



# Health Disparities and People with Disabilities

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Health disparities are differences in health outcomes between groups that reflect social inequalities. Disability rates vary by ethnicity, age, sex and income, ranging from 10.4% among Asians to 22.6% among non-Hispanic black to 31.3% among American Indians and Alaska Natives. Unsurprisingly, disability is more prevalent in those age 65 and older (37.8%) than those age 18 to 44 (13.4%). Disability rates are slightly higher for women than for men: 22.4% versus 21.1%. Among people whose incomes are less than \$15K, 38.8% have a disability, while the percentage is a much lower 16.2% for those with incomes of \$50,000 or more.<sup>1</sup>

Health disparities are greater for people who both have disabilities *and* are people of color. U.S. National Health Interview Survey data show that people with both mobility limitations *and* minority status experience greater health disparities than adults with minority status *or* mobility limitations alone in most outcomes measured. Among the measures with the greatest disparities were worsening health, depressive symptoms, diabetes, stroke, visual impairment, difficulty with activities of daily living, obesity, physical activity and low workforce participation.<sup>2</sup>

Disparities between members of racial and ethnic minorities with disabilities and whites with disabilities are profound. For example, according to the CDC, whites with Down syndrome in the United States had a median death age of 50 in 1997, while the median age was 25 for blacks, and only 11 for people of other races.<sup>3</sup> When compared with whites who exhibit the same symptoms, African Americans are diagnosed more frequently with schizophrenia and less frequently with affective disorders. Further, while 44% of whites first diagnosed with depression received antidepressants, only 27% of blacks received the medication.<sup>4</sup>

Disability rates also vary widely by state. The states with the highest disability rates for adults are West Virginia (29.5%), Kentucky and Oklahoma (27%), Alabama (26.3%) and Arkansas (26.2%). North Dakota and Iowa have the lowest rates, at 17.7% and 17.8%, respectively.<sup>5</sup>

## *Gaps in data and interventions*

There are significant data gaps in the critical disparity domains defined in the *Healthy People* series of national planning objectives: 1) disability status and 2) sexual orientation and identity. Only eight of the 22 disparity topics analyzed by CDC include disability, and few effective interventions to overcome disparity based on disability exist.<sup>6</sup>

The Department of Health and Human Services (HHS) Healthy People 2010 and 2020 intend to include a standard set of disability questions in the core of all relevant data systems. Health care reform imposes new

statutory requirements to collect disability and inequity data. The AAHD policy and legislative analysis and summary on disparities will list these requirements.

The few disability equity measures reported by CDC reveal some relative good news: People with disabilities have better health insurance coverage than persons without disabilities (although both groups have significant coverage gaps). In 2008, slightly more people with disabilities received fecal occult blood tests and lower endoscopy tests than those without disabilities (66% versus 63%). The prevalence of binge drinking was lower for people with disabilities than for those without disabilities (14% versus 16%).<sup>7</sup>

But there are alarming disparities for people with disabilities related to the prevalence of diabetes and hypertension. People with disabilities of all ages have more than twice the incidence of diabetes than those without disabilities. And people with disabilities older than 18 have a 10% higher incidence of hypertension than adults without disabilities (29.3% versus 39.3%).<sup>8</sup>

### *People with disabilities often lack basic care*

People with disabilities often do not receive basic primary and preventive care others take for granted, such as weigh-ins, preventive dental care, pelvic exams, x-rays, physical examinations, colonoscopies and vision screenings.<sup>9</sup> Research shows that individuals with intellectual disabilities must contact 50 physicians before they can find one trained to treat them.<sup>10</sup>

- Women age 40 and older with disabilities were less likely than their counterparts without disabilities to report having had a mammogram in 2008 — 72.2% versus 77.8%.<sup>11</sup>
- Nonelderly adults with mobility limitations are less likely to receive preventive health services — including cholesterol screening and blood pressure checks — than their same-age counterparts without disabilities. Yet people with disabilities are more likely to have high cholesterol and high blood pressure. In 2002, 19% of adults with disabilities had high cholesterol compared with 17% of adults without a disability, and 37% of adults with disabilities had high blood pressure compared with 29% of adults without a disability.<sup>12</sup>
- In 2002, only 40% of children and adults with disabilities visited a dentist compared with 45% of children and adults without disabilities.<sup>13</sup> Dental care is the most prevalent unmet health care need for children with special health care needs.<sup>14</sup>
- People with significant vision loss are more likely to have heart disease and hypertension, experience a greater prevalence of obesity and smoke more than the general population.<sup>15</sup>

Health care providers gather more information on pain, depression, stress and work/hobbies from patients with disabilities and collect less information about smoking, blood pressure, cholesterol, mammograms, colorectal exams and sexual activity.<sup>16</sup> This is despite the fact that people with certain disabilities are at higher risk of developing certain cancers, especially smoking-related cancers. Moreover, people with certain disabilities are also at higher risk for having their cancers diagnosed at a late stage. For example, the risk of late colorectal cancer detection was higher for those with moderate or severe cognitive impairment, whereas late-stage breast cancer detection was associated more closely with mobility impairments.

Three out of five people with serious mental illness die 25 years sooner than those without such illnesses from preventable chronic diseases such as asthma, diabetes, cancer, heart disease and cardiopulmonary conditions.<sup>17</sup> Inaccessible medical equipment and lack of trained physicians, dentists and other health

professionals prevent individuals with disabilities from receiving the basic primary and preventive care others take for granted, such as getting weighed, preventative dental care, pelvic exams, x-rays, physical examinations, colonoscopies and vision screenings.<sup>18</sup>

The 2001 Surgeon General's report on mental health cited striking disparities in access, quality, and availability of mental health services for racial and ethnic minority Americans<sup>19</sup>, and an accompanying press statement noted that the failure to address these inequities is being played out in human and economic terms across the nation. According to Surgeon General Dr. David Satcher:

The revolution in science that has led to effective treatments for mental illnesses needs to benefit every American of every race, ethnicity, and culture. Culture, broadly defined as a common set of beliefs, norms, and values, influences many aspects of mental illness and mental health. It influences, for better or for worse, how patients communicate and manifest their symptoms, how they cope, the range of their family and community supports, and their willingness to seek treatment. A history of racism, discrimination, and economic impoverishment can combine with mistrust and fear to deter minorities from using services and receiving appropriate care.

### *The way forward*

AAHD concurs with CDC that the ongoing racial/ethnic, economic and other social disparities in health are both unacceptable and correctable. The nation needs to increase its focus on health disparities facing persons with disabilities. We need to eliminate the barriers to quality care that people with disabilities now face, beginning by measuring the social determinants of health as outlined in Healthy People 2020, since these determinants significantly affect access to and the quality of health care provided to people with disabilities. We must also measure access to primary care and related services, as well as home- and community-based services for improved/sustainable community participation.



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- <sup>3</sup> Friedman, JM (2001, June 08). Racial disparities in median age at death of persons with Down syndrome — United States, 1968-1997. *MMWR Weekly*. CDC. 50(22);463-5.
- <sup>4</sup> U.S. Department of Health and Human Services. (2001). *Mental Health: Culture, Race, and Ethnicity — A Supplement to Mental Health: A Report of the Surgeon General*. Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services.
- <sup>5</sup> Age-adjusted prevalence of disability by state, adults 18 years of age or older, 2008 BRFSS, CDC, <http://www.cdc.gov/ncbddd/disabilityandhealth/prevalence-data.html> (accessed 12/2/2010).
- <sup>6</sup> "Health Disparities and Inequalities Report," *Morbidity and Mortality Weekly Report*, Supplement, Volume 60, January 14, 2011, U.S. Department of Health and Human Services, CDC ([www.cdc.gov](http://www.cdc.gov)).
- <sup>7</sup> Ibid.
- <sup>8</sup> Ibid.
- <sup>9</sup> Kirschner K.L., Breslin, M.L., Iezzoni, L.I. (2007, March 14). Structural impairments that limit access to health care for patients with disabilities. *JAMA*, 297:10:1121-1125; Chan L, Doctor JN., MacLehose RF., et al. (1999). Do Medicare patients with disabilities receive preventive services? *Arch Phys Med Rehabil*. 80:642-646; and Manderscheid R., Druss B., Freeman E. (2007, August 15). Data to manage the mortality crisis: Recommendations to the Substance Abuse and Mental Health Services Administration. Washington, D.C.
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- <sup>11</sup> BRFSS data. Atlanta, Georgia: U.S. Department of Health and Human Services, CDC, 2008.
- <sup>12</sup> U.S. Department of Health and Human Services (2005). The Surgeon General's Call To Action, To Improve the Health and Wellness of Persons with Disabilities. U.S. Department of Health and Human Services, Office of the Surgeon General.
- <sup>13</sup> Ibid.
- <sup>14</sup> Lewis, C., Robertson, S., Phelps, S., "Unmet Dental Care Needs Among Children with Special Health Care Needs: Implications for the Medical Home," *Pediatrics*, Vol. 116, No. 3 (September 2005).
- <sup>15</sup> National Council on Disability (2009), "The Current State of Health Care for People With Disabilities." Available online at [www.hhs.gov/ohs/initiatives/mcc/federal-register051410.pdf](http://www.hhs.gov/ohs/initiatives/mcc/federal-register051410.pdf).
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- <sup>17</sup> Colton C.W., Manderscheid R.W. (2006, April). Congruencies in increased mortality rates, years of potential life lost, and causes of death among public mental health clients in eight states. *Preventing Chronic Disease: Public Health Research, Practice and Policy*. 3(2), 1-14. Available at [www.pubmedcentral.nih.gov/articlerender.fcgi?tool=pubmed&pubmedid=16539783](http://www.pubmedcentral.nih.gov/articlerender.fcgi?tool=pubmed&pubmedid=16539783).
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