

People with Disabilities

Definition: People with disabilities are those who report being limited in any way in any activities because of physical, mental, or emotional problems, or who have health problems that require them to use special equipment. (BRFSS)

Summary

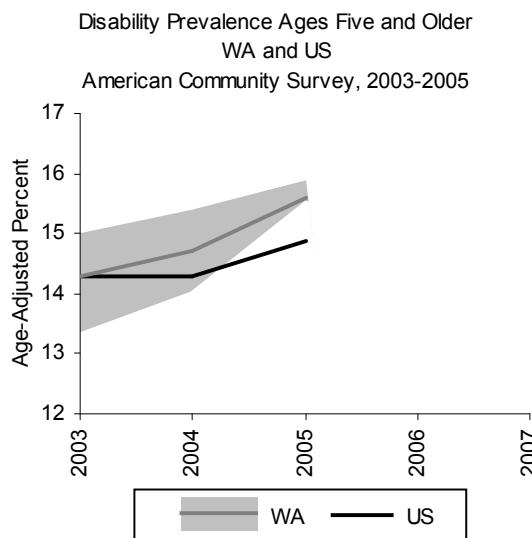
In 2005, 16% of Washington State residents ages five years and older reported living with a disability. Disability prevalence rose sharply with age, reaching 53% in people ages 75 years and older. Even though disability prevalence is greatest in this age group, most people with disabilities are younger.

People with disabilities can enjoy excellent health, but many are at increased risk for one or more health problems that result from their primary impairment. Adults with disabilities report poorer health, more days of health-related activity limitation, and poorer health behaviors than do adults without disabilities. These differences are independent of poverty, which is both a cause and result of disability.

Healthy People 2010 objectives addressing social support, life satisfaction, social participation, and employment for people with disabilities have not been met in Washington.

Time Trends

From 2003 to 2005, the prevalence of disability in Washington increased for all people ages five years and older, those 16–64 years, and those 65 years and older. During this period, the prevalence of disability in the United States also increased significantly for the total population and for each age group. With only three years of comparable data, it is not clear if the increase in disability prevalence is part of an overall trend in Washington.



Year 2010 Goals

The national *Healthy People 2010* objectives addressing disability and secondary conditions seek to “promote the health of people with disabilities, prevent secondary conditions, and eliminate disparities between people with and without disabilities in the U.S. population.”¹

In Washington, health disparities between people with and without disabilities persist. According to the 2005 [Behavioral Risk Factor Surveillance System](#) (BRFSS) survey, 35% ($\pm 2\%$) of Washington adults with disabilities reported that their health was fair or poor compared to 7% ($\pm 1\%$) of those without disabilities. Relative to people without disabilities, adults with disabilities also identified five times as many days when their physical health was not good in the past 30 days and twice as many days when their mental health was not good in the past 30 days.

There are 13 *Healthy People 2010* objectives for disability, not all of which are covered in this chapter.

Many of the objectives have not been met for Washington, including the following:

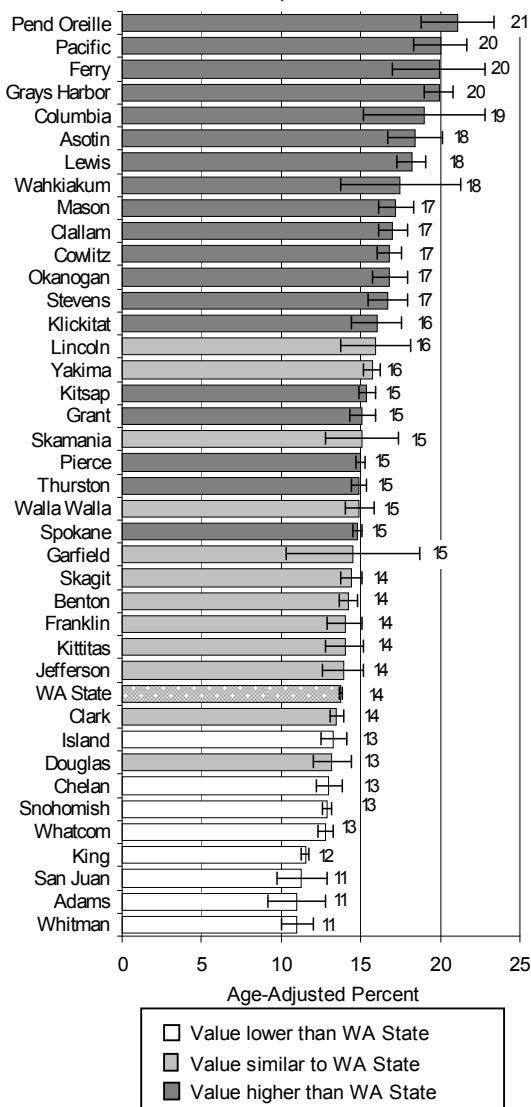
1. Reduce the proportion of adults with disabilities who report feelings such as sadness, unhappiness, or depression that prevent them from being active to 7%. According to 2005 BRFSS data, 31% ($\pm 2\%$) of adults with disabilities in Washington said that in the last month, they had one or more days when their mental health kept them from doing daily activities. This is much higher than the 11% ($\pm 1\%$) of adults without disabilities who said that mental health limited daily activities.
2. Increase the proportion of adults with disabilities who take part in social activities to 100%. The 2001 and 2003 BRFSS disability supplement data show that 45% ($\pm 3\%$) of adults with disabilities and 93% ($\pm 1\%$) of adults without disabilities in Washington reported no limits to their participation.
3. Increase the proportion of adults with disabilities reporting enough emotional support to 79%. In 2005, 71% ($\pm 2\%$) of adults with disabilities and 81% ($\pm 1\%$) of adults without disabilities said they got enough social support.
4. Increase the proportion of adults with disabilities reporting satisfaction with life to 98%. The 2005 BRFSS found that 84% ($\pm 2\%$) of adults with disabilities and 97% ($<1\%$) of adults without disabilities said they were "very satisfied" or "satisfied" with their lives.
5. Eliminate differences in employment rates between working-age adults with and without disabilities by increasing the proportion of adults with disabilities who are employed to 82%. In the Washington State Population Survey, the employment rate was measured as the percentage of all people ages 16–64 years who were working in the week before the survey. In the combined 2002, 2004, and 2006 surveys, the employment rate of people with disabilities averaged 45% ($\pm 2\%$) compared to 76% ($\pm 1\%$) of those without disabilities. During this four-year period, half (49% $\pm 2\%$) of people with disabilities ages 16–64 years were not working.

The *Healthy People 2010* objectives focusing on youth with disabilities are discussed in the [Children and Youth with Special Health Care Needs chapter](#).

Geographic Variation

Census data from 2000 show rural counties on the edges of the state had higher [age-adjusted](#) disability prevalence. The differences in prevalence reflected the education, age, and income differences among counties rather than rural and urban differences. Counties with more wealth, larger populations, and more young people had the lowest disability prevalence.

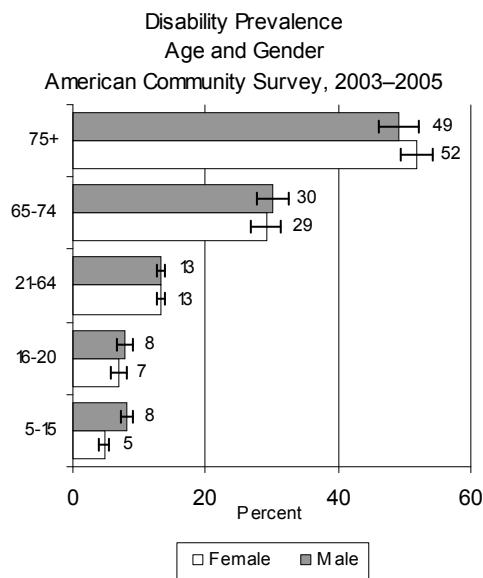
**Disability Prevalence Ages Five and Older
County Data
Census, 2000**



Age and Gender

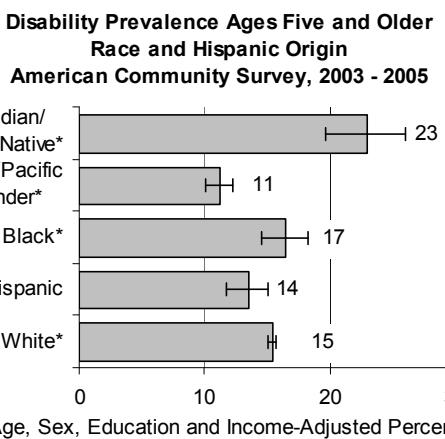
According to the 2003–2005 American Community Survey, disability *prevalence* in Washington rose with age and was highest among people 75 years

and older. The largest *number* of people with disabilities was among those 15–65 years old. Disability prevalence did not differ by gender except among youth younger than 16 years old (5% ±1% among girls and 8% ±1% among boys).



Race and Hispanic Origin

Some race and ethnic groups differed in disability prevalence. Compared to non-Hispanic whites of similar age, education, gender, and income, the likelihood of reporting a disability was higher for American Indian and Alaska Natives (23% ±3%) and lower for Asians and Pacific Islanders (11% ±1%). Blacks (17% ±2%) and Hispanics (14% ±2%) had the same likelihood of a disability as non-Hispanic whites (15% <1%).

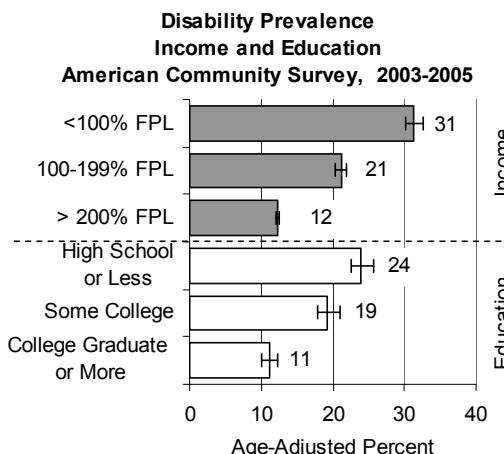


Income and Education

Disability prevalence among people with income less than the Federal Poverty Level (FPL) was nearly three times higher than that of people with incomes greater than 200% of the FPL. Even when differences in education, age, race or Hispanic origin, and health status were taken into account, people with disabilities were more likely to be poor or “near poor” than were those without disabilities. Poverty is both a result of and risk factor for disability. Poverty results from disability because people with disabilities have lower employment rates and lower average incomes than those without disabilities. Often costs associated with disability require a higher income to attain a similar level of material well-being.² Also, benefits are often not enough to raise income above the poverty level, and federal benefit programs have limits on income earned or conditions about working status. Poverty increases disability risk by reducing access to medical and preventive care and by exposure to poor living conditions and high-risk occupations.³

Data from the 2002–2006 Washington State Population surveys showed that, compared to similar people without disabilities, those with disabilities were less likely to be in the labor force, be employed, work full-time, or work as much as they wanted even after adjustment for education.

Disability was more common among people with less education, even when age differences were taken into account. Among people 25 years and older with a high school diploma or less, disability prevalence was 24% (±1%) compared to 19% (±1%) among people with some college and 11% (±1%) among college graduates. These differences reflected the lower educational attainment of people with disabilities.



Other Measures of Impact and Burden

People with disabilities have been identified as a target group for public health programs in part because of the direct and indirect costs linked with disability and poor health. There are no Washington data on costs, but in Fiscal Year 2002, federal expenses for Social Security and disability income, health care, housing, food assistance, rehabilitation, and other programs for working-age people with disabilities made up about 2.7% of the nation's gross domestic product (GDP). These costs were growing much faster than GDP and all federal outlays.⁴

Healthy People 2010 identified prevention of secondary conditions as an important way to improve the health of people with disabilities. Secondary conditions are preventable physical, mental, and social problems resulting directly or indirectly from an initial disabling condition.⁵ In Washington, 87% of adults with disabilities said they had one or more of 16 common conditions that posed a moderate or very big problem for them in the previous 12 months. The most common conditions include: chronic pain, depression, problems with weight, severe anxiety, persistent fatigue, muscle spasms, sleep problems, falls and other injuries, and difficulty getting out in the community. These conditions affected people without disabilities as well. But the burden was higher among people with disabilities and contributes to the poor health and restricted social participation in this population.

Improving access to medical, health promotion, and disease prevention services is another goal of *Healthy People 2010*. In 2005, many Washington adults with disabilities reported using preventive services, and most had public or private health insurance. When compared to adults without disabilities, however, they were more likely to report being unable to see a doctor because of cost (24% ±2% and 11% ±1%, respectively). In addition, adults with disabilities were more likely to smoke (25% ±2% and 16% ±1%, respectively), more likely to be overweight or obese (64% ±2% and 54% ±1%, respectively), and less likely to meet physical activity recommendations at work or play (54% ±2% and 66% ±1%, respectively). According to the 2004 BRFSS, adults with disabilities were less likely to have seen a dentist in the past year (62% ±4%) than adults without disabilities (73% ±2%). According to the 2003 BRFSS, they were

more likely to have fallen in the past three months than adults without disabilities (22% ±2% and 12% ±1%). Similar differences in smoking, overweight and obesity, and physical activity were seen in youth with disabilities in the 2004 [Healthy Youth Survey](#).

Because people with disabilities experience these and other health disparities, we should include disability status in all our measurements of risk factors and disease when characterizing Washington's health.

Intervention Strategies

Studies have shown that people with disabilities often face barriers affecting their access to health care facilities and services.^{6,7} Barriers are physical, cultural, economic, and attitudinal. Barriers could be reduced if facilities were physically and socially accessible and health care systems were culturally competent to address disability. An accessible and culturally competent system would provide individual attention to people with disabilities, accommodations such as American Sign Language interpreters, and information in alternative formats (Braille, large font), improving access to resources that support healthy living for all.

To better monitor whether people with disabilities are getting services, disability data should be collected and used more consistently in health data assessments. Using disability as a key demographic variable for health indicators, social and economic participation, care-giving, and emotional support would support ongoing evaluation of Washington's progress in meeting *Healthy People 2010* goals.

See Related Chapters: [Children and Youth with Special Health Care Needs](#), [Tobacco Use, Mental Health, Obesity and Overweight](#), and [Physical Activity](#).

Data Sources (For additional detail, see [Appendix B](#))

American Community Survey 5% Public Use Micro Sample (PUMS), 2003–2005. Prepared by the University of Washington Center for Disability and Policy Research.

Census 5% PUMS, 2000. Prepared by the University of Washington Center for Disability and Policy Research.

Washington Healthy Youth Survey: Office of Superintendent of Public Instruction, Washington State departments of Health, Social and Health Services, and Community, Trade, and Economic Development, and the Family Policy Council, 2002, 2004, 2006.

Washington State Behavioral Risk Factor Surveillance System (BRFSS) data: 2004–2005.

BRFSS disability supplements, 2001 and 2003.

Washington State Population Survey, 2002, 2004, and 2006. Office of Financial Management.

For More Information

U.S. Centers for Disease Control and Prevention, Disability and Health website: www.cdc.gov/hcbddd/dh/default.htm

The Surgeon General's Call to Action to Improve the Health and Wellness of Persons with Disabilities.
www.surgeongeneral.gov/library/disabilities

Technical Notes

Disability prevalence and time trend data: The American Community Survey, U.S. Census Bureau, provides the most current estimates of disability prevalence in Washington. This survey population is civilian, non-institutionalized residents. Due to changes in questions and to errors in data collection in earlier years, data are available only for 2003, 2004, and 2005. To provide three-year estimates, the Public Use Micro Sample (PUMS) data for each year, a 5% random sample, were merged. The 2003 and 2004 data are provided without geographical identifiers, so standard errors were calculated using census methods, and age-adjustment was done using calculated errors.

www.census.gov/acs/www/Downloads/2005/AccuracyPUMS.pdf

County disability prevalence: To compensate for Census 2000 over counts of disability subgroups, an alternative measure was computed using only the four measures of limitation for which over counts were not observed. County data from Summary File 3, table PCT026 were used to compute prevalence of physical, mental, sensory, or self-care limitation in persons ages five years and older. This corrected disability prevalence was age-adjusted to permit county comparisons. For additional information see Stern, S. and Brault, M., *Disability Data from the American Community Survey: A Brief Examination of the Effects of a Question Redesign in 2003*. U.S. Census Bureau, Housing and Household Economic Statistics Division, January 28, 2005.

http://www.census.gov/acs/www/Downloads/ACS_disability.pdf, accessed January 12, 2007.

Data on *Healthy People 2010* objectives and secondary conditions: BRFSS Disability Supplement 2001 and 2003 were stand-alone supplements conducted for the Washington State Department of Health using the BRFSS contractor, sampling strategy and procedures.

Data on employment and wages: The 2002, 2004, and 2006 Washington State Population surveys, conducted by the Washington State Office of Financial Management, provide detailed data on employment for people with disabilities using the census definition of disability.

Endnotes

¹ U.S. Department of Health and Human Services. (2000, November). *Healthy People 2010* (2 vols., 2nd ed.). With Understanding and Improving Health and Objectives for Improving Health. Washington, DC: U.S. Government Printing Office.

² She, P., & Livermore, G. A. (2006). *Material hardship, poverty, and disability among working-age adults*. Ithaca, NY: Cornell University, Rehabilitation Research and Training Center on Employment Policy for Persons with Disabilities.

³ Pope, A., & Tarlov, A. (1991). *Disability in America*. Washington, DC: National Academy Press.

⁴ Goodman, N., & Stapleton, D. (2005). *Federal program expenditures for working-age people with disabilities: research report*. Ithaca, NY: Cornell University, Rehabilitation Research and Training Center for Economic Research on Employment Policy for People with Disabilities.

⁵ Kinne, S., Patrick, D., & Doyle, D. (2004). Prevalence of secondary conditions among people with disabilities. *American Journal of Public Health*, 94(3), 443-445.

⁶ 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*. Washington, DC: U.S. Department of Health and Human Services, Office of the Surgeon General.

⁷ Institute of Medicine. (2007). *The Future of Disability in America*. Washington, DC: The National Academies Press.