
Racial and Ethnic Disparities among Adults with Intellectual and Developmental Disabilities

Sandra Magaña¹, Susan Parish², Miguel A. Morales¹, Henan Li² and Glenn T. Fujiura¹

Overview

This study investigated the extent of racial and ethnic disparities in the health of adults with intellectual and developmental disabilities. Analyzing data from the 2002-2011 Medical Expenditure Panel Survey and the 2000-2010 National Health Interview Survey, we found that Black and Latino adults with intellectual and developmental disabilities have markedly worse health in contrast to their white peers with intellectual and developmental disabilities.



Decades of research has clearly established that people of Black, Latino and American Indian descent living in the United States receive worse health care and have worse health outcomes in contrast to white people. These disparities are a persistent, pervasive public health problem. Emerging research indicates there are health disparities between people with intellectual and developmental disabilities compared to the general population. However, little is known about the extent of racial and ethnic health disparities among adults with intellectual and developmental disabilities.

Recent research shows that adults with intellectual and developmental disabilities also experience health disparities compared to those without disabilities. For example, compared to other adults, adults with intellectual and developmental disabilities are more likely to have fair or poor health (Havercamp & Scott, 2015), obesity (Hsieh, Rimmer, & Heller) and diabetes (Balogh et al., 2015).

We analyzed data from the 2002-2011 Medical Expenditure Panel Survey and 2000-2010 National Health Interview Survey datasets. The total sample size was 972,099 adults, including 1,131 adults with intellectual and developmental disabilities. The adults in our sample lived in community, and not institutional, settings. The outcome variables were 1) perceived health, 2) perceived mental health 3) obesity, and 4) diabetes. Statistical analyses controlled for age, sex, income, urban living status, education and insurance status.

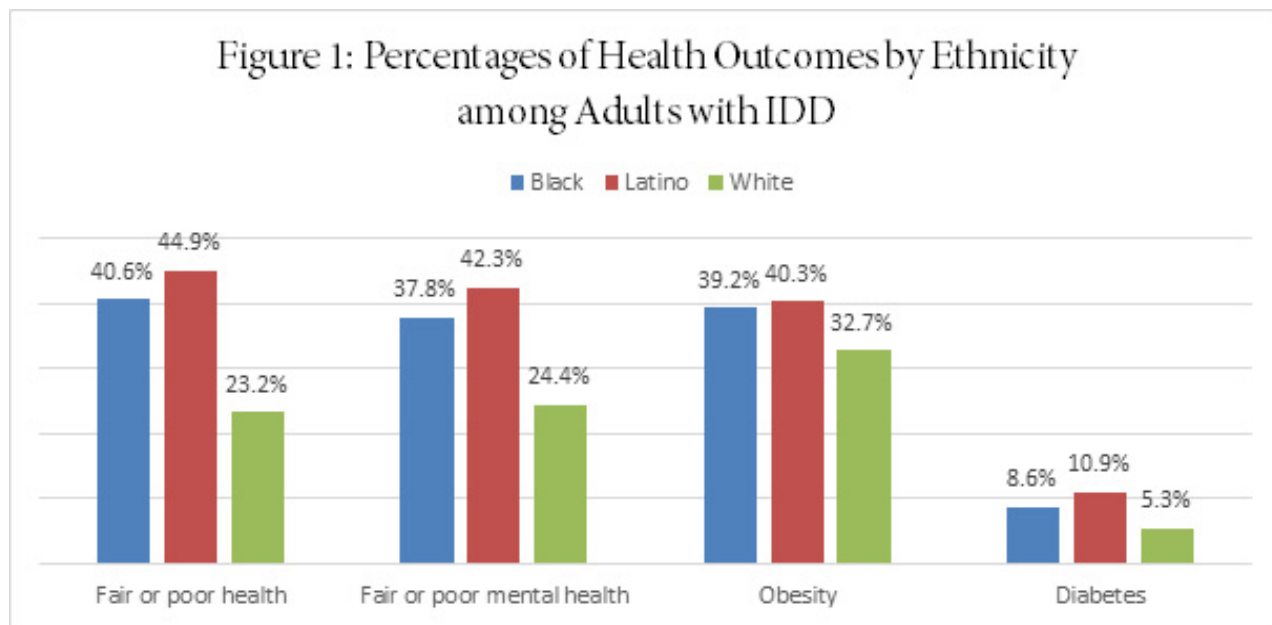


1 Department of Disability and Human Development, University of Illinois at Chicago

2 Lurie Institute for Disability Policy, The Heller School for Social Policy and Management, Brandeis University

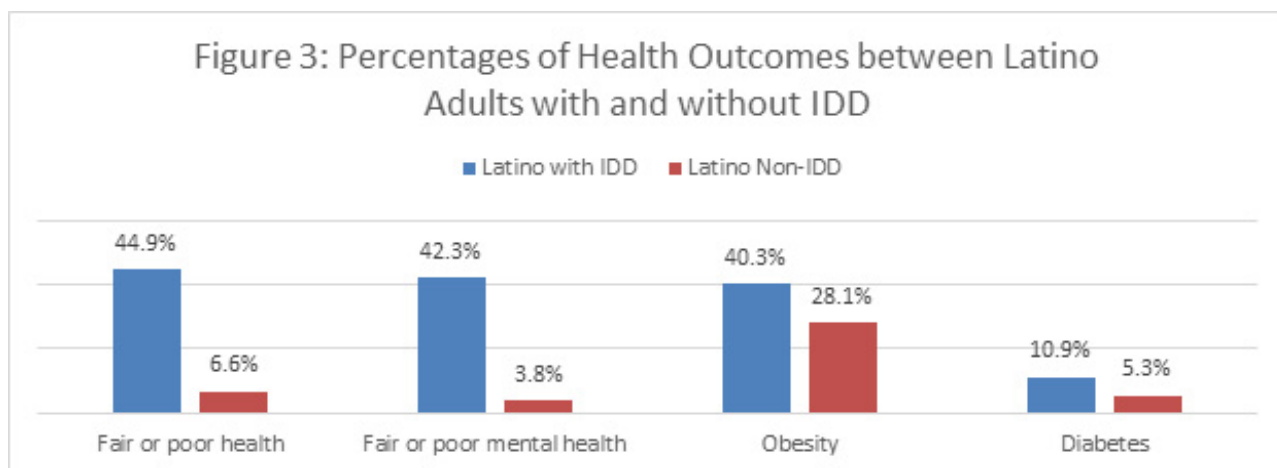
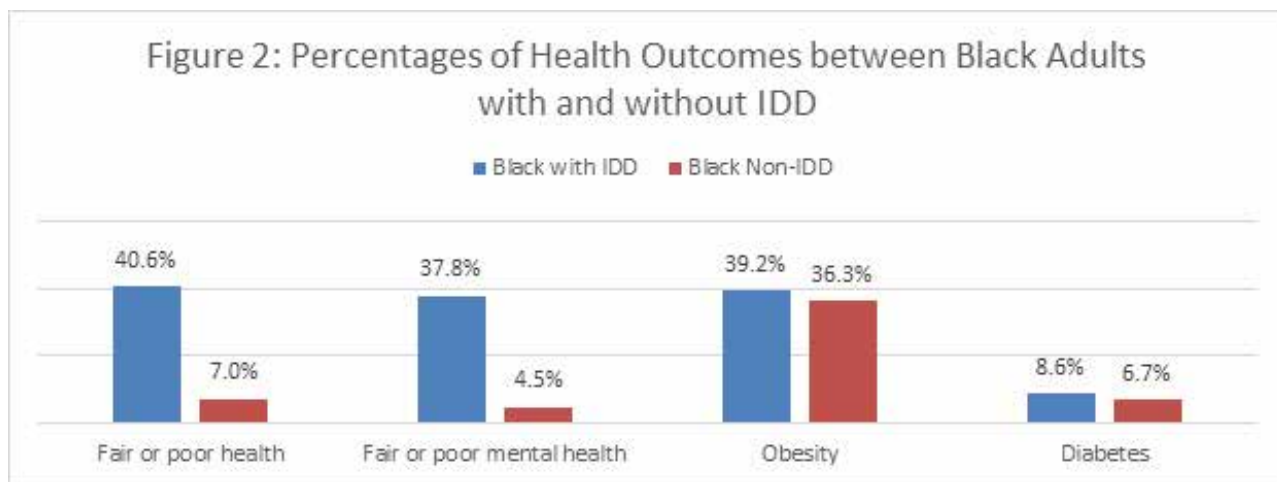
Findings

When comparing Latino, Black and White adults with intellectual and developmental disabilities on demographic variables, we found that Latino adults in our sample were younger, 32 years on average compared to 35 for White adults and 37 for Black adults. Notably, we found that Latino and Black adults with intellectual and developmental disabilities had lower levels of income and education than White adults with intellectual and developmental disabilities. Furthermore, Latino adults with intellectual and developmental disabilities were less likely to be insured all year than their Black and White counterparts. **Consistent with long-standing evidence of racial and ethnic differences in the general population, Black and Latino adults with intellectual and developmental disabilities were significantly more likely to be in fair or poor health and mental health than White adults with intellectual and developmental disabilities (See Figure 1).** We found marginal differences between Latino and White adults with intellectual and developmental disabilities related to obesity and diabetes in which Latino adults were more likely to be obese and to have diabetes than their White peers. All of these findings were robust, and persisted after controlling for a range of demographic characteristics that typically influence health care and health, including age, sex, income, urban living status, education and insurance status.



We also examined the extent of disability-based disparities between adults with and without intellectual and developmental disabilities within the larger Black and Latino subsets of the population. Black and Latino adults with intellectual and developmental disabilities were significantly more likely to report fair or poor health and mental health than those without intellectual and developmental disabilities. Figures 2 and 3 show that these differences are quite stark.

Among Latino adults (Figure 3), those with intellectual and developmental disabilities were more likely to be obese and have diabetes. Statistically significant differences in the likelihood of diabetes and obesity were not found between Black adults with and without intellectual and developmental disabilities (Figure 2).



These findings suggest that Black and Latino adults with intellectual and developmental disabilities have markedly worse health status than both their white counterparts with intellectual and developmental disabilities, and nondisabled adults within their racial and ethnic groups.

Overall, the results indicate that racial and ethnic health disparities are significant problems for adults with intellectual and developmental disabilities. The substantial body of evidence synthesized in the 2002 Institute of Medicine report *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care* found that racial and ethnic disparities in health and health care persist and constitute a major, costly public health problem that should be eliminated. These disparities continue to affect racial and ethnic minorities despite national initiatives to address this problem. Likewise, the Surgeon General’s “Closing the Gap Report”, also issued in 2002, argued for aggressive measures to improve the health and well-being of adults with intellectual disabilities. Our findings indicate that troubling gaps in health persist for adults with intellectual and developmental disabilities.

Further research is needed to understand the costs of the impact of these social determinants of poor health. It is clear that the existing federal initiatives to address racial- and disability-based health disparities have fallen far short of their targets. Innovative and aggressive new measures are urgently needed to address these disparities.

Policy Opportunities

Ben Jackson and Adriane Griffen³

Health Disparities

Cultural competence is widely seen as a foundational pillar for reducing disparities through culturally sensitive and unbiased quality care. Culturally competent care is defined as care that respects diversity in the patient population and cultural factors that can affect health and health care, such as language, communication styles, beliefs, attitudes, and behaviors. Accessibility in this context refers to the “ability to access” the functionality and possibly benefit from a system giving it the ability to be utilized by as many people as possible. Current legislation and initiatives must be amended to be culturally (and linguistically) competent, as well as accessible, and better able to be delivered in community-based settings. This would reduce health disparities in racial and ethnic minorities with intellectual disabilities.

To remedy the problem of health disparities, laws and regulations need to be focused on providing universal access to participants. It is not enough that the Department of Health and Human Services (HHS) declared the intent to have “a nation free of disparities in health and healthcare,” as stated in the 2010 Disparities Action Plan. This “Disparities Action Plan” needs to be accessible to incorporate individuals with intellectual disabilities within that population. This combination of concepts would greatly benefit racial and ethnic minorities with intellectual disabilities. For health outcome areas that have not yet addressed, it would be beneficial to design measures based on that critical combination.

Obesity

Obesity is more prevalent in adults with intellectual disabilities than in the general population, and has been shown to contribute to their reduced life expectancy and increased health needs.

There is a need to adjust to the needs of especially vulnerable populations. Current legislation is proposed to remedy the obesity healthcare crisis in America, the *Treat and Reduce Obesity Act* of 2015. The existing bill makes no mention of disability or the intersection of race and ethnicity. Additionally, while many population-level policy changes may be equally effective for everyone, such as making healthy choices the default option, disability-specific policy initiatives are critical and necessary.

Emerging research shows evidence for tailoring and adjusting weight loss approaches for people with intellectual disabilities. The result of having few research studies and minimal evidence is that evidence-based federal initiatives have then overlooked people with disabilities. Few disability resources are highlighted in the “Guide to Community Preventive Services” and the “Common Community Measures Project for Obesity Prevention,” two evidence-based federal initiatives that provide recommendations for public health efforts on effective intervention approaches for obesity prevention and weight management.

Relatively few studies have examined the effectiveness of weight loss interventions for adults with intellectual disabilities. However, there is evidence to support interventions that take into account the context of the lives of adults with intellectual disabilities, including career involvement in interventions. The population this study surveyed focused solely on individuals living in the community. To reduce the health inequalities experienced by adults with intellectual disabilities, there is a clear need to develop accessible, evidence-based clinical weight management services.

³ Association of University Centers on Disabilities, Silver Spring, MD

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