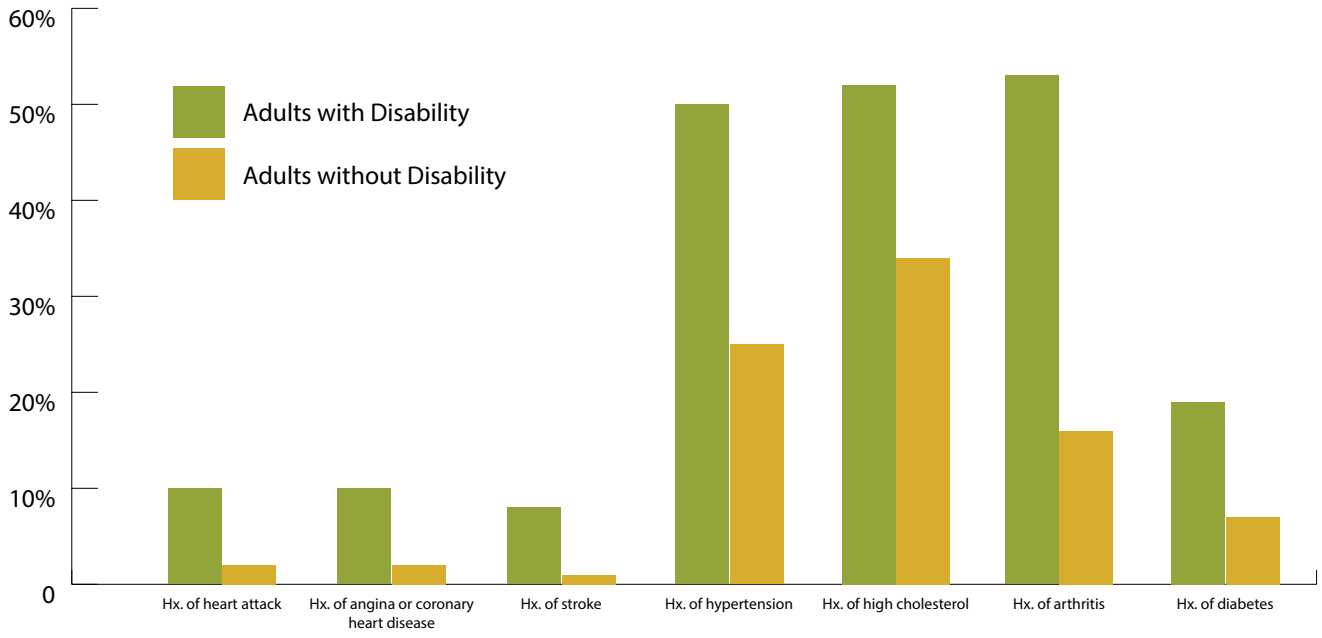
Create Health Equity for People with Disability

Healthy, inclusive communities are ones that make the healthiest choices the easiest and most accessible ones by removing barriers and providing needed assistance and resources to all community members at all levels. A failure to actively ensure that optimal, individual-level health is achievable for all can cause a community to experience an absence of health equity. This absence can lead to and exacerbate health disparities in individuals and groups with shared traits and characteristics, including:

- ***education level***
- ***socioeconomic status***
- ***gender***
- ***race***
- ***sexual orientation***
- ***ability level***
- ***age***
- ***religious beliefs***

Individuals with disability are at a greater risk of experiencing health disparities than any other demographic group in the country. Males and females with functional limitations across the lifespan self-report worse overall, mental, and physical health than those without functional limitations [1]:

Health and Disease Risk for Individuals with and without Disability[2]



While this inequity is astonishing in and of itself, it is doubly alarming considering that disability prevalence is likely to increase across the lifespan due to[3]:

- *Growing aging population*
- *Increasing survival rate of high-risk infants*
- *Increasing prevalence of disabling conditions and behaviors in childhood (overweight/obese, autism, asthma, sedentary behavior, etc.)*
- *Overweight/obese levels and trends in young- and middle-aged adults*

Eliminate Disparities through Inclusive Public Health Practice

Within the broad categories of physical and mental health and health behaviors, adults with disability experience greater health disparities than adults without disabilities, including:

- *Higher rates of obesity (38.1% vs. 25%) and body mass index (41% vs. 33%)[4]*
- *Higher rate of inactivity (39.3% vs. 23.8%)[2]*
- *Higher prevalence of cigarette smoking (25.4% vs. 17.3%)[5]*
- *Higher prevalence of HIV/AIDS (45.8 vs. 39%)[4]*
- *Greater inability to visit health care providers due to cost (23.5 vs. 12.3%)[4]*
- *Higher risk of exposure to violence, unintentional injury, and premature death[6]*
- *Increased likelihood of developing secondary and co-morbid conditions[6]*

Health inequity and disparities *are not* caused by an individual's disability condition, but rather by a lack of access to healthy opportunities. This lack of access can occur on multiple societal levels, including:

- ***Physical:*** *natural and architectural environments*
- ***Programmatic:*** *resource allotment, investment, and availability; policies, procedures, and protocols; lack of training and professional competence; etc.*
- ***Attitudinal:*** *personal beliefs, opinions, knowledge, and prejudices of individuals with disability, their families and friends, program and event staff, planners, and participants, and community leaders, workers, and peers*





References

1. *Thompson W.W., Zack M.M., Krahn G.L., Andresen E.M., Barile J.P. (2012). Health-related quality of life among older adults with and without functional limitations. American Journal of Public Health 102(3), 496-502.*
2. *Centers for Disease Control and Prevention (CDC) (2012). Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention.*
3. *Institute of Medicine. (2007). The Future of Disability in America. Washington (DC): National Academies Press.*
4. *Centers for Disease Control and Prevention (CDC) (2010). Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention.*
5. *National Health Interview Survey (2011). Available at http://www.cdc.gov/nchs/nhis.htm. Reprinted from MMWR 2012;61(44).*
6. *World Health Organization. (2011). World Report on Disability. Geneva, Switzerland: WHO Press.*

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