment.

Analysing the general healthcare standard: HAI and JCI

The conceptual framework was then used to analyse the disability inclusiveness of the Thai Hospital and Health Care Standard (HAI 2006) and the 4th edition of the Joint Commission International Accreditation Standards for Hospitals[1] (JCI 2011).

Concerning **Accessibility**, the JCI and HAI standard state almost the same requirement that '… *(The organization or the healthcare team) seeks to reduce physical, language, cultural, and other barriers to access of services.*' However, in terms of physical environment of the facilities, both standards address only safety issues, emergency management, and equipment and utility systems. Physical accessibility or universal design is not mentioned.

Table 1: Summarizing the UNCRPD and ICF concepts in relation health standard

UNCRPD general principle	Hospital and health care standard
1) Respect for inherent dignity, individual autonomy including the freedom to make one's own choices, and independence of persons	- should be considered in all patient care processes - should be stressed in Patients' Rights category
2) Non-discrimination	- should be considered in all patient care processes - should be stressed in 'Patients' Rights' and 'Access & Entry' category
3) Full and effective participation and inclusion in society	- Effective participation should be stressed in 'Planning, Patient care delivery, and Continuity of care' category - Inclusion in society should be stressed in the 'Result' part.
4) Respect for difference and acceptance of persons with disabilities as part of human diversity and humanity	- should be considered in all patient care processes - should be stressed in Patients' Rights category
5) Equality of opportunity	- should be considered in all patient care processes - should be stressed in 'Patients' Rights' category and 'Access & Entry' category
6) Accessibility	- should be stressed in 'Access & Entry' and 'Environment of care' category
7) Equality between men and women	- should be considered in all patient care process - should be stressed in Patients' Rights category
8) Respect for the evolving capacities of children with disabilities and respect for the right of children with disabilities to preserve their identities	- should be considered in all patient care processes - should be stressed in Patients' Rights category
ICF concept	Hospital and health care standard
Functioning and disability as part of a global notion of health, comprising any or all of body structure/function, activity and participation, taking into account the interactions among health conditions, personal and environmental factors	- should be stressed along the patient care process especially in 'Assessment, Planning, Patient Care Delivery, and Continuity of Care' categories. - Optimal functioning in the person's usual environment should be stressed in the 'Result' part.

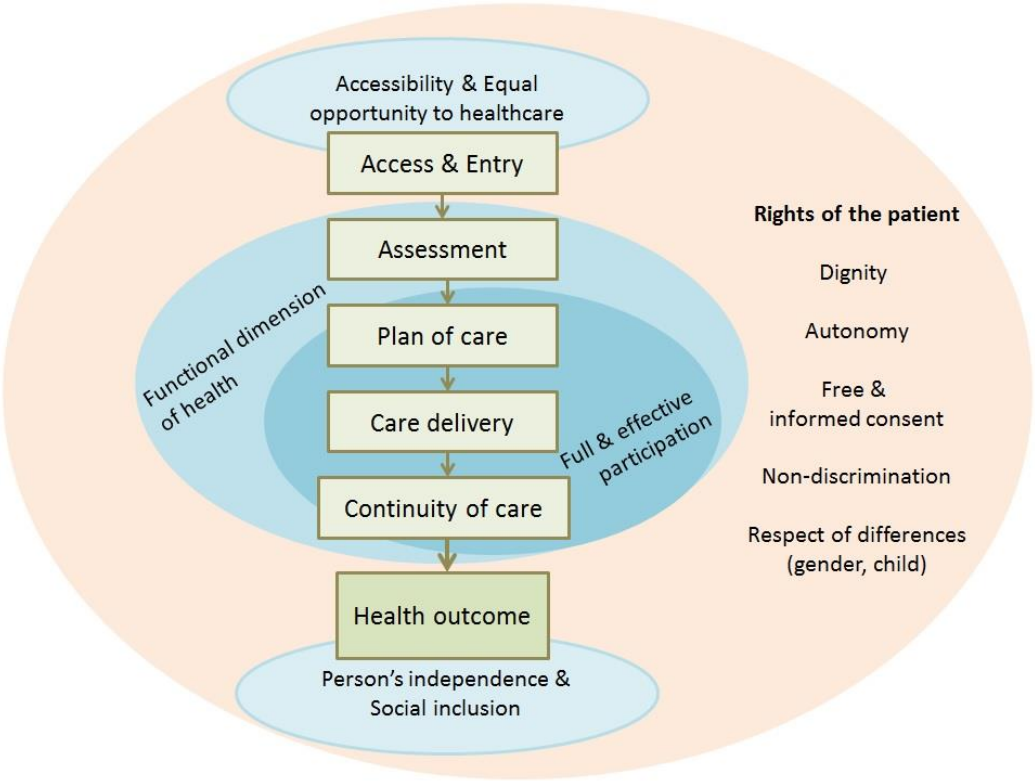

Figure 2: The disability-inclusive conceptual framework in relation to the patient care process and result

Concerning **Information and Communication** accessibility, the JCI standard states as a requirement that '*patient and family communication and education are provided in an understandable*[2] *format and language*.' The HAI standard describes this issue separately in two categories. In the Assessment category, it states '*the healthcare team shares the assessment results with patients and families in a clear and easy-to-understand way*.' In the Information and Empowerment category, it states '*the healthcare team provides essential information and facilitates learning for self-care and good health behaviour to patients and families*.' A footnote clarifies the term 'essential information' as knowledge about nature of diseases, healthy lifestyles, and way of promoting good health during sickness and in the home environment.

Both standards place **'Patients' Rights'** in a distinct category which covers all matters and concerns related to equality and non-discriminating practice, respect for autonomy and dignity, and free and informed consent. Both standards state that *'children, disabled individuals, and the elderly receive appropriate protection*.' However, the HAI standard requests the healthcare facilities to follow the Thai version of Declaration of Patient's Rights which state that '*the*

father/mother or legal representative may use their rights in place of a child under the age of eighteen or who is physically or mentally handicapped wherein they could not exercise their own rights.'

Concerning the **Patient Care Process**, the JCI standard does not require participation of clients. It states clearly that health care organizations and staff are responsible for identifying and addressing functional issues in that '*patients are screened for functional needs and are referred for further assessment and treatment when necessary.*' In contrast, the HAI standard mentions extensively the participatory process from planning of care to discharge planning stage. Nonetheless, it lacks concern over functional evaluation. The standard, however, places 'Rehabilitation services' as a separate element on the 'Specific Care' sub-category. It states: *"A rehabilitation plan, based on assessment of the patient's physical, emotional, and social status, is developed to guide rehabilitation services to reach personal rehabilitation goals."* And that *"Rehabilitation restores, improves, or maintains the patient's optimal level of functioning, self-care, self-responsibility, independence, and quality of life."*

Even with the clear distinct statements in 'Rehabilitation service', the HAI standard does not connect people receiving rehabilitation care to the '**Continuity of Care**' pathway. In the 'Continuity of Care' element, it focuses on follow up care without concern over clients' independence or social reintegration as part of their goals. The same concept applies to JCI standard.

In summary, the two general standards conceptually raise many important issues related to disability inclusiveness namely patient's rights protection, barriers in access to healthcare and health information. For the patient care process, JCI reveals concern for the functional dimension of health through the requirement of functional evaluation and by connecting general healthcare to rehabilitation services, while HAI stands out for its participatory approach but disconnects general healthcare from rehabilitation services by not requiring functional assessment. Neither approach demonstrates significant concern over the determination toward clients' independence nor the social re-integration outcomes.

Analysing the standard for rehabilitation facilities in three countries

We retrieved three international rehabilitation standards for reviews; these are (a) the Standards for the provision of Inpatient Adult Rehabilitation Medicine Services in Public and Private Hospitals 2011 by Australasian Faculty of Rehabilitation Medicine and The Royal Australasian College of Physicians[3] (Australasian Faculty of Rehabilitation Medicine & The Royal Australasian College of Physicians 2011), (b) the 2009 British Society of Rehabilitation Medicine

Standards for Rehabilitation Services Mapped on to the National Service Framework for Long-Term Conditions[4] (British Society of Rehabilitation Medicine 2009), and (c) the 2013 Medical Rehabilitation Standards Manual by Commission on Accreditation of Rehabilitation Facilities, the USA[5] (The Commission on Accreditation of Rehabilitation Facilities 2013).

All three standards emphasize the **accessibility** of the physical environment of health facilities and suggest concrete adaptations are needed. The BSRM and CARF standards show further concern over transportation barriers. Only the CARF standard elaborates concern regarding all barriers and accessibility issues, e.g., attitude, communication, finances, and community integration. It also highlights examples in overcoming barriers in education about medication usage for populations with special needs, e.g. persons' having difficulty in opening medication bottles or living with a vision limitation.

All three standards state clearly the importance of **active participation of clients and families in care processes and decision making** and show substantial concerns over functional evaluation, activity limitation and participation restriction, and even include an adaptive devices provision in order to enhance functional and vocational rehabilitation programmes to support participation. In doing so, they establish the final goal of functional independence and social re-integration.

Among the three standards, only CARF addresses '**Rights of Persons Served'** as a distinct category. The BSRM and AFRM standards do not address the patient's rights. However, the AFRM notes that the facilities should follow the Evaluation and Quality Improvement Programme (EquiP) of the Australian Council of HealthCare Standard (ACHS).

In summary, all three rehabilitation standards include statements about accessibility, express concrete concerns over various kinds of barriers, and emphasize the importance of active participation in decision making along the patient care process, and the goal of achieving functional independence and social re-integration. The right of clients is addressed only in the CARF standard. Additionally, other than functional needs, general healthcare need assessments of persons with disabilities are barely mentioned.

Discussion

The study reveals that rehabilitation standards demonstrate substantial concern with various points of care in addressing the functional dimension of health, including removal of barriers to access services, supporting social re-integration and promoting independence outcomes.

However, only one rehabilitation standard specifically addresses patients' rights, whereas both general health care standards of HAI and JCI clearly express concern for this issue. It appears that the more specialized the standard, the more concerned it is with technical rather than human rights issues. However, it is important to recognize that two of the rehabilitation standards included in the study (the BSRM and AFRM) were developed for specialty rehabilitation programmes where their clients are persons with physical disabilities, which potentially explains their narrow focus. Moreover, the general healthcare needs of persons with disabilities might be unrecognized in specialized rehabilitation facilities.

Nonetheless, rehabilitation is not the only health care requirement for persons with disabilities. Many experts report plenty of unmet health needs, other than rehabilitation, such as, the low level of dental care, pap smears (for cervical cancer screening), mammograms, and treatment of other co-morbidities (Lawthers et al 2003). The UNCRPD distinguishes between health care accessibility and rehabilitation services for persons with disabilities, and stresses the importance of reproductive health and population-based public health programme provision on an equal basis (The Office of the United Nations High Commissioner for Human Rights 2006). In this view, the more inclusive the standards for general healthcare facilities, the greater the benefit for persons with disabilities. As rehabilitation services are often integrated in general health facilities, and specialized rehabilitation facilities are scarce (Kheawcharoen et al 2009), a higher level of inclusiveness in standards for general health is required.

HAI and JCI standards are supposed to guide the patient care process in general healthcare facilities in Thailand. This study reveals the standards have little concern over inclusiveness which may create difficulties for persons with disabilities at several stages of the care process. However, JCI standard picks up '**Functional evaluation'** as the essential requirement which helps link people in need of functional restoration to a specific care pathway such as rehabilitation. HAI, in contrast, fragments care for persons with disabilities in regard to the 'Rehabilitation service' element. Without a pivotal link such as functional evaluation, it does not guarantee that people in need of such care can enter the pathway to rehabilitation, thus exacerbating the fragmented care system inside the hospital. A report by Suksathien (2014) from an accredited regional hospital in Thailand, confirms this situation. In 2012, in that regional hospital, there were 3,026 new stroke patients admitted, only 18.4% received rehabilitation consultation before discharge, and only 23 patients were admitted to rehabilitation ward for intensive rehabilitation programmes.

HAI and JCI share a similar service focus for persons with disabilities – a focus which jumps directly to rehabilitation: in JCI through functional evaluation and in HAI through a specific

section on rehabilitation service. The significant components that both standards leave out are the identification of barriers to care and the requirement to remove such barriers. Even though the HAI standard states *"…the healthcare team seeks to reduce physical, language, cultural, spiritual and other barriers to access of services…",* concrete processes and results of reducing such barriers for disabled population are not required to monitor and hence not a requirement for being accredited. Apparently, both standards also fail to stress removal of explicit barriers such as those within the physical environment. Those more ill-defined barriers, e.g., communication or attitudinal barrier, would almost certainly be left untouched.

The full **substituted decision making** stipulated in the Thai Declaration of Patient's Rights, that forms part of the HAI standard, differs from the World Medical Assembly Declaration of Lisbon on the Rights of the Patient which states '*if a patient is a minor or otherwise legally incompetent, the consent of a legally entitled representative is required. Nevertheless the patient must be involved in the decision-making to the fullest extent allowed by his/her capacity…*' and *'… if the legally incompetent patient can make rational decisions, his/her decisions must be respected…'*(World Medical Assembly 2015). On this issue, there is evidence that substituted decision making especially in reproductive health of persons with disabilities is still widely practiced in Thailand, thus, violating Lisbon Declaration on the Rights of Patient and the basic principle of the UNCRPD. (Disability Thailand and Network of Disability Rights Advocates 2016, ed. Chuengsatiansup 2005)

From this review, it is obvious that the effort to mainstream disability in general healthcare facilities is still lacking. The neglect of these important issues reflects limited understanding in **human rights** based approach in healthcare as required by the UNCRPD and the **functional dimension** of health as indicated in the ICF framework. That internationally accredited standards such as the HAI and JCI are still "disability-neglected", should be of crucial concern to the healthcare community and to all those concerned with ensuring the rights to health of persons with disabilities.

There are certain limitations of this study that must be acknowledged. First, we used a purposive search and retrieval approach to review only two general healthcare standards. Though widely applied in Thailand, they may not be representative of all general healthcare accreditation systems. Second, the rehabilitation standards that were included in the review, especially the AFRM, are supposed to be used in addition to the general healthcare standard which was not reviewed in this paper. Some of the disability inclusive concepts missed by the rehabilitation standards may well be addressed by the general healthcare standards. Third, even though the general healthcare standard is the core component of the accreditation programme, to be able to

evaluate it comprehensively, other elements of the process, including the accreditation survey and organizations' self-assessments, should also be taken into account.

Recommendations and conclusions

With the initial assessment of the standard, a few recommendations towards a more disability-inclusive accreditation programme are offered. To achieve the goal of disability-inclusive healthcare service through hospital accreditation, there needs to be a revision of the general hospital standard, mainstreaming systems of care that recognize and support persons with different abilities, and identify and deliberately remove barriers to services throughout the range of care processes. Emphasis should be given to participation by persons with disabilities who are patients in care provision, both in general health care and rehabilitation. Functional evaluation and restoration through rehabilitation, as one of many needs of persons with disabilities, should be a parallel track in the care process with distinct entry points and integrated in post-hospital care, driven by the concepts of personal independence and social re-integration (as shown in Fig.3). Most importantly, Patient's rights need to be affirmed along the course of health care service.

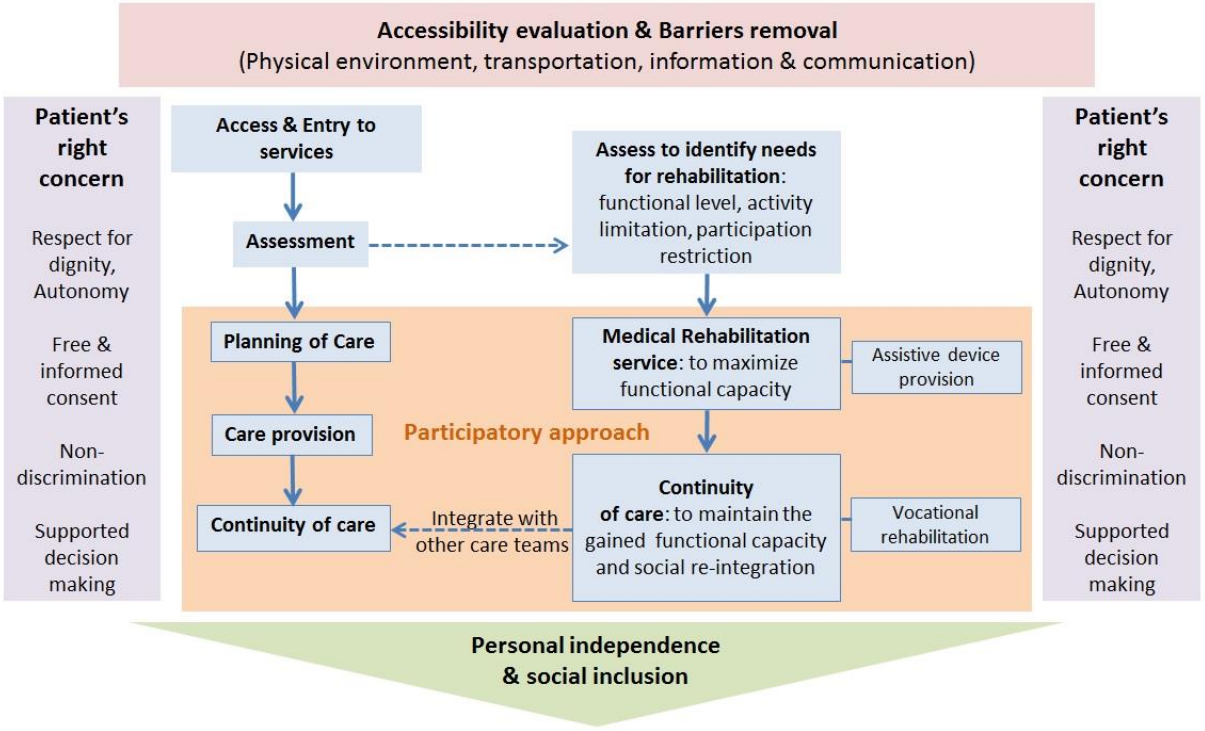

Figure 3: The proposed disability inclusive operational framework for standard revision

We believe standard development and revision should be collaborative learning processes, involving healthcare providers, surveyors, and clients including persons with disabilities, to elaborate detail on each category of the standard, develop the assessment framework, and establish the performance indicators which are disability-inclusive.

This enquiry is a starting point for a long journey of reorienting the accreditation programme toward disability inclusiveness. Further work should take into account the role of surveyors as learning facilitators of the programme and provide them with training in the specific issues of functioning and healthcare needs of the diverse population of persons with disabilities during the survey process. Likewise, a workshop or learning session on disability inclusive health service provision needs to be set for healthcare providers.

The healthcare accreditation programme is one catalyst, among others, for disability-inclusive healthcare development. Many other healthcare policies still need to be advocated, for example, the number and distribution of human resource, health financing systems which facilitate equitable financial access by all, and information systems on disability.

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[1] Later on referred to as JCI standard

[2] As stated in Article 9 of the UNCRPD, accessibility is not only to ensure access to physical environment but also to information and communications, including information and communications technologies and systems. In this sense, access to information and communication in health care service should include the format of language and channel of communication that people with various levels of hearing, intelligence, and cognitive function could receive essential information.

[3] later on referred to as AFRM standard

[4] later on referred to as BSRM standard

[5] later on referred to as the CARF standard