

Health Care for Americans with Disabilities — 25 Years after the ADA

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Twenty-five years ago, on July 26, 1990, President George H.W. Bush signed the Americans with Disabilities Act (ADA), designed to meet four goals for people with disabilities: equal opportunity, full participation in the community, independent living, and economic self-sufficiency. This landmark civil rights law aimed to prevent employment discrimination and give equal access to public and private services for all people with disabilities. At the signing ceremony, Bush exclaimed, “Let the shameful wall of exclusion finally come tumbling down.”

Since the passage of the ADA, there have been extensive gains in access to public services, the built environment (e.g., crosswalks with curb cuts for wheelchair access and accessible pedestrian signals to assist people who are blind or have low vision), and attitudes toward and understanding of the abilities of people with disabilities. The ADA established a right to equal access to public services offered by governments and private providers and has demonstrated the importance of contributions that people with disabilities can make to our economy.

Yet despite these advances, substantial disparities remain in areas of employment, earned income, access to the Internet, transportation, housing, and educational attainment. Each of these disparities contributes to poorer health for this segment of our population.¹ The recent Affordable Care Act (ACA) may help improve

access to health care for people with disabilities, but the persistence of health disparities and barriers to health care indicates that more remains to be done.

Approximately 56.7 million Americans live with disabilities, with rates ranging from 8.4% among children under 15 years of age to 70.5% among adults over 80 years of age.² Over our life spans, most of us will acquire disabilities. The Centers for Disease Control and Prevention recently reported that among U.S. adults living in community settings, 22% have a disability, with prevalence in individual states ranging from 16% (Minnesota) to 31% (Alabama). These disability rates are similar to rates of key health problems such as diabetes and uncontrolled hypertension. The prevalence of disability is more than twice as high among unemployed adults as among employed adults (33.5% vs. 12.6%), about 25% higher among women than men (24.4% vs. 19.8%), and generally highest in the oldest age group (≥ 65 years).³ Given the increasing prevalence of diabetes, arthritis, and other chronic conditions, new interventions for extremely premature infants, and increased life expectancies for people with congenital conditions (e.g., spina bifida and congenital heart defects), the number of Americans with disabilities in all age groups is likely to increase.

Healthy People 2020, which set national health priorities for 2010 to 2020, documented that people with disabilities were more likely than those without disabili-

ties to experience difficulties or delays in getting health care they need, not have had a mammogram in the past 2 years, not have had a Pap test within the past 3 years, not have had an annual dental visit, not engage in fitness activities, use tobacco, be overweight or obese, have high blood pressure, and experience symptoms of psychological distress.⁴ According to the 2013 *National Healthcare Disparities Report* from the Agency for Healthcare Research and Quality, while more than 60% of quality indicators, such as measures of patient-centered care and access to care, had improved for people without any activity limitations (one measure of disability), only 20 to 35% had improved for people with such limitations.⁵

Many factors may contribute to these disparities, including physical barriers to care (e.g., inaccessible medical diagnostic equipment such as examination tables, weight scales, and imaging technologies); noninclusive health or wellness programs designed for people without disabilities; transportation problems, especially in areas with poor public transportation; inaccurate or inadequate knowledge or stigmatizing attitudes of clinicians about disabling conditions; competing priorities in the health care system; prior difficult or unpleasant experiences getting health care; and communication barriers, such as failure to accommodate deaf patients who require sign-language interpreters. The effects vary depending on

the disability type: stigma, for instance, is especially problematic for people with mental health or intellectual disabilities, whereas inaccessible equipment can prevent someone with significant mobility disability from obtaining even basic services (e.g., getting weighed).

Recognizing persisting health and health care disparities, lawmakers inserted provisions related to disability into the ACA. Provisions preventing insurers from rejecting applicants on the basis of preexisting health conditions will eliminate barriers to obtaining health insurance for people with disabilities or disabling health conditions. In addition, caps on annual out-of-pocket expenditures, the lifting of total lifetime limits on insurance coverage, and the separation of affordable, good-quality health insurance from employment will benefit people with disabilities, who have disproportionately high unemployment rates and low levels of coverage through traditional employer-based plans. Health care delivery systems and administrative reforms, such as patient-centered medical homes, can improve coordination of care for people with disabilities. Accountable care organizations hold potential for improved care integration if careful monitoring can ensure high-quality service delivery.

Other ACA provisions specifically target disability. To enhance public health surveillance and monitor interventions, Section 4302 calls for gathering systematic and consistent data on populations affected by health disparities, including people with disabilities. Section 5307 authorizes federal funding for training

health care professionals in competencies related to “disability culture” and development of model curricula on the needs of people with disabilities. Of critical importance, for example, is training in the cervical- and breast-cancer screening needs of women with physical, intellectual, or mental disabilities.

Section 4203 of the ACA calls for the “establishment of standards for accessible medical diagnostic equipment”; having accessible equipment should increase the use of preventive services and improve safety for health care staff by reducing their risks of injuries during patient transfers. The U.S. Access Board is working with the Food and Drug Administration to develop equipment-accessibility standards with which manufacturers will need to comply in order to claim that their equipment is accessible. Ensuring accessibility of health care facilities and equipment can improve the provision of both acute and preventive care for people with disabilities and make it easier, safer, and more comfortable for them to receive routine care and screening tests.

Twenty-five years after the passage of the ADA, great advances have been made for people with disabilities. Yet they remain at a significant disadvantage with respect to health and health care. With the number of disabled Americans growing, every physician and health care delivery system can expect to see increasing numbers of such patients. To improve their health outcomes, health care professionals can prepare — through education, planning, and policy changes — to care for them effectively in accessible environments and responsive delivery

systems supported by networks of community-based, long-term services. In doing so, we will help create an environment that promotes full participation in our society, more independent living, and improved quality of life built on better health. The ACA offers policies and tools that should benefit people with disabilities. However, concerted attention from practitioners and delivery systems will be needed to improve care for this population that ultimately most of us will join.

The views expressed in this article are those of the authors and do not necessarily represent the official position of the Centers for Disease Control and Prevention (CDC).

Disclosure forms provided by the authors are available with the full text of this article at NEJM.org.

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