

Why are people with intellectual disabilities clinically vulnerable to COVID-19?



In *The Lancet Public Health*, Maarten Cuypers and colleagues¹ add to the growing literature showing that people with intellectual disabilities were more likely to die from COVID-19 during the first 2 years of the pandemic—in this paper around five-times more likely. Putting these figures into context, around 600 more people with intellectual disabilities died in the Netherlands than would be expected if they had the mortality rates of others in the population. Cuypers and colleagues also showed that this mortality gap existed before the pandemic, and that non-COVID causes of death were elevated for people with intellectual disabilities during the pandemic. Other sources of data show that the adverse impact of COVID-19 for people with intellectual disabilities went beyond mortality risk. For instance, qualitative research highlights the isolation, loneliness, and lost sense of self-worth experienced by people with intellectual disabilities during the COVID-19 pandemic.^{2,3} Family members and caregivers were also put under immense strain.⁴ A key question is why the impact of COVID-19 was greater for people with intellectual disabilities? More fundamentally, why was this group clinically vulnerable?

First, we must consider the nature and cause of vulnerability. Some people with intellectual disabilities have a biological vulnerability to COVID-19. For instance, immune response dysfunction in people with Down syndrome is likely to contribute to their elevated risk of dying from COVID-19—in a study over a 30-times increased risk of death was found.⁵ Other individuals with intellectual disabilities might be at elevated risk of death from COVID-19 because of a high prevalence of other risk factors, such as obesity or diabetes.⁶ However, we must also recognise the discriminatory and exclusionary social structures that create clinical vulnerability in people with disabilities, particularly people with intellectual disabilities. Inaccessible health facilities and health information, removal of social care, a lack of protective measures in care homes, poorly trained health staff, and delayed vaccine prioritisation are all failings that made people with intellectual disabilities clinically vulnerable to COVID-19. People with intellectual disabilities were abandoned and forgotten in government responses to the pandemic

across the world, particularly in the early stages.^{2,4} They were made clinically vulnerable, in part, by neglect.

Sadly, this information is not new. For many years, there has been substantial evidence on health inequalities of people with intellectual disabilities because of structural, societal, and institutional failings, but governments have not adequately responded, entrenching clinical vulnerability.⁷ These failings include the social inequalities for people with disabilities, such as poor access to health care, education, and employment, poverty, and an increased risk of violence and abuse.⁸ These social inequalities further contribute to the clinical vulnerability of people with intellectual disabilities to health issues (including mental health problems). We should not place the burden of clinical vulnerability to COVID-19 (and wider morbidity and mortality) on individual people with intellectual disabilities, but on the failings of our societies, policies, and services.

As we move forward, there is hope and potential power in data, such as the study by Cuypers and colleagues,¹ to highlight and address health risks. Evidence showing that people with intellectual disabilities were more likely to die from COVID-19 allowed them to be prioritised for vaccination in many countries, including in the UK.⁹ As another example, the 2013 UK Confidential Inquiry showed that people with intellectual disabilities were dying 13–20 years earlier than their peers without disabilities, often because of health systems failure.¹⁰ Consequently, the UK National Health Service introduced a range of services to close this gap, including mandatory training of health-care workers about intellectual disability, establishment of a learning disability register, invitation to routine health check-ups, and routine monitoring of the health gaps through the Learning Disability Mortality Review.^{11,12} Although there is huge progress still to be made, we should take inspiration from these concrete examples of how evidence can be transformative. We need to put people with disabilities at the centre of health-care planning and delivery, so that inclusion in health care is not considered nice to have, but is entrenched as a priority and a right. We must not assume that these issues are too expensive or complex to address. There is a growing range of good practice,

Published Online
April 16, 2023
[https://doi.org/10.1016/S2468-2667\(23\)00077-4](https://doi.org/10.1016/S2468-2667(23)00077-4)
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showing how we can create inclusive health systems, and how they are likely to be cost saving and work better for all.^{13,14} In the words of the recently deceased Disability Rights activist Judy Heumann, “most things are possible when you assume problems can be solved”.¹⁵

We declare no competing interests.

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