

Institutional Ableism and The Social Determination of Health A Bioethical Analysis of Healthcare Exclusion of Persons With Disabilities in Peru

Ramírez Preciado Marialita Catalina¹, Eber Wilfredo Zavaleta Llanos², Manuel Guzmán Palomino Márquez³, Doraliza Correa Human⁴

¹mramirez@unab.edu.pe, <https://orcid.org/0000-0003-3714-561X>, Universidad Nacional de Barranca, Barranca, Peru

²eber.zavaleta@usanpedro.edu.pe, <https://orcid.org/0000-0003-1451-4283>, Universidad San Pedro, Chimbote, Peru

³manuel.palomino@usanpedro.edu.pe, <https://orcid.org/0000-0002-7578-7544>, Universidad San Pedro, Chimbote, Peru

⁴doralizac@gmail.com, <https://orcid.org/0000-0002-3723-7277>, Hospital III EsSalud, Chimbote, Chimbote, Peru

Abstract

Objective

Healthcare exclusion of persons with disabilities is often explained in terms of isolated barriers or individual clinical needs. This article offers a different perspective by examining institutional ableism as a process that mediates between social structures, ways of life, and concrete experiences of care. Through a theoretical reflection grounded in conceptual, normative, and empirical sources, it brings together the social determination of health, models of disability, the human rights approach, and bioethics. The analysis shows how infrastructure, procedures, communication, territorial organization, information systems, and professional practices can turn particular physical, sensory, intellectual, and psychosocial capacities into implicit requirements for access. It argues that inclusive healthcare requires moving beyond merely formal equality, guaranteeing comprehensive accessibility and reasonable accommodations, recognizing autonomy with support, and ensuring the meaningful participation of persons with disabilities. Its central contribution is a critical framework for understanding and transforming healthcare exclusion in Peru.

Keywords: disability; ableism; social determination of health; bioethics; accessibility; Peru.

Introduction

Disability is a central public health and human rights issue. The World Health Organization estimates that 1.3 billion people, approximately 16% of the world's population, live with a significant disability. This population experiences poorer health outcomes and avoidable barriers to timely, affordable, and high-quality services (World Health Organization [WHO], 2022).

In Peru, the General Law on Persons with Disabilities and the National Multisectoral Disability Policy for Development to 2030 recognize equality, accessibility, and non-discriminatory care. Yet legal recognition coexists with territorial, economic, communication, administrative, and attitudinal barriers that restrict the effective exercise of the right to health (Congress of the Republic of Peru, 2012; Ministry of Women and Vulnerable Populations [MIMP], 2021). Regional evidence confirms that regulatory progress has not yet been translated consistently into sustained institutional mechanisms (Economic Commission for Latin America and the Caribbean [ECLAC] & Pan American Health Organization [PAHO], 2026).

Some of the literature describes these difficulties as barriers to access, while other studies examine them through models of disability, clinical ethics, or social determinants. Although these contributions are necessary, considering them separately may obscure the process that links them. Institutional ableism helps explain how policies, organizational designs, and professional practices privilege particular ways of functioning and place the burden of adapting to services on individuals (Lundberg & Chen, 2024).

This article aims to analyze healthcare exclusion of persons with disabilities in Peru by integrating the social determination of health, institutional ableism, bioethics, and the human rights approach. It argues that exclusion does not arise exclusively from individual conditions, but from social and institutional processes that turn certain capacities into implicit requirements for receiving care on equal terms. This perspective shifts the response from exceptional accommodation to the structural transformation of services.

Reflective approach

This theoretical reflection article is based on a critical narrative review. The argument integrates foundational works on models of disability and the social determination of health, international instruments and Peruvian regulations, technical reports from public institutions, and academic literature on inequities, ableism, and bioethics. Sources were selected for their conceptual relevance, institutional authority, and direct relationship to the problem under analysis; bibliographic data, DOIs, and official links were verified. Given its nature, the article does not report findings from a primary study. Its contribution is an argumentative synthesis and a conceptual proposal that should subsequently be examined through empirical research.

1 Initial epistemological position

Disability has historically been interpreted from a predominantly biomedical perspective focused on identifying physical, sensory, intellectual, or psychosocial impairments and seeking their correction, rehabilitation, or compensation. From this perspective, the limitations that people experience are attributed mainly to their individual conditions, while the characteristics of the social and institutional environment remain secondary. Consequently, healthcare responses concentrate on intervening in the body considered different, without sufficiently examining the structures that restrict participation, autonomy, and the effective exercise of rights.

The social model and the human rights approach broke with this interpretation. The Convention on the Rights of Persons with Disabilities recognizes that disability arises from the interaction between individual conditions and barriers that hinder full and effective participation on an equal basis with others. This position shifts attention from individual deficit to the responsibility of society and its institutions in producing exclusion. Nevertheless, normative recognition alone does not transform healthcare practices or eliminate the power relations that continue to place persons with disabilities in subordinate positions (United Nations, 2006).

The health inequities experienced by this population cannot be explained solely by greater healthcare needs or by conditions associated with particular impairments. They also reflect inaccessible facilities, transportation difficulties, the absence of information in accessible formats, communication barriers, healthcare costs, fragmented services, and inadequate professional preparation. The World Health Organization warns that persons with disabilities experience persistent inequities in access to timely, affordable, and high-quality services, even though many of these inequities could be prevented through changes in health systems (WHO, 2022).

In Latin America and the Caribbean, regulatory advances have likewise not been translated consistently into inclusive health systems. A recent ECLAC and PAHO report notes that inclusion often continues to depend on isolated actions rather than sustained institutional mechanisms. Weaknesses persist in information systems, the provision of reasonable accommodations, continuity of care, staff training, and the participation of persons with disabilities in health-related decisions (ECLAC & PAHO, 2026).

In Peru, the General Law on Persons with Disabilities recognizes the right to health without discrimination and establishes state responsibilities related to access to services, benefits, and insurance. The existence of this legal framework must, however, be distinguished from its practical realization. A gap may persist between the formally recognized right and the concrete experience of care because of territorial, economic, administrative, communication, and attitudinal barriers (Congress of the Republic of Peru, 2012).

To understand this gap, the article adopts the perspective of the social determination of health. This perspective does not merely list factors associated with a greater or lesser likelihood of receiving care; it seeks to explain the social, economic, political, and institutional processes that produce and unequally distribute opportunities for healthy living. From this standpoint, healthcare exclusion is not an accidental accumulation of independent obstacles. It reflects a form of social organization that determines which bodies and modes of functioning are regarded as normal, productive, autonomous, and fully recognizable (Breilh, 2013).

The concept of institutional ableism is therefore relevant. It refers to the values, norms, designs, and practices that treat particular physical and mental capacities as the standard of normality. Ableism is not limited to overt

discrimination. It also appears when a facility is designed on the assumption that everyone can walk, see, hear, understand standardized instructions, move without assistance, or communicate decisions independently through speech. It is also present in paternalistic practices, infantilization, assumptions of incapacity to decide, and the automatic attribution of any health problem to a pre-existing disability. Contemporary literature identifies these manifestations as forms of structural ableism that can affect access, quality of care, and health outcomes (Lundberg & Chen, 2024).

This position does not disregard the bodily dimension of disability or deny the need for clinical care, rehabilitation, assistive technology, or specialized care. Its purpose is to prevent bodily conditions from becoming a total explanation for experienced disadvantage. Disability is shaped by a dynamic relationship among embodiment, living conditions, environmental barriers, institutional organization, and power relations. The body cannot be understood in isolation from society, nor should social barriers be analyzed while disregarding each person's concrete and diverse needs.

From this perspective, vulnerability is not considered a natural or permanent characteristic of persons with disabilities. Many situations described as vulnerability are socially produced through a lack of support, imposed dependency, poverty, inaccessibility, and exclusion from decision-making spaces. This distinction has a fundamental bioethical implication: it shifts the response from paternalistic protection toward the guarantee of autonomy, justice, accessibility, support for decision-making, and effective participation (Guidry-Grimes, 2022).

Accordingly, this article argues that healthcare exclusion of persons with disabilities in Peru does not arise exclusively from individual impairments, but from processes of social determination shaped by institutional ableism. Overcoming this exclusion requires more than expanding coverage or adopting general rules. It requires transforming how services are conceived, organized, financed, and evaluated, while recognizing the experience of persons with disabilities as a legitimate source of knowledge and a basis for health-related decisions.

2 From bodily normalization to recognition of disability as a rights issue

How a society understands disability determines the responses it considers legitimate. Healthcare practices, public policies, and professional relationships are not neutral; they express particular understandings of normality, autonomy, dependency, and human worth. Reviewing models of disability is therefore more than a historical exercise. It provides a way to identify the ideas that continue to shape the organization of health services.

Agustina Palacios distinguishes three major historical models: the exclusionary model, the rehabilitation model, and the social model. They should not be understood as stages that have been fully overcome. Although contemporary regulations recognize the social and rights-based approach, welfare-oriented, rehabilitative, and exclusionary practices may coexist within institutions (Palacios, 2008).

2.1 The exclusionary model and lives considered unnecessary

In the exclusionary model, disability was associated with religious explanations, punishment, family misfortune, or supposed social uselessness. Persons with disabilities were subjected to marginalization, concealment, institutionalization, or charitable dependency. Their existence was valued according to the burden they were presumed to place on the family or community.

Although these expressions may appear remote, some of their assumptions persist when a person with a disability is thought to have an inevitably tragic, unproductive, or unfulfilling life. They also reappear when healthcare decisions are made on the premise that certain lives have a lower quality or merit fewer resources.

From a bioethical perspective, this view is incompatible with the recognition of human dignity as an intrinsic value. Dignity does not depend on productivity, physical independence, cognitive performance, or the ability to conform to a dominant bodily model.

2.2 The medical rehabilitation model and normalization of the individual

The medical rehabilitation model represented progress over absolute exclusion because it recognized that people could receive treatment, rehabilitation, education, and assistance. However, it located the source of the problem mainly in the individual's body or mind. Disability came to be interpreted as a deviation from functioning considered normal.

From this perspective, professional intervention seeks to cure, correct, compensate for, or move the person closer to prevailing standards of functioning. The professional assumes a central position as expert, while the person may be reduced to the role of patient, recipient of instructions, and object of technical decisions.

The problem does not lie in rehabilitation itself. Rehabilitation, assistive technology, medication, and specialized care can expand opportunities for action and improve well-being. The difficulty arises when rehabilitation becomes the only response and inclusion depends on the person changing their body, behavior, or way of communicating.

The prevailing question in this model is, 'What limitation does this person have?' Responsibility for adaptation rests with the individual, while the environment remains largely unquestioned.

2.3 The biopsychosocial model and its advances and ambiguities

The International Classification of Functioning, Disability and Health introduced a broader understanding by recognizing the interaction among health conditions, body functions and structures, activities, participation, and contextual factors. Disability was no longer explained exclusively through diagnosis and began to be understood as a multidimensional experience (WHO, 2001).

This perspective offers important advantages for healthcare because it supports the identification of barriers and facilitators, the assessment of participation, and a view in which clinical diagnosis is not the only source of information. It can also contribute to individualized support planning and interdisciplinary interventions.

Its application is not free of tension. When social factors are treated only as additional variables in a clinical assessment, the biomedical component may retain its dominant position. The environment then appears as one more element to be measured, but not necessarily as an expression of power relations, political decisions, or structural inequalities.

Including environmental factors does not therefore amount automatically to adopting a critical perspective. A facility may use biopsychosocial language while continuing to organize care without accessibility, reasonable accommodations, or the effective participation of persons with disabilities.

2.4 The social model and shifting attention to barriers

The social model distinguishes between a physical or functional condition and disability produced through social barriers. Its main contribution is to challenge the idea that disadvantage is a natural and inevitable consequence of impairment. A person may have a functional limitation, but the organization of the environment turns that difference into exclusion (Palacios, 2008).

From this perspective, stairs without an accessible alternative, the absence of a sign language interpreter, an incomprehensible informed-consent form, or a digital system incompatible with screen readers are not individual difficulties. They are institutional decisions designed around an assumed user: someone who walks, sees, hears, understands, and communicates according to standardized parameters.

The social model changes the initial question. The issue is no longer only what limitation the person has, but rather, 'What barriers has the institution created, and why do they continue to exist?'

A rigid interpretation of the social model could, however, minimize bodily experiences, pain, fatigue, support needs, or the importance of particular clinical interventions. This analysis does not adopt that extreme interpretation. It recognizes that the experience of disability encompasses both embodiment and environment, but that inequality emerges when society distributes resources, support, and opportunities for participation unjustly.

2.5 The human rights model from recipient of assistance to rights holder

The Convention on the Rights of Persons with Disabilities legally consolidated the paradigm shift. Persons with disabilities ceased to be understood solely as recipients of assistance and were recognized as rights holders with the capacity to participate in decisions that affect their lives.

This approach establishes concrete obligations for states and institutions: to eliminate discrimination, guarantee accessibility, provide reasonable accommodations, recognize legal capacity, and ensure the right to the highest attainable standard of health without discrimination. Article 25 of the Convention specifically establishes the right of persons with disabilities to access health services of the same range, quality, and standard as those provided to others (United Nations, 2006).

The rights-based approach also changes the clinical relationship. Autonomy cannot be reduced to signing an informed-consent form. It requires accessible information, sufficient time, support to understand and decide, respect for diverse forms of communication, and recognition of the person's preferences (Committee on the Rights of Persons with Disabilities, 2014).

Likewise, reasonable accommodations are not favors, privileges, or voluntary expressions of solidarity. They are necessary measures for ensuring substantive equality, and their denial may constitute discrimination.

2.6 The coexistence of models in health services

The main tension today does not lie in an absolute absence of standards, but in the contradictory coexistence of different models. An institution may claim to follow a rights-based approach while simultaneously doing the following:

- Maintaining inaccessible infrastructure.
- Addressing a companion instead of speaking to the person.
- Assuming incapacity to make decisions.
- Failing to provide information in accessible formats.
- Requiring administrative procedures that do not allow accommodations.
- Reducing all health needs to the disability diagnosis.
- Treating everyone identically under the assumption that this constitutes equal treatment.

This coexistence shows that a transition to the rights-based approach cannot be achieved through terminology alone. It requires changes in the distribution of power within health services, planning criteria, professional education, and the mechanisms used to evaluate quality of care.

Table 1. Models of disability and institutional responses

Model	Location of the problem	Predominant response	Position of the person
Exclusionary	Existence considered undesirable or unproductive	Segregation, concealment, or charity	Object of compassion
Medical rehabilitation	Individual impairment	Treatment, correction, and rehabilitation	Patient
Biopsychosocial	Interaction between health condition and context	Multidimensional assessment	Service user
Social	Barriers constructed by society	Accessibility and removal of barriers	Social actor

Model	Location of the problem	Predominant response	Position of the person
Human rights	Discrimination and structural inequality	Guarantees, reasonable accommodations, and participation	Rights holder

The analysis indicates that the human rights model provides the normative horizon, but requires the social determination of health to explain why barriers persist despite legal prohibition. In turn, the social determination of health must incorporate ableism as a specific power relation through which certain bodies and modes of functioning are privileged over others.

This articulation is the article's original core argument: healthcare exclusion is neither solely a lack of accessibility nor merely regulatory noncompliance. It results from social and institutional processes that turn certain capacities into implicit requirements for receiving care on equal terms.

3 Disability and the social determination of health among structures ways of life and individual experiences

The social determinants approach generally identifies circumstances associated with health inequalities, including income, education, employment, housing, gender, and territory. Although this perspective broadens analysis beyond biological factors, it can present reality as a sum of independent variables. The social determination of health offers a different interpretation by seeking to understand the historical processes and power relations that produce, organize, and reproduce these inequalities.

From this perspective, disability should not be included only as a demographic variable or an individual characteristic associated with greater health risk. Analysis must address how economic, political, cultural, and institutional arrangements shape the conditions in which persons with disabilities are born, live, work, receive care, and access health services.

Breilh proposes that health processes are produced through the relationship among general, particular, and singular dimensions. These dimensions are neither separate levels nor a linear chain of causes. They interact dynamically: social structures condition collective ways of life, which in turn find differentiated expression in each person's body, experiences, and opportunities for action (Breilh, 2013).

3.1 General dimension social organization and the structural production of exclusion

The general dimension encompasses the economic, political, and cultural organization of society. In disability, it includes the orientation of public policies, healthcare financing, the territorial distribution of services, labor market conditions, social protection systems, and the criteria used to determine who may access particular rights.

At this level, ableism operates when institutions are designed around a body and mind considered standard. Accessibility becomes a later adaptation instead of an original planning principle. People who do not conform to the anticipated user must prove their condition, apply for exceptions, or depend on institutional discretion to receive support.

Protective legislation is a necessary advance, but it does not eliminate these relationships by itself. In the absence of funding, oversight, disaggregated information, professional education, and enforcement mechanisms, a right may be recognized formally yet restricted in practice.

The territorial distribution of resources also belongs to this dimension. Concentrating specialists, rehabilitation services, and assistive technologies in particular cities can produce lengthy journeys, higher costs, and discontinuity of care. The healthcare barrier therefore arises not only from an individual condition, but from a historical decision about where and for whom services are organized.

3.2 Particular dimension ways of life and cumulative inequalities

The particular dimension concerns the ways of life of social groups. It reveals that persons with disabilities do not constitute a homogeneous population. Their opportunities differ by gender, age, socioeconomic position, employment, ethnicity, territory, family networks, type of disability, and support needs.

Disability can interact with pre-existing inequalities and produce cumulative disadvantage. A woman with a disability who lives in a rural area, has no income of her own, and depends on others for transportation does not face a single barrier. She experiences the intersection of territorial inequality, economic dependency, the family organization of care, gender discrimination, and healthcare inaccessibility.

This dimension also includes the strategies that families develop in response to limitations in public systems. Households may pay for transportation, medication, therapy, assistive devices, or care that is not covered. When institutional responses are insufficient, responsibility shifts to families and, within them, frequently to women.

Dependency does not therefore always arise directly from impairment. It may be increased by the absence of accessible transportation, personal assistance, assistive technology, sufficient income, or nearby services. A society that does not provide support ultimately attributes to individuals the limitations that it helps produce.

3.3 Singular dimension embodiment and the concrete experience of care

The singular dimension encompasses each person's bodily, subjective, and everyday experience. It includes health conditions, functional possibilities, support needs, decision-making capacity, and relationships with health professionals.

At this level, ableism may be expressed through seemingly ordinary practices: speaking only to a companion, simplifying information without checking understanding, assuming that the person has no sexual life, attributing every symptom to the disability, or considering their participation in decisions unnecessary.

These practices have bioethical consequences. Infantilization undermines dignity; inaccessible information limits autonomy; the absence of reasonable accommodations produces discrimination; and the automatic attribution of symptoms to a pre-existing disability can compromise safety and quality of care.

Focusing only on clinical interaction, however, may place responsibility entirely on the professional. Individual attitudes develop within institutions that impose short consultation times, lack inclusive protocols, fail to provide communication resources, and offer little disability-related training. Professional conduct must be examined together with the institutional conditions that encourage or normalize it.

3.4 Relationship among the three dimensions

Healthcare exclusion is produced through the interaction of all three dimensions:

Table 2. Social determination of healthcare exclusion

Dimension	Disability-related processes	Healthcare expressions
General	Policies, financing, centralization, social protection, and conceptions of normality	Services not universally designed and rights without sufficient implementation

Dimension	Disability-related processes	Healthcare expressions
Particular	Gender, poverty, territory, employment, family networks, and support needs	Additional expenses, discontinuity of care, and cumulative barriers
Singular	Embodiment, communication, autonomy, and clinical experience	Infantilization, inaccessible care, paternalism, and delayed diagnoses

An underfunded policy at the general level can create service shortages in particular territories. This situation alters families' ways of life at the particular level and ultimately appears at the singular level as delay, treatment discontinuation, or loss of autonomy.

The movement can also occur in the opposite direction. When individual experiences are recognized collectively and transformed into social participation, they can challenge institutional practices and promote regulatory change. Persons with disabilities are not passive recipients of structural conditions; they can organize, produce knowledge, and transform the policies that affect their lives.

4 Institutional ableism in health services

Institutional ableism is not limited to explicit discriminatory behavior. It is also embedded in infrastructure, regulations, administrative procedures, information systems, and professional practices that assume a nondisabled user. Under these conditions, the person must adapt to the service rather than the service responding to human diversity (Iezzoni et al., 2021; Krahn et al., 2015; Lundberg & Chen, 2024).

The World Health Organization recognizes that persons with disabilities experience inequities associated with structural and social factors and with characteristics of health systems. These inequities include physical, communication, economic, and attitudinal barriers that affect the availability, accessibility, acceptability, and quality of care (WHO, 2022).

4.1 A narrow understanding of physical accessibility

Accessibility is often equated only with the presence of ramps or elevators. A service may nevertheless have a ramp and remain inaccessible because of narrow doors, inadequate signage, fixed furniture, nonadjustable equipment, or toilets that cannot be used independently.

In healthcare, inaccessibility can also be found in examination tables, scales, diagnostic equipment, and gynecological units designed for a single bodily and functional standard. When an institution lacks accessible equipment, an examination may be incomplete or omitted altogether. A failure of institutional design thus results in lower-quality care.

From the perspective of health justice, enabling physical entry to a facility is insufficient. A person must be able to move through it, use its services, undergo necessary procedures, and communicate under safe and dignified conditions.

4.2 Communication barriers and unequal access to information

Communication is an essential condition of care. Many services, however, continue to rely almost exclusively on spoken language, complex printed documents, and digital platforms that are not always compatible with assistive technologies.

Deaf people may encounter difficulties because interpreters or alternative means of communication are unavailable. Persons with visual disabilities may receive prescriptions, consent forms, or instructions that they cannot read independently. Persons with intellectual disabilities may encounter overly technical information without easy-to-read formats or sufficient time to understand it.

These barriers directly affect informed consent. A signature does not demonstrate an autonomous decision when information has not been provided in an understandable and accessible format. The ethical obligation is not simply to deliver information, but to create the conditions in which a person can understand, ask questions, deliberate, and decide.

4.3 Substitution of the person's voice and clinical paternalism

A common manifestation of ableism occurs when a professional addresses a family member or companion even though the person can participate in the conversation. This practice displaces the person's voice and reinforces the assumption that disability is equivalent to an inability to understand or decide.

Support from another person may be necessary and legitimate, but it must not automatically replace the person's will. The rights-based approach requires recognition of different forms of communication and the provision of decision-making support before representation is considered.

Paternalism may also appear as protection. Deciding for a person 'for their own good' without exploring their preferences can restrict autonomy and consolidate dependency. Ethical care requires balancing care with respect for the person's will and preventing protection from becoming control.

4.4 Infantilization and denial of adult life

Persons with disabilities may be addressed through expressions, tones, or attitudes that are inappropriate for their age. Infantilization symbolically diminishes their status as citizens and may affect decisions concerning sexuality, reproduction, motherhood, fatherhood, and family formation.

This situation is particularly concerning in sexual and reproductive health. Assumptions of asexuality can lead to the omission of counseling, preventive tests, or information about contraception. Conversely, a belief that a person should not reproduce can result in pressure or interventions contrary to their will.

Respect for dignity requires understanding that support needs do not eliminate adult status or justify denying the right to make decisions about one's own body.

4.5 Diagnostic overshadowing

Diagnostic overshadowing occurs when a symptom or health problem is automatically attributed to a pre-existing disability. This practice can prevent a comprehensive clinical assessment and delay the identification of illnesses unrelated to the underlying condition (Hallyburton, 2022).

Pain, changes in behavior, fatigue, or communication difficulties, for example, may be interpreted as inevitable manifestations of disability. As a result, the examination may be less thorough, suffering may be normalized, or diagnostic procedures may be omitted.

Ableism in this context is not an explicit refusal to provide care, but a diminished clinical expectation. Particular levels of discomfort, dependency, or deterioration are presumed to be a natural part of life with disability. This normalization can violate the principles of beneficence and nonmaleficence.

4.6 Fragmentation of care

Another problem arises when care focuses exclusively on rehabilitation or on the condition that led to recognition

of the disability. General health needs may be neglected, including prevention, vaccination, mental health, sexual and reproductive health, chronic disease management, and early detection. The person is treated as a 'rehabilitation patient,' 'psychiatric patient,' or 'neurological patient' rather than as someone with comprehensive health needs. This fragmentation reproduces a reductionist view and may undermine continuity of care across levels and specialties.

4.7 Denial of reasonable accommodations

Reasonable accommodations are necessary and appropriate modifications that enable a person to exercise rights on an equal basis with others, provided that they do not impose a disproportionate burden. In healthcare, they may include the following:

- ☐Allowing a reasonably longer consultation.
- ☐Providing an alternative method for requesting appointments.
- ☐Providing accessible information.
- ☐Facilitating communication support.
- ☐Adapting the clinical procedure.
- ☐Allowing a support person to be present when requested.
- ☐Modifying procedures that create an unnecessary barrier.

Their absence is often justified by stating that 'the procedure is the same for everyone.' Yet providing exactly the same response to people in different circumstances can reproduce inequality. Justice does not require uniformity, but effective conditions that allow each person to exercise the same right.

4.8 Invisibility in information systems

The lack of complete, disaggregated data is another form of exclusion. When health systems do not adequately record disability, support needs, experienced barriers, or accommodations provided, this population remains underrepresented in planning.

Statistical invisibility can create a persistent cycle: a lack of information restricts policymaking, absent policies maintain barriers, and these barriers further impede access and registration. ECLAC has emphasized that improving data sources from a social and rights-based perspective is essential for designing inclusive policies (García, 2025).

Analytical synthesis

The manifestations described above reveal four expressions of institutional ableism:

Table 3. Expressions of institutional ableism

Expression	Manifestation	Bioethical consequence
Material	Inaccess ble infrastructure and equipment	Inequality and safety risks
Communication	Inaccessible information and consent processes	Restricted autonomy

Expression	Manifestation	Bioethical consequence
Relational	Paternalism, infantilization, and substitution of the person's voice	Violation of dignity
Organizational	Rigid procedures, fragmentation, and lack of data	Exclusion and unjust distribution of resources

These expressions do not operate in isolation. A physical barrier may combine with economic difficulties, inadequate communication, and paternalistic attitudes to produce cumulative experiences of exclusion. Institutional ableism should therefore be understood as a structural process rather than merely as a lack of individual sensitivity. Staff training is necessary but insufficient unless infrastructure, procedures, financing, information systems, and participation mechanisms are transformed at the same time.

5 Disability and intersecting inequities of gender poverty territory and dependency

Persons with disabilities do not constitute a homogeneous group. The experience of disability is shaped differently by gender, age, economic circumstances, territory, ethnicity, type of disability, and support needs. These conditions neither operate in isolation nor simply add disadvantages; they interact and produce particular forms of exclusion.

An intersectional perspective shows that the same policy or health service may produce different outcomes depending on a person's social position. It is therefore insufficient to compare people with and without disabilities. Inequalities within the population of persons with disabilities must also be examined.

5.1 Gender and disability

Women with disabilities may experience simultaneous discrimination based on gender and disability. Stereotypes that portray them as dependent, asexual, incapable of motherhood, or permanently in need of protection affect their family relationships and healthcare experiences.

These representations are particularly relevant in sexual and reproductive health services. Physical barriers to gynecological equipment, the absence of understandable information, and the tendency to direct decisions toward relatives or caregivers can restrict autonomy.

There may also be risks of violence, reproductive coercion, or interventions performed without sufficiently free and informed consent. Difficulties reporting abuse, economic dependency, and the lack of accessible channels increase exposure and reduce opportunities to receive timely protection.

Women with disabilities should not be regarded solely as recipients of care. Many simultaneously manage self-care, paid work, family care, and household responsibilities. Ignoring these responsibilities reproduces the assumption that disability automatically removes their capacity to contribute, decide, and care for others.

The Committee on the Rights of Persons with Disabilities recognizes that women and girls with disabilities face multiple and intersecting forms of discrimination that require responses sensitive to both gender and disability (Committee on the Rights of Persons with Disabilities, 2016).

5.2 Disability and poverty as a bidirectional relationship

The relationship between disability and poverty should not be interpreted as inevitable. Disability can increase

particular expenses and restrict economic opportunities when accessible services, social protection, and reasonable accommodations are absent. At the same time, poverty increases exposure to unsafe working conditions, delayed care, inadequate nutrition, and difficulties accessing prevention and rehabilitation (WHO, 2022).

Households may bear additional costs for transportation, medication, therapy, assistive devices, home adaptations, or care. Even when a consultation is covered, these indirect costs can make formal access materially unattainable.

Labor exclusion intensifies this process. A lack of personal income may limit the ability to choose providers, purchase assistive technology, or travel to specialized facilities. It may also increase dependency on relatives and reduce the person's bargaining power within the household.

A circular process thus emerges: social barriers restrict economic opportunities, economic insecurity hinders access to healthcare, and inadequate care can intensify limitations and support needs. The problem does not reside exclusively in disability, but in a social organization that distributes resources and opportunities unequally.

5.3 Territory and healthcare centralization

Territory is more than the place where a person lives. It reflects the unequal distribution of infrastructure, professionals, transportation, information, and institutional power.

Persons with disabilities who live in rural or remote areas may face long distances, higher transportation costs, and limited availability of specialists, rehabilitation, and assistive technologies. Inaccessible transportation may force them to depend on others, reschedule appointments, or discontinue follow-up (García, 2025; MIMP, 2021).

Territorial barriers also affect people who live on urban peripheries. The presence of a facility in the same city does not guarantee accessibility when transportation, pedestrian routes, or appointment procedures remain exclusionary.

Centralization also creates a silent transfer of costs to individuals and their families. The system offers a service at a particular location, but users must arrange transportation, lodging, time away from work, and a companion. Institutional coverage can therefore be maintained while effective access remains restricted.

5.4 Produced dependency and the absence of support

Dependency is often attributed directly to individual characteristics. A substantial part of it, however, may be produced or intensified by a lack of support and by environments that do not permit autonomous action.

A person may require assistance with particular activities without being unable to direct their own life. The need for support must be distinguished from substituted decision-making. Confusing the two promotes paternalism and exclusion from decision-making processes.

Autonomy should not be understood as absolute self-sufficiency. All human beings live through relationships of interdependence. The difference is that some forms of support are socially normalized, while others are used to classify people as dependent.

This distinction is fundamental in bioethics. A relational conception of autonomy recognizes that decisions are exercised under social conditions and with support. Strengthening autonomy therefore does not mean withdrawing care; it means ensuring that care respects the person's will, preferences, and life plans (Ho, 2008).

5.5 The family and the feminization of care

When health and social systems do not provide sufficient support, care shifts to families. Within families, women - mothers, daughters, wives, or sisters - often bear a disproportionate share.

This arrangement may generate physical, emotional, and financial strain. It can also create complex relationships in which the person with a disability and the caregiver both experience restrictions on autonomy.

It would be inappropriate to blame families individually for overprotective practices without examining the context

in which they occur. In many cases, families are responding to real risks in unsafe and inaccessible environments. Transformation requires support services, respite care, personal assistance, and social protection, not merely recommendations about family attitudes.

5.6 Cumulative inequalities in healthcare

The conditions described above may converge in a single experience:

Table 4. Intersecting inequalities in healthcare

Social position	Predominant barrier	Possible consequence
Woman with a disability	Stereotypes and substituted decision-making	Restriction of sexual and reproductive rights
Person with a low income	Direct and indirect costs	Postponement or discontinuation of care
Person living in a rural area	Distance and limited services	Discontinuity of care
Person with extensive support needs	Lack of assistance and accessible communication	Imposed dependency
Caregiver without social protection	Overload and loss of income	Deterioration of their health and the family system

These circumstances should not be used to classify people as intrinsically vulnerable. What should be described as vulnerable is the social position produced by a lack of resources, support, and institutional guarantees.

6 Toward a bioethics of disability dignity autonomy justice and care

The relationship between bioethics and disability has been marked by persistent tension. On the one hand, bioethics provides principles for protecting people's dignity, autonomy, and rights. On the other, some bioethical reasoning has reproduced ableist conceptions by linking the value of life to independence, rationality, productivity, or particular standards of quality of life (Guidry-Grimes, 2022).

It is therefore insufficient to apply the principles of autonomy, beneficence, nonmaleficence, and justice mechanically. Their interpretation, the authority that defines their content, and the conception of the human being underlying clinical and institutional decisions must also be examined.

6.1 Dignity beyond capacity and productivity

Dignity is inherent in every person. It does not depend on level of functioning, cognitive capacity, speech, physical independence, or economic contribution. Yet some healthcare practices may establish implicit hierarchies between lives considered autonomous and lives interpreted as dependent, impaired, or of lower quality.

These judgments appear when professionals presume that life with a disability is necessarily tragic, project their own fears onto a person, or treat dependency as an automatic indicator of indignity. Such assessments may affect clinical recommendations, resource allocation, and treatment decisions.

Respect for dignity requires distinguishing actual experiences of suffering from prejudices about what makes a life valuable. A person may experience pain, limitations, or intensive support needs without any reduction in moral worth or any basis for assuming that their life lacks well-being, relationships, projects, or meaning.

6.2 From individual to relational autonomy

The classical conception of autonomy generally imagines an independent, rational, fully informed person who can

decide without assistance. This ideal can exclude people who need support to understand information, communicate, or express their preferences.

Relational autonomy recognizes that human decisions are formed within family, social, and institutional relationships. No one decides in complete isolation. Relationships can promote autonomy by providing information, trust, and support, but they can also restrict it through coercion, overprotection, or substituted decision-making.

In disability, respect for autonomy requires identifying the person's forms of communication, adapting information, and offering support before concluding that they cannot decide. The Convention on the Rights of Persons with Disabilities requires recognition of legal capacity on an equal basis with others and the provision of the support needed to exercise it (Committee on the Rights of Persons with Disabilities, 2014).

Supported decision-making does not mean deciding what another person considers most beneficial. Its purpose is to help the individual understand alternatives, assess their consequences, and express their own will and preferences.

6.3 Beneficence without paternalism

Beneficence requires promoting well-being, but it can become paternalism when a professional unilaterally defines what is best. This risk increases when disability is assumed to limit a person's general capacity to understand or direct their own life.

Caring does not mean automatically substituting another person's judgment. Beneficent intervention must be developed through dialogue and consideration of the person's values, priorities, and projects. A technically correct decision may be ethically inappropriate if it disregards the person's will or imposes an ideal of normality that they do not share.

Protection is legitimate when it strengthens a person's capacity to act and reduces risks without unnecessarily eliminating freedom. It becomes domination when it restricts rights on the basis of diagnoses, stereotypes, or institutional fears alone.

6.4 Nonmaleficence and harms produced by exclusion

The principle of nonmaleficence is generally associated with avoiding direct clinical harm. Institutions can also cause harm through omissions, delays, inaccessible information, a lack of reasonable accommodations, or fragmented care.

Harm may be physical when inaccessible equipment prevents an adequate assessment, psychological when a person is humiliated or infantilized, moral when their voice is ignored, and social when institutional barriers increase dependency.

From this perspective, patient safety must incorporate accessibility. A service that cannot communicate adequately with a person or lacks the means to examine them safely presents a clinical risk, not merely an administrative deficiency.

6.5 Justice from formal equality to substantive equality

Formal equality provides everyone with the same rules and procedures. Applying a rule identically, however, may produce unequal outcomes when people have different needs.

Substantive justice requires identifying and removing barriers that prevent people from exercising their rights. Within this framework, reasonable accommodations are not privileged concessions, but instruments of equality. Extending consultation time, changing a communication method, or adapting a procedure enables the person to exercise the same right effectively.

Health justice also requires examining the distribution of resources. Expanding coverage is insufficient when services remain territorially concentrated, inaccessible, or impose excessive costs on families.

6.6 An ethics of care without imposed dependency

The ethics of care recognizes human fragility, interdependence, and responsibility toward others. These contributions are especially valuable in challenging the ideal of self-sufficiency that dominates some conceptions of autonomy.

Care must nevertheless be examined critically. It can become control when a caregiver monopolizes information, restricts activities, or replaces the person's decisions. It may also be unjust when responsibility falls entirely on the family and particularly on women.

Ethically appropriate care must meet three conditions: it must respond to actual needs, respect the recipient's will, and receive social and institutional support. Care should not be used to justify imposed dependency or conceal the absence of public policies.

6.7 Questioning intrinsic vulnerability

The Universal Declaration on Bioethics and Human Rights recognizes the need to protect human vulnerability and respect personal integrity (UNESCO, 2005). This principle is fundamental, but its application requires caution.

Classifying persons with disabilities broadly as a 'vulnerable population' can reinforce an image of fragility, dependency, and incapacity. The label may justify protective measures that exclude their participation and reduce their opportunities to decide.

It is more precise to distinguish three dimensions:

Table 5. Dimensions of vulnerability

Dimension	Meaning
Human vulnerability	Fragility shared by all people
Situational vulnerability	Risk produced by a specific circumstance
Structural vulnerability	Exposure to harm generated by inequalities and power relations

Disability does not automatically constitute vulnerability. A person may face greater risk because of inaccessible services, poverty, violence, discrimination, or a lack of support. In these circumstances, the ethical response should not merely protect the individual; it should transform the conditions that produce the risk.

Bioethical literature warns that attributing generalized vulnerability to persons with disabilities can turn them into infantilized objects of paternalistic protection (Guidry-Grimes, 2022).

6.8 Epistemic justice and participation

Knowledge about disability has often been produced without sufficient participation by those who live these experiences. Professionals, managers, and relatives may speak on their behalf while their testimony is treated as subjective or secondary.

Epistemic justice requires recognizing persons with disabilities as legitimate producers of knowledge. Their experience can reveal barriers that are not always visible to those who design or manage services.

Participation should not be limited to validating decisions already made. It must be incorporated into policymaking, protocol development, quality assessment, and health research. The principle expressed by the disability movement - 'nothing about us without us' - represents both an ethical and a methodological requirement (United Nations, 2006).

7 From declarative inclusion to transformative healthcare practice

Normative recognition of the rights of persons with disabilities is essential, but it does not by itself guarantee inclusive care. Transformation requires changing the structures, procedures, and relationships through which services produce accessibility or exclusion.

Transformative practice cannot be limited to isolated interventions, awareness campaigns, or commemorative activities. It must mainstream disability throughout health system planning, financing, service delivery, evaluation, and oversight.

7.1 Incorporating disability into health planning

Inclusion must be considered when policies, facilities, programs, and services are designed. When it is incorporated only after a barrier has been identified, accessibility is reduced to an exceptional accommodation.

Inclusive planning requires the following:

- ☐ Specific and verifiable funding.
- ☐ Accessibility-related goals and indicators.
- ☐ Territorial distribution of services and assistive technologies.
- ☐ Protocols for providing reasonable accommodations.
- ☐ Participation of people with different types of disabilities.
- ☐ Oversight and accountability mechanisms.

Disability must not be confined to specialized or rehabilitation services. It should be incorporated into primary care, mental health, sexual and reproductive health, disease prevention, emergency care, chronic disease management, and palliative care.

7.2 Moving from physical access to comprehensive accessibility

Inclusive care requires physical, communication, cognitive, digital, economic, and attitudinal accessibility. These dimensions must be assessed together.

Table 6. Dimensions of comprehensive accessibility

Dimension	Required transformation
Physical	Accessible infrastructure, furniture, and clinical equipment
Communication	Sign language, captioning, and alternative media
Cognitive	Clear information, easy-to-read materials, and support for understanding
Digital	Platforms compatible with assistive technologies
Economic	Reduction of direct and indirect costs
Attitudinal	Elimination of paternalism and stereotypes
Administrative	Flexible procedures and reasonable accommodations

Comprehensive accessibility must form part of quality and patient-safety standards. It cannot depend exclusively on an individual request because many barriers are foreseeable and should be removed through universal design.

7.3 Institutionalizing reasonable accommodations

Facilities need clear procedures for requesting, providing, and recording reasonable accommodations. Without an institutional pathway, each person must negotiate their conditions of care individually.

The procedure should define the following:

1. How a support need is identified.
2. Who receives and assesses the request.
3. Which measures can be adopted immediately.
4. How the accommodation provided is documented.
5. Which mechanism is activated when a request is denied.
6. How continuity is ensured in future care.

The decision about an accommodation must be made with the person. An institution should not define the support someone needs unilaterally without knowing their preferences and experience.

7.4 Transforming the clinical relationship

Inclusive care requires a professional relationship based on recognition, listening, and participation. The following practices should be treated as minimum standards:

- ☐ Speak directly to the person.
- ☐ Ask how the person prefers to communicate.
- ☐ Avoid assumptions about the person's capacity.
- ☐ Provide information in understandable formats.
- ☐ Allow reasonable time for questions.
- ☐ Identify support chosen by the person.
- ☐ Confirm understanding without infantilizing.
- ☐ Consider the person's health needs comprehensively.
- ☐ Avoid attributing every symptom to the disability.

These practices do not depend exclusively on professional goodwill. Institutions must provide the time, resources, protocols, and training needed to make them possible.

7.5 Critical and context-sensitive professional education

Training should not be limited to describing types of disability or legal rules. It must examine prejudices concerning dependency, capacity, sexuality, productivity, and quality of life.

Education should incorporate experiences narrated by persons with disabilities, case analysis, simulation of reasonable accommodations, and bioethical reflection. It should also develop competencies for accessible communication and supported decision-making.

This transformation is especially relevant in nursing because of the continuity and proximity of care. Nurses can identify barriers, facilitate communication, protect autonomy, and coordinate support. They must also review overprotective practices that, although motivated by care, may unnecessarily replace the person's voice.

7.6 Producing information for action and accountability

Information systems should record disability variables using comparable criteria that respect the rights-based approach. They also need to document encountered barriers, accommodations provided, and gaps in continuity and quality.

Knowing how many persons with disabilities use services is insufficient. Analysis should address the following:

- ☐ Which services they use and which they cannot use.
- ☐ How long they wait.
- ☐ Which additional costs they bear.
- ☐ Which barriers they encounter.
- ☐ Which accommodations they request and receive.
- ☐ How they assess their care.
- ☐ How experiences differ by gender, age, and territory.

Information must be used to make decisions, allocate resources, and demand accountability. Recording data without transformation would turn data production into another bureaucratic procedure.

7.7 Meaningful participation

Participation by persons with disabilities must go beyond token consultation. Representative organizations and service users need to be involved in identifying problems, developing solutions, implementing them, and

evaluating outcomes.

Genuine participation requires accessibility, advance information, sufficient time, and resources that enable people to participate on equal terms. It also requires including the diversity within this population and avoiding the assumption that a single organization represents every experience.

Lived knowledge does not replace scientific evidence, but neither should it be subordinated to it. Both forms of knowledge must inform the development of policies and services.

7.8 Social oversight and enforceability of rights

Transformative practice requires accessible mechanisms for submitting complaints, reporting discrimination, and requesting corrective action. These mechanisms must provide timely responses and generate institutional learning. Evaluation should not focus solely on confirming the existence of ramps, protocols, or documents. It should determine whether people receive timely care, participate in decisions, and continue treatment on equal terms.

ECLAC and PAHO note that the region must move from isolated initiatives to sustained inclusive systems by strengthening information, reasonable accommodations, continuity of care, and social participation (ECLAC & PAHO, 2026).

Proposed transformation matrix

Table 7. Matrix for transforming health services

Level	Identified problem	Transformative action
General	Rights without sufficient implementation	Funding, regulation, oversight, and decentralization
Particular	Barriers differentiated by gender, poverty, and territory	Intersectoral responses and context-sensitive support
Singular	Paternalism, inaccessible communication, and fragmented care	Reasonable accommodations and supported decision-making
Cross-cutting	Institutional ableism	Participation, critical education, and accountability

8 Conclusions

Healthcare exclusion of persons with disabilities cannot be explained solely by their physical, sensory, intellectual, or psychosocial conditions. It is produced through social relations, political decisions, forms of institutional organization, and cultural conceptions that determine which capacities are considered normal and which require exceptional accommodations. Through this process, institutional ableism turns human differences into avoidable and unjust inequalities.

The transition from the medical rehabilitation model to social and human rights models has shifted attention from individual impairment to environmental barriers. This transition remains incomplete. In health services, rights-based discourse coexists with inaccessible infrastructure, rigid procedures, nonadapted information, paternalistic practices, and responses focused exclusively on rehabilitation.

The social determination perspective shows that these barriers are not isolated incidents or simple administrative deficiencies. They are related to processes operating at general, particular, and singular levels. Policies, financing, and the territorial distribution of services shape collective ways of life and ultimately appear in concrete experiences of delay, dependency, fragmented care, or exclusion.

This article's main conceptual contribution is the proposal that institutional ableism acts as a mediating process between social structures, ways of life, and individual experiences of care. Through this process, particular bodily, cognitive, and communication patterns become implicit requirements for accessing the health system on equal

terms.

Disability also intersects with inequalities related to gender, poverty, territory, and access to support. These relationships do not simply accumulate disadvantages; they produce differentiated experiences of exclusion. General policies must therefore recognize the heterogeneity of this population and respond to its particular contexts.

From a bioethical perspective, the association between dignity and self-sufficiency must be questioned. Requiring support neither diminishes moral worth nor authorizes the automatic substitution of a person's will. A bioethics committed to disability must recognize relational autonomy, guarantee supported decision-making, and understand care as a practice that strengthens capacity without becoming control.

The general classification of persons with disabilities as an intrinsically vulnerable population must also be reconsidered. Many situations of vulnerability are produced by inaccessibility, discrimination, poverty, a lack of support, and exclusion from decision-making spaces. The ethical response should not be limited to protecting individuals; it should transform the structures that expose them to harm.

Inclusive healthcare requires moving from normative declarations to verifiable institutional mechanisms. These include funded planning, comprehensive accessibility, reasonable accommodations, disaggregated information, critical professional education, meaningful participation, and accessible procedures for enforcing rights. Individual awareness is valuable but insufficient if the ableist organization of services remains unchanged.

Persons with disabilities must be recognized as moral agents, citizens, and legitimate producers of knowledge. Their participation is not merely a strategy for improving policy relevance; it is a requirement of justice. No transformation can be considered inclusive while decisions continue to be made without their effective participation.

An inclusive health system is therefore not one that makes exceptions to admit people who differ from a user considered normal. It is one that recognizes physical, sensory, intellectual, and psychosocial diversity as an ordinary part of the human condition and organizes its services, relationships, and decision-making mechanisms accordingly.

Integrating the social determination of health, institutional ableism, bioethics, and human rights provides a critical framework for studying and transforming healthcare exclusion in Peru. This framework should subsequently be examined through research that incorporates the experiences of persons with disabilities, evaluates the implementation of reasonable accommodations, and analyzes differences across territories and healthcare facilities.

References

1. Breilh, J. (2013). La determinación social de la salud como herramienta de transformación hacia una nueva salud pública (salud colectiva) [The social determination of health as a tool for transformation toward a new public health (collective health)]. *Revista Facultad Nacional de Salud Pública*, 31(Suppl. 1), S13-S27. https://www.scielo.org/co/scielo.php?script=sci_arttext&pid=S0120-386X2013000400002
2. Economic Commission for Latin America and the Caribbean, & Pan American Health Organization. (2026). Inclusión de la discapacidad en los sistemas de salud y gestión de emergencias de América Latina y el Caribe: Brechas, prácticas institucionales y desafíos para el ejercicio efectivo del derecho a la salud [Disability inclusion in health systems and emergency management in Latin America and the Caribbean: Gaps, institutional practices, and challenges to the effective exercise of the right to health] (LC/TS.2026/34). <https://www.cepal.org/es/publicaciones/90005-inclusion-la-discapacidad-sistemas-salud-gestion-emergencias-america-latina>
3. Committee on the Rights of Persons with Disabilities. (2014). General comment No. 1 (2014), Article 12: Equal recognition before the law (CRPD/C/GC/1). United Nations. <https://docs.un.org/en/CRPD/C/GC/1>
4. Committee on the Rights of Persons with Disabilities. (2016). General comment No. 3 (2016) on women and

- girls with disabilities (CRPD/C/GC/3). United Nations. <https://docs.un.org/en/CRPD/C/GC/3>
5. Congress of the Republic of Peru. (2012). Ley N.º 29973, Ley General de la Persona con Discapacidad [Law No. 29973, General Law on Persons with Disabilities]. <https://www.leyes.congreso.gob.pe/Documentos/Leyes/29973.pdf>
 6. García, L. (2025). Fuentes de datos sobre las personas con discapacidad en América Latina desde un enfoque social y de derechos [Data sources on persons with disabilities in Latin America from a social and rights-based perspective] (LC/TS.2025/53). Economic Commission for Latin America and the Caribbean. <https://crpd.cepal.org/6m/es/documentos/fuentes-datos-personas-discapacidad-america-latina-un-enfoque-social-derechos>
 7. Guidry-Grimes, L. (2022). Disability bioethics and the commitment to equality. *Theoretical Medicine and Bioethics*, 43(4), 209-220. <https://doi.org/10.1007/s11017-022-09575-2>
 8. Hallyburton, A. (2022). Diagnostic overshadowing: An evolutionary concept analysis on the misattribution of physical symptoms to pre-existing psychological illnesses. *International Journal of Mental Health Nursing*, 31(6), 1360-1372. <https://doi.org/10.1111/inm.13034>
 9. Ho, A. (2008). The individualist model of autonomy and the challenge of disability. *Journal of Bioethical Inquiry*, 5(2-3), 193-207. <https://doi.org/10.1007/s11673-007-9075-0>
 10. Iezzoni, L. I., Rao, S. R., Ressler, J., Bolcic-Jankovic, D., Agaronnik, N. D., Donelan, K., Lagu, T., & Campbell, E. G. (2021). Physicians' perceptions of people with disability and their health care. *Health Affairs*, 40(2), 297-306. <https://doi.org/10.1377/hlthaff.2020.01452>
 11. Krahn, G. L., Walker, D. K., & Correa-De-Araujo, R. (2015). Persons with disabilities as an unrecognized health disparity population. *American Journal of Public Health*, 105(S2), S198-S206. <https://doi.org/10.2105/AJPH.2014.302182>
 12. Lundberg, D. J., & Chen, J. A. (2024). Structural ableism in public health and healthcare: A definition and conceptual framework. *The Lancet Regional Health - Americas*, 30, 100650. <https://doi.org/10.1016/j.lana.2023.100650>
 13. Ministry of Women and Vulnerable Populations. (2021). Política Nacional Multisectorial en Discapacidad para el Desarrollo al 2030 [National Multisectoral Disability Policy for Development to 2030] (Supreme Decree No. 007-2021-MIMP). <https://www.gob.pe/institucion/mimp/normas-legales/1951868-007-2021-mimp>
 14. United Nations. (2006). Convention on the Rights of Persons with Disabilities. <https://www.ohchr.org/en/instruments-mechanisms/instruments/convention-rights-persons-disabilities>
 15. United Nations Educational, Scientific and Cultural Organization. (2005). Universal Declaration on Bioethics and Human Rights. <https://unesdoc.unesco.org/ark:/48223/pf0000146180>
 16. World Health Organization. (2001). International classification of functioning, disability and health: ICF. <https://iris.who.int/handle/10665/42407>
 17. World Health Organization. (2022). Global report on health equity for persons with disabilities. <https://www.who.int/publications/i/item/9789240063600>
 18. Palacios, A. (2008). El modelo social de discapacidad: Orígenes, caracterización y plasmación en la Convención Internacional sobre los Derechos de las Personas con Discapacidad [The social model of disability: Origins, characterization, and embodiment in the International Convention on the Rights of Persons with Disabilities]. Ediciones Cinca. <https://dds.cepal.org/redesoc/publicacion?id=4010>