Disability, Income, and Rural Poverty

2

William A. Erickson, Sara VanLooy, Sarah von Schrader, and Susanne M. Bruyère

Poverty anywhere is a threat to prosperity everywhere.
(United Nations Development Program, 1995)

Overview

Poverty exists as a cycle. The occurrence of poverty in one social, cultural, or economic dimension tends to affect other dimensions such as health or income investment. The less income a person, community, or country has, the less capital they have to reduce poverty over time (Lynn, 2005). Poverty, particularly persistent poverty, in rural America is greater than in urban areas (Weber, 2007). Many rural residents have been left behind or shut out of our nation's prosperity. Regionally, rural and small town poverty rates are highest in the South and lowest in the Northeast and Midwest. Too often poverty has the most detrimental impact on people who are the most vulnerable, overwhelmingly children, older adults, and people with disabilities (Housing Assistance Council, 2012). Even during good economic times in America, rural communities have experienced disproportionate poverty rates, with persistent poverty being more prevalent among more remote counties and areas with distinctive concentrations of racial/ethnic minorities (Weber, 2007).

The response to poverty in rural communities has been a combination of targeted governmental programs and policies, yet poverty persists. Edelman (2006) discussed the lessons we have learned from the "war on poverty" and identified lessons for future programs. Among these lessons were that poverty cannot be addressed successfully without addressing the question of income and rural poverty cannot be addressed in a vacuum.

The situation for people with disabilitiesis particularly dire, with over one in five persons with a disability living in poverty (21.5%) compared to slightly more than one in ten of those without (12.5%). The situation is even worse when one focuses on the working-age population (ages 21–64) where 28.1% of those with a disability live in poverty compared with 12.2% of those of working age without a disability (Erickson, Lee & von Schrader, 2016). Given that people with disabilities may have greater financial burdens due to their disabilities or health conditions, the implications for living in poverty may be even greater than these numbers would suggest.

Learning Objectives

By the end of the chapter, the reader should be able to:

- Understand how poverty is officially measured and the potential limitations and implications of the measurements used

W.A. Erickson (✉) • S. VanLooy • S. von Schrader
S.M. Bruyère
K. Lisa Yang and Hock E. Tan Institute on Employment and Disability, Cornell University, Ithaca, NY, USA
e-mail: wae1@cornell.edu; sav22@cornell.edu; sv282@cornell.edu; smb23@cornell.edu

D.A. Harley et al. (eds.), *Disability and Vocational Rehabilitation in Rural Settings*,
DOI 10.1007/978-3-319-64786-9_2

- Understand the extent and significance of income inequality and the disability poverty gap in rural areas
- Be able to identify factors that may be related to the high poverty rates among the rural population with disabilities
- Become familiar with poverty alleviation/elimination policies and initiatives to date and their perceived outcomes and impact
- Understand the implications of poverty factors on the functioning of human service and vocational rehabilitation agency service administration and practice in rural areas, as well as on professional preparation and related research

Introduction

The interactions between disability and poverty are complex, and relatively little research exists that is specific to rural areas in the USA. Working-age individuals with disabilities in the USA are 2.3 times more likely to be living in poverty than their nondisabled peers (Erickson et al., 2016). Likewise individuals living in rural areas are more likely to live in households that live below the poverty line (US Department of Agriculture, 2014). Individuals with disabilities who live in rural areas may be doubly disadvantaged. In this chapter we provide a description of how poverty is defined in US policy, a broad overview of federal and state antipoverty public policy, and statistics describing the current status of people with and without disabilities with regard to poverty and economic well-being, as well as factors that may be related to the high poverty rates among the rural population with disabilities. Specific statistics about disability prevalence, economic conditions, and factors that may differentially impact the economic opportunities of individuals with disabilities in rural areas are presented. This information is a critical first step to understand income inequality and the disability poverty gap in rural areas, and to design policy to address issues specific to rural areas. Subsequent chapters will expand on this overview with chapters targeting barriers to reducing poverty in rural areas, specifically as they may differentially impact individuals with disabilities.

Theories of Rural Poverty

The majority of the world's poor live in rural areas, and a greater percentage of the population is poor in rural areas of the world (Dwyer & Sanchez, 2016). Rural poverty's causes are diverse, but many are rooted in a combination of economic underdevelopment, decline, or neglect. The rural economy is largely concerned with food and commodity production rather than emerging technologies and industries, and the lack of diverse opportunities leads younger and more educated residents to migrate away (Dwyer & Sanchez, 2016).

It is widely understood that poverty is linked to geographical disparities and that some communities and locations lack the resources to improve the well-being of their population (Bradshaw, 2006; Dwyer & Sanchez, 2016). It has been observed that economic resources tend to cluster or aggregate together – successful businesses attract more businesses, pulling resources away from other communities, while communities left behind experience economic restructuring and delays in receiving new technologies (Bradshaw, 2006).

Studies of poverty, however, particularly studies of poverty in the USA, have largely focused on the issue of urban poverty. "The American public generally perceives poverty as an urban problem" (Dudenhefer, 1993). Rural poverty has been considered a logical outcome of rural work culture, a lack of skills and preparation on the part of rural workers, and a lack of rural human capital. However, the 1990 Task Force on Persistent Rural Poverty suggested a reframing of these assumptions, stating that the changing nature of the rural economy since the end of World War II has created a fundamental problem: low wages and inadequate opportunities for youth, minorities, women, and the least educated (Dudenhefer, 1993). These changes have resulted

from the restructuring of US manufacturing base, the growing influence of resource-extraction firms in rural areas, and the privatization of management of rural lands.

US Antipoverty Public Policy

The US dialog on poverty over the last few decades has been framed in terms of welfare policies rather than poverty itself, such that poverty has come to be discussed largely in terms of what benefits the poor receive, rather than the underlying social structures that put people on the benefit rolls (Edelman, 2009). Edelman (2009) suggests that the national debate on poverty since the 1980s has not been about addressing its causes but about blaming its victims.

This perspective on poverty puts the USA at odds with most other "wealthy" nations. The USA has higher poverty rates than most rich nations, spends less on antipoverty programs than most other rich nations, and defines poverty at a much lower threshold. It spends less on public programs and more on private social expenditures, and the money it does spend has a markedly smaller effect in reducing poverty than does similar amounts spent in European Union nations (Caminada & Martin, 2011; Smeeding, 2008). Most of these other nations also invest heavily in preventing childhood poverty in particular, due to clear evidence that child poverty is a significant risk factor for adult health conditions and disability (Racine, 2016; Smeeding & Thevenot, 2016). These differences are rooted in long-standing social and economic issues, including attitudes toward the poor, notions of social and personal responsibility, and attitudes about race (Caminada & Martin, 2011; Edelman, 2009; Martin & Caminada, 2011; Sachs, 2016).

Ways That Poverty Has Been Defined in US Public Policy

In January 1964, President Lyndon B. Johnson declared a "War on Poverty," introducing initiatives intended to "replace despair with opportunity" and improve the education, health, skills, jobs, and access to resources of the poor (Council of Economic Advisors, 2014). In 1969, the federal government set an official measure of poverty for these programs that was based on the cost of food (Fisher, 1992).

Currently, the US Census Bureau sets the "poverty threshold" with a formula based on "the cost of a minimum food diet … updated annually for inflation" (Institute for Research on Poverty, 2014b). This measure was first determined by economist and statistician Mollie Orshansky in 1963, using a list of foods then commonly considered acceptable and necessary, and was based on the assumption that food expenditures accounted for about one-third of a typical family's overall income (Fisher, 1992). That assumption was in turn based on a 1955 USDA Household Food Consumption Survey (Fisher, 1992). The cost of food used in this calculation was drawn from the USDA's "Economy Food Plan," which was created in 1961 as a food plan for short-term or emergency use, a lower step even than their "Low-Cost Food Plan."

Thus, the "poverty level" is based on a number of assumptions rooted in the 1950s and 1960s, reflecting situations that may not still exist today. The "Thrifty Food Plan" (the 1975 replacement for the "Economy Food Plan") has been criticized as including impractical and no-longer-realistic foods, as lacking the variety called for in updated dietary guidelines issued by the government, and as having unrealistic expectations regarding the availability of food and the facilities and time for food preparation (Food Research and Action Center, 2012). The poverty level calculations do not take into account the changing structure of the economy, including the decline in food costs as a proportion of overall expenses and the rapid rise in the cost of housing. It also does not reflect changed expenses including taxes, work expenses, childcare costs, or resources such as the availability of some in-kind benefits (Institute for Research on Poverty, 2014a). Others observe that income and consumption are not strongly correlated, and a consumption measure better reflects the desire to reduce material

deprivation (Meyer & Sullivan, 2012; U.S. House of Representatives, 2014). Orshansky herself knew her measure was flawed from the start, believing that it understated poverty. She stated in the *Social Security Administration Bulletin* in 1965, "if it is not possible to state unequivocally how much is enough, it should be possible to assert with confidence how much, on an average, is too little" (Council of Economic Advisors, 2014, p. 9).

In response to these concerns, the US Census Bureau introduced the Supplemental Poverty Measure (SPM) in 2010. The measure is intended to "Provide an alternative view of poverty in the United States that better reflects life in the 21st century" (Institute for Research on Poverty, 2014a). It takes into account the costs of owning vs. renting homes, as well as a wide array of necessary expenditures, including medical costs, and the definition of minimum needs is adjusted each year based on recent data (Council of Economic Advisors, 2014). The measure is supplemental, however, and has not replaced the official poverty measure for use in government programs and means-tested benefit eligibility. However, SPM indicates even greater differences in poverty rates between individuals with and without disabilities; that is, the percentage point difference between individuals without disability and with disabilities is larger (Brucker, Mitra, Chaitoo, & Mauro, 2015).

Multidimensional poverty measures that focus beyond income on well-being may be even more relevant. These more complex measures may include dimensions such as "education, employment, economic resources and expenditures (including food security), health and heath care, political participation, and social inclusion" (Brucker, Mitra, et al., 2015, p. 274) and demonstrate even greater poverty for individuals with disabilities relative to nondisabled peers. Attempts to construct such measures, which reflect the links between income poverty, material hardship, and health, have confirmed that income-only measures underestimate the extent to which families experience economic disadvantage (Neckerman, Garfinkel, Teitler, Waldfogel, & Wimer, 2016).

Rural areas tend to have higher rates of poverty than metro areas, but the differences have decreased significantly over the last 45 years. When poverty rates are adjusted for different housing costs in metro and rural areas, poverty rates are actually higher in metro areas (Council of Economic Advisors, 2014). The cost of living in a rural region tends to be lower than in urban areas, largely due to lower food and housing costs (Arnold, Crowley, Bravve, Brundage, & Biddlecombe, 2014; Kurre, 2003; Nord, 2000). Methods of calculating cost of living, however, may underestimate actual costs for important areas of the country and do not take into account that nonhousing costs tend to rise with decreases in housing costs (Nord, 2000).

Despite overall lower costs of living, extreme poverty remains an issue in rural counties identified as "persistently poor" (high levels of poverty for over 30 years); 85% are rural counties. Since the Great Recession, rural counties have not seen as much employment growth as urban counties, although there are exceptions in areas with employment in oil and gas extraction (US Department of Agriculture, 2014). Our subsequent presentation of data that examines disability, income, and poverty by geographic region and rural area status sheds light on factors that may help to explain disparities and how to alleviate them. However, first we provide an overview of approaches to combat poverty at the national, state, and more local levels.

National Approaches to Poverty Alleviation

The leading federal antipoverty programs (in terms of expenditures) are the Earned Income Tax Credit (EITC) and the Supplemental Nutrition Assistance Program (SNAP) (Kearney & Harris, 2014). Other federal programs include Social Security (SSI and SSDI), unemployment insurance, housing subsidies, the national school lunch program, Temporary Assistance for Needy Families (TANF), and Women, Infants, and Children (WIC) nutrition support. Some of these programs are entirely administered at the federal level, in the form of federal benefits or federal tax credits, while others are administered via block grants to individual states (Council of Economic Advisors, 2014).

The federal safety net kept 41 million people above the poverty line in 2012, including 9 mil-

lion children (Center on Budget and Policy Priorities, 2014, sec 3). The single most effective safety-net program is Social Security's provision of assistance to the elderly, people with disabilities, and the surviving spouses and children of workers. In 2012, Social Security reduced the overall poverty rate by 8.5 percentage points and lifted 26.6 million people above the poverty line, including 17 million senior citizens and 1 million children (Center on Budget and Policy Priorities, 2014; Council of Economic Advisors, 2014, sec 3).

The two largest safety-net programs by expenditure outlay, the Earned Income Tax Credit (EITC) and the Supplemental Nutrition Assistance Program (SNAP), are generally regarded by poverty scholars as effective (Kearney & Harris, 2014). SNAP in particular has proven to respond to economic conditions as a true safety-net program, with caseloads rising during downturns and falling during recoveries. Further, its long-term benefits to low-income children have been well-documented (Center on Budget and Policy Priorities, 2014; Kearney & Harris, 2014). Likewise, the EITC has been shown to boost employment among parents and increase their earnings by 17%, and is the most important factor in increasing employment among single mothers. In addition, children in families receiving EITC do better in school, are more likely to attend college, and have higher earnings as adults (Center on Budget and Policy Priorities, 2014, sec 3).

These programs are extremely important in the context of disability. Three-quarters of all low-income working-age people with disabilities participate in one or more of these safety-net programs, with public healthcare programs being the largest non-disability program category. Over half (52%) of people with disabilities aged 25–61 accessed at least one public health insurance program, compared to only 8% of people without disabilities (Houtenville & Brucker, 2014).

State and County/Local Government Approaches

While much of the funding for antipoverty programs comes from the federal government, many policies are now set at the state level. Welfare reforms of the 1990s gave states broad power to experiment with different approaches to delivering programs (Stanford Center on Poverty and Inequality, 2015), and many states have initiated their own programs and tax credits to support low-income workers (Weber, 2007). In turn, many of the most populous states shifted direct administration of these welfare programs to counties, giving counties new responsibilities for workforce development and poverty alleviation efforts (Lobao, Jeanty, Partridge, & Kraybill, 2012).

States have taken different paths in this area, with differing outcomes, attempting to balance the desire to encourage self-sufficiency with the need to prevent poverty. In general most states have chosen to either offer higher levels of benefits that taper off quickly as family income increases or to provide much lower levels of assistance to the very poor, but to continue to provide support to low-income workers (Stanford Center, 2015).

State and local approaches reflect the importance of local context in understanding poverty. As Weber (2007) states, "Local economic conditions matter" (p. 49). Local job growth is vital to moving people out of poverty, and community social capital is also a key component. Communities with greater civic participation and organizational membership also have seen greater poverty reduction (Weber, 2007). These observations echo those of Stauber (2001) who concluded, "Communities that survive and prosper also invest in building the social and human capital of their institutions and people. But communities with high social and human capital and declining economic opportunity are not likely to have positive futures" (p. 44).

The question remains, however, as to how effective local government responses to poverty have been. Lobao et al. (2012) analyzed the degree to which county government capacities and policies correlated with economic indicators. Counties are a good unit of study for this; they contain more residents than municipalities and are the fastest-growing general type of government. They provide more services such as welfare, health, and housing than cities do, and they raise more of the funds to do so themselves.

Despite this, county governments are rarely studied in this context and are often seen as barriers to poverty alleviation because of their tendency to adopt "race to the bottom" strategies in an effort to pursue growth at the expense of social welfare, accepting the growth of low-wage industries in order to be able to claim that growth is happening at all (Lobao et al., 2012).

Counties can alleviate poverty by developing and using administrative capacity in order to enhance efficiencies when enacting policies and programs. Lobao et al. (2012) found that it is administrative capacities such as the existence of professionalized staff and centralized resources, much more than specific policies, which seem to promote job growth and reduce poverty. Popular policies intended to attract business had no statistical effect on residents' well-being, while programs designed to divert resources to local entrepreneurs failed to create growth and reduced poverty alleviation efforts. The counties that were the most successful at promoting job growth and reducing poverty levels in their study were the most centralized governments with the greatest fiscal autonomy.

Rural Poverty and Disability

The local aspect of poverty in the USA is very important when considering rural disability and poverty. County-level poverty rates are lowest in the suburbs and increase as counties become more rural, while persistent poverty is disproportionately found in rural areas (Weber, Jensen, Miller, Mosely, & Fisher, 2005). Tickamyer and Duncan (1990) state that rural poverty has historically been linked to limited opportunity structures in rural communities, and these limits have been exacerbated by modern economic restructuring. With the globalization of the labor market and the transition from a resource-production and manufacturing economy to a market of services and ideas, isolation and instability have increased. Weber et al.'s review of the rural poverty literature (2005) found that all types of studies they examined report some form of "rural effect," that is, economic and demographic differences do not fully explain the increased poverty levels of rural communities. They suggest, however, that all the studies have methodological concerns that have not been addressed and that quasi-experimental studies are especially needed.

Suggested causes for this concentration of poverty in rural settings vary, with some concluding that isolation from institutions such as schools and the labor market is a major factor, while others suggest that a persistent system of "haves" and "have nots" enforce long-term poverty by socially isolating the have nots and preventing access to the resources they need for economic participation (Weber et al., 2005). The quality and type of locally available jobs also plays a role (Stauber, 2001; Weber et al., 2005).

The study of poverty has historically been the study of urban poverty, while rural studies have been marginalized. Rural poverty is the domain of agriculture schools rather than sociology or economics departments (Gurley, 2015). While rural and urban poverty share a common root in the inability of individuals to find work that pays a living wage, many causal factors of poverty are worse in remote areas, which lack the diverse human capital, transportation efficiencies, and labor market opportunities of cities (Gurley, 2015).

Writing before the recent Great Recession, Stauber (2001) observed, "We are headed back to a rural America of the rich and the poor – of resorts and pockets of persistent poverty" (p. 33). He stated that rural policies tended to be products of a "one size fits all" approach, created without regard to sector issues and often poorly modified urban or national-level policies (p. 41). He sees this as a result of cultural changes in the social contract between the urban majority and the rural minority and argues for specific investments in rural communities that he believes will make a difference. Based on studies of successful rural communities, he states that critical factors for community investment include investment in infrastructure, a focus on entrepreneurship and growth, emphasis on inclusion in the community, and strong leadership. Further, rural communities that have overcome poverty are those with people and institutions that

work effectively across class lines and avoid domination by economic and social elites. State strategies for reducing poverty in rural areas can include support for local economic development (see Chap. 1), building community capacity, rewarding work efforts through tax credits and child care subsidies, increasing work supports such as transportation (see Chap. 3) and childcare, and improving worker productivity through education and training (Weber, 2007).

Both rural residence and poverty are inextricably tied to health status and disability (Braithwaite & Mont, 2009; Elwan, 1999; Fremstad, 2009; von Reichert & Myers, 2014). Longitudinal studies have shown that people earning less than twice the poverty level had significantly higher risk of diabetes, arthritis, back pain, hypertension, and heart disease (Givon, 2016). Rural residence limits access to healthcare; patients must travel greater distances to see doctors and are more likely to encounter barriers such as lack of transportation, severe weather, or bad roads. Rural areas also have significantly fewer physicians and have less than half the number of specialists per 100,000 residents, as well as fewer dentists, while rural hospitals often struggle financially as they attempt to care for a large number of Medicaid and Medicare patients, for whom reimbursements often do not cover actual costs (Joint Economic Committee, 2014).

According to Newkirk and Damico (2014), residents of rural areas are less likely than urban residents to have employer-provided health insurance. Half of all rural workers work in industry categories in which less than 80% of workers are covered by employer-sponsored insurance. Yet as a result of state policy decisions, rural areas are much more likely to fall into the "coverage gap" in which the Medicaid Expansion has not been implemented – 65% of the rural population lives in states that are not expanding Medicaid, compared to 50% of residents of metropolitan areas. Burton, Lichter, Baker, and Eason (2013) reviewed the literature of poverty, inequality, and health in rural America and report a wide range of health disparities: rural residents were more likely to report poor health, and a variety of chronic disease including cardiovascular conditions and cancer. Rural obesity rates are significantly higher than those of urban residents, and they have higher rates of injuries and accidental fatalities. Rural residents have poor dental health and less access to reproductive health services, and there are significant mental health differences (see Chap. 26) (p. 1138).

Policies have been enacted to address these issues of healthcare access. The Critical Access Hospital Program allows hospitals in remote areas a higher reimbursement for Medicare services, to keep rural hospitals economically stable and prevent closures and further reductions in numbers of providers. In addition, National Health Service Corps awards scholarships and loan forgiveness to primary care providers who agree to practice in underserved areas (Joint Economic Committee, 2014).

In addition, the rural population is aging more rapidly than the population as whole, and there is greater out migration of younger people. A disproportionate share of older Americans live in rural areas (Glasgow & Brown, 2012), and a larger share of them are the "oldest old" (age 85 and older). Overall, the more rural an area is, the older its residents and with this comes increased levels of chronic illness and disability.

Another major disadvantage of people with disabilities in rural areas is in obtaining safe, clean, and affordable housing. In 2009, nearly one-third of all rural households were cost-burdened, meaning that more than 30% of household income was required to cover housing costs (Housing Assistance Council, 2011). The number of cost-burdened renter households in rural areas increased by over 10 percentage points between 2000 and 2010, driven by rising rents and stagnating wages. While housing does cost less in rural than in urban areas, household incomes are similarly lower (Arnold et al., 2014). Additionally housing stocks in rural areas provide other challenges; housing is older and more likely to be in poor condition (Duncan, 1994). Aging rural residents who become disabled may require expensive home improvements to address hazardous bathrooms, steep staircases, narrow doors, and dated electrical installations (Housing Assistance Council, 2014).

Documenting Disability Prevalence and the Economic Divide Across Urban, Rural, and Persistently Poor Rural Counties

Thus far in this chapter, we have discussed national, state, regional, and local public policy approaches to reduce poverty. Additional insight on policy development can be gained by examining specific issues, such as in this case rural poverty and disability. In the following section, we present some estimates to better understand disparities and the factors associated with rural poverty and disability, beginning with a description of our approach to obtaining these estimates from existing data sources.

Data Sources and Measures

There are very few data sources that can provide reasonable substate estimates for rural areas such as at the county level. Based on recommendations of the US Census Bureau and the US Department of Agriculture (USDA) Economic Research Service (ERS) regarding subnational rural poverty statistics (US Department of Agriculture, 2016), we use data from the US Census Bureau's American Community Survey (ACS) for the majority of the estimates presented in this chapter. The ACS is nationally representative and surveys over three million households annually as well as the population living in a sample of institutional facilities (i.e., nursing homes, correctional facilities) and noninstitutionalized facilities (i.e., college dorms, military barracks, etc.) (Erickson, 2012). The Census Bureau compiles ACS data over a period of 5 years to provide an adequate sample to develop a limited number of estimate tables for even the most sparsely populated areas such as rural counties. However, due to the limited number of topics covered by the Census Bureau county-level tables, we also performed analysis of the ACS Public Use Microdata Sample (PUMS) to examine other topics of interest in greater depth for this chapter. Because of Census Bureau data confidentiality concerns, only larger, more populous areas can be specifically identified in the PUMS data. To address this limitation, we focus our analysis on predominantly rural areas, those with 70% or more of the total population living in rural areas.

The other data source used in this chapter is Social Security Administration's (SSA) administrative data for which is also available at the county level and provides insight into the receipt of SSA old age, survivor, and disability insurance (OASDI) benefits. Generally individuals who receive OASDI benefits between the ages of 18 and 64 do so because of a disability.

Defining Disability

There is no single accepted definition of disability. Different definitions and disability questions may identify different populations with disabilities and result in larger or smaller prevalence estimates. The six questions that are used in the ACS to identify persons with disabilities are primarily aimed at identifying sensory, functional, and activity limitations (Brucker, Houtenville, & Lauer, 2015). Note that respondents to the ACS can report more than one disability type and that some disability questions are not asked of children. The "Disability" category used in this chapter includes persons who reported one or more of the individual disability types:

- *Hearing disability (asked of all ages)*: Is this person deaf or does he/she have serious difficulty hearing?
- *Visual disability (asked of all ages)*: Is this person blind or does he/she have serious difficulty seeing even when wearing glasses?
- *Cognitive disability (asked of persons age 5 or older)*: Because of a physical, mental, or emotional condition, does this person have serious difficulty concentrating, remembering, or making decisions?
- *Ambulatory disability (asked of persons age 5 or older)*: Does this person have serious difficulty walking or climbing stairs?
- Self-care disability (asked of persons age 5 or older): Does this person have difficulty dressing or bathing?

- *Independent living disability (asked of persons age 15 or older)*: Because of a physical, mental, or emotional condition, does this person have difficulty doing errands alone such as visiting a doctor's office or shopping?

Defining Rural Areas

There are a number of ways of defining and classifying urban and rural areas (Cromartie & Bucholtz, 2008; Enders, Seekins, Brandt, 2005, U.S. Department of Health and Human Services, 2015). Given the topics we are discussing in this chapter, it was decided to utilize the Urban-Rural Classification Scheme for Counties[1] developed by the CDC's National Center for Health Statistics (NCHS). The NCHS Urban-Rural Classification Scheme for Counties was specifically designed for their utility in examining health differences across the urban-rural continuum. Counties may appear to be rather large areas to work with; however, there are difficulties in developing reliable estimates for entities below that geographical level, especially for areas with sparse populations. Given that limitation, it was determined that counties were the smallest reasonable geographical entity to use in this chapter to examine disability prevalence, poverty, and employment-related issues using existing data from the US Census Bureau and SSA.

The NCHS Urban-Rural Classification Scheme begins with the US Office of Management and Budget (OMB) metropolitan and nonmetropolitan categories, based on US Census Bureau population data. The OMB identifies metro counties as those containing one or more urbanized areas, including both high-density urban areas containing 50,000 people or more and outlying counties that are economically tied to the central counties (as measured by the share of workers commuting on a daily basis to the central counties). These counties are referred to as "urban" in the remainder of this chapter. Nonmetro (rural) counties lie outside the boundaries of metro areas and contain no cities with 50,000 residents or more. NCHS then further divides these basic categories into a six-part county classification comprised of four metro (urban) and two nonmetro (rural) groupings (Ingram & Franco, 2013).

For the purposes of analysis in this chapter, we combine the six classifications into four categories, focusing primarily on the two rural "size" categories: micropolitan and noncore counties (which can be thought of as the most "rural"). The 2013 NCHS Urban-Rural Classification Scheme includes 1167 metropolitan (urban) counties and 1976 nonmetropolitan (rural) counties. Nearly one in five Americans live in rural counties, and these counties comprise approximately 75% of the US land mass.

We further separate and examine the characteristics and economic situation of individuals living in the 301 "persistently poor" rural counties to provide a more detailed examination of these economically marginalized counties. Note that "persistently poor" rural counties are excluded from the micropolitan and noncore rural county estimates that are presented below.

Figure 2.1 shows the distribution of counties in the USA across the following four categories:

- Urban (1167 counties): metropolitan counties containing one or more urban core of 50,000 or more people. Less populous counties with close commuting ties may also be categorized as urban.
- Micropolitan rural (564 counties): rural counties with an urban core of 10,000–50,000 people. Excludes rural counties experiencing persistent poverty.
- Noncore rural (1111 counties): rural counties with an urban core population of less than 10,000. Excludes rural counties experiencing persistent poverty.
- Rural counties with persistent poverty (n = 301: 77 micropolitan and 224 noncore): includes all rural counties that have been identified as experiencing persistent poverty.

As can be seen, the vast majority of the US landmass is rural with the majority of the urban

[1]Note that counties also include county "equivalents," 3141 total, and include 3007 entities called "counties," 16 boroughs and 11 census areas in Alaska, 64 parishes in Louisiana, and 42 independent cities (1 in Maryland, 1 in Missouri, 1 in Nevada, and the remainder in Virginia) and the District of Columbia.

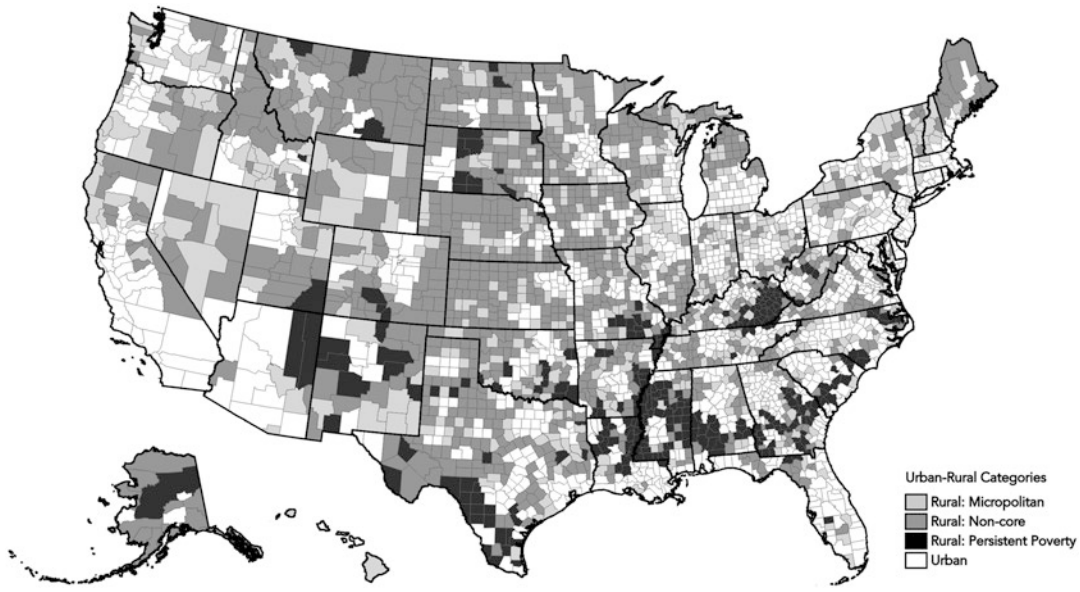

Fig. 2.1 US county map identified as urban, rural, micropolitan, noncore, and persistently poor (Data sources: adapted from Ingram and Franco (2013). Persistent poverty counties: http://www.ers.usda.gov/dataFiles/County_Typology_Codes/PersistentPovertyCounties.xls. Map produced by Michael Ward)

counties located along the coastal areas. There are a number of persistent poverty hot spots located in southern Appalachia and in the Deep South including the states of Alabama, Louisiana, Arkansas, and Missouri. Large swaths of central and western US counties are either rural noncore or micropolitan with a number of states comprised almost entirely of rural counties.

Disability Prevalence

Table 2.1 presents disability prevalence aggregated at the county level into the four county groupings: (1) urban counties, (2) micropolitan rural counties, (3) noncore rural counties, and (4) rural counties with persistent poverty. Disability prevalence is consistently higher in rural areas, with an average across counties of 15.2% for micropolitan counties, 16.4% in noncore rural counties, and 20% in the persistently poor rural counties, compared to 13.7% in urban counties.

As with overall prevalence, the prevalence of nearly every disability type is lowest in urban counties and increases from micropolitan to noncore and is highest in the persistently poor counties. This can clearly be seen in the maps provided in Figs. 2.1 and 2.2. There is a distinct cluster of about two-dozen persistently poor rural counties in the southern Appalachia region around the intersection of three states: Kentucky, Virginia, and West Virginia that is visible in Fig. 2.1. That same area also has some of the highest disability prevalence rates as well.

This same pattern of higher prevalence rates in the more rural areas holds for males, females, and each race grouping (see Table 2.1). Further, disability prevalence also varies greatly by age group. In the rural persistently poor counties, nearly one in five (18.6%) working-age individuals (18–64) reports a disability. Nearly 40% of individuals ages 65 and older have a disability in the urban, micropolitan, and noncore county categories; however, the highest prevalence rate (nearly 50%) is seen in the rural persistently poor counties. Clearly, across nearly all breakdowns presented, the prevalence of disability is higher in rural areas; however, prevalence rate is not all of the story. How do these individuals with disabilities actually fare in rural areas? In the next section,

Table 2.1 Average disability prevalence across urban and rural counties

Characteristics	Urban (n = 1167) (%)	Rural		
		Micropolitan (n = 564) (%)	Noncore (n = 1115) (%)	Persistent poverty (n = 301) (%)
Disability prevalence	13.7	15.2	16.4	20.0
Disability type				
Hearing	4.0	4.8	5.8	5.7
Visual	2.4	2.7	3.0	4.7
Cognitive	5.4	5.8	5.8	8.2
Ambulatory	7.8	8.6	9.4	12.6
Self-care	2.8	3.0	3.2	4.5
Independent living	6.2	6.5	6.7	9.7
Sex				
Male	13.8	15.4	17.1	20.3
Female	13.7	14.9	15.8	19.6
Race				
White	13.9	15.4	16.4	20.4
Black	14.9	15.1	19.1	21.4
Asian	6.8	7.8	8.5	10.0
Other race	11.7	13.3	16.1	18.4
Age				
Age < 5	0.9	1.0	1.0	1.0
Ages 5–17	5.8	6.1	5.9	7.0
Ages18–64	11.8	13.1	13.6	18.6
Age greater than 64	37.3	38.6	39.3	48.0

Note: Counties are the unit of analysis. Estimates include only civilian, noninstitutionalized population
Data source: Based on US Census table, S1810 disability characteristics, 2010–2014 American community survey 5-year estimates

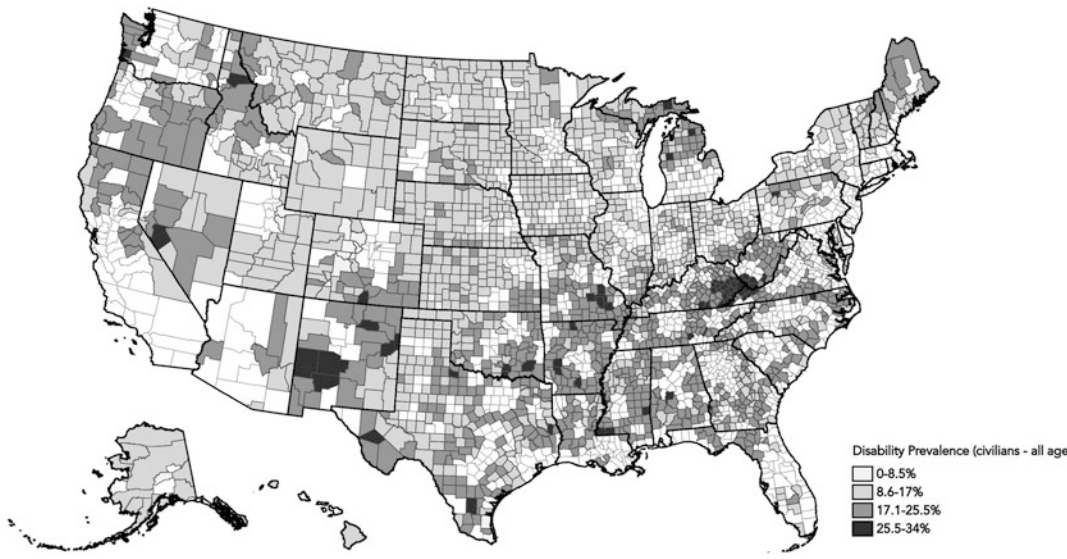

Fig. 2.2 Disability prevalence in rural counties (Note: Data for urban counties is not included. Urban counties are left unshaded. Data source: Based on US Census table, S1810 disability characteristics, 2010–2014 American community survey 5-year estimates. Map produced by Michael Ward)

we examine various indicators of economic well-being by disability status across these same county groups to explore this question.

Employment, Income Disparities, and Poverty Rate by Disability Status

Urban and rural micropolitan and noncore counties have similar employment rates for persons without a disability – around 75%. The employment rates for working-age (18–64) persons with disabilities are far lower, around 35–37%. Table 2.2 presents employment rate, median earnings, and poverty rate by urban and rural counties, again breaking down the rural counties into the three categories. Persons with disabilities are employed at only about half the rate of persons without as reflected in the employment rate ratios ranging from 0.46 to 0.49.

The employment situation in persistently poor rural counties is far worse than the other areas, with only 64.4% of persons without disabilities employed and less than a quarter of those with a disability, resulting in a 0.38 employment rate ratio. Not surprisingly, median earnings are slightly higher in urban counties, where the cost of living may be higher. Differences between individuals with and without disabilities are relatively consistent, with a typical individual with a disability earning only around 70% (0.70 earnings ratio) the amount of a typical person without a disability.

As discussed earlier in this chapter, the official poverty measure used in government programs and means-tested benefit eligibility has some

Table 2.2 Employment, earnings, poverty, and OASDI receipt by urban and rural county categories

Measure	Urban (n = 1167)	Rural		
		Micropolitan (n = 564)	Noncore (n = 1115)	Persistent poverty (n = 301)
Employment rate (ages 18–64)[a]				
No disability	74.3%	74.4%	75.5%	64.4%
With disability	34.7%	35.3%	37.1%	24.3%
Employment rate ratio	0.46	0.47	0.49	0.38
Median earnings (workers ages 16+ with earnings in the past 12 months)[b]				
No disability	$30,817	$27,233	$27,074	$23,453
With disability	$21,103	$18,697	$19,317	$17,840
Median difference	$ 9700	$ 8512	$ 7738	$ 5613
Median earnings ratio	0.70	0.71	0.73	0.78
Poverty rate (ages 18–64)[c]				
No disability	12.6%	14.1%	13.0%	23.3%
With disability	26.4%	28.3%	26.6%	37.1%
Poverty rate ratio	2.28	2.16	2.23	1.65
OASDI receipt (ages 18–64)[d]	2.6%	3.0%	2.9%	6.6%

Numerator: Number of recipients in state (by eligibility category, age, and receipt of OASDI benefits) and amount of payments, by county, December 2014 (persons ages 18–64) https://www.ssa.gov/policy/docs/statcomps/ssi_sc/2014/table03alt.xlsx and denominator from U.S. Census table, S1810 disability characteristics, 2010–2014 American Community Survey 5-Year Estimates

Note: Counties are the unit of analysis. Estimates include only the civilian, noninstitutionalized population. Median difference and median earnings ratio are calculated using as the median of county differences and earnings ratios

Data sources:

[a]C18120 employment status by disability status. Universe: Civilian noninstitutionalized population 18–64 years 2010–2014 American Community Survey 5-Year Estimates

[b]B18140 median earnings in the past 12 months (in 2014 inflation-adjusted dollars) by disability status by sex for the civilian noninstitutionalized population 16 years and over with earnings. Universe: Civilian noninstitutionalized population 16 years and over with earnings in the past 12 months, 2010–2014 American Community Survey 5-Year Estimates

[c]C18130 age by disability status by poverty status. Universe: Civilian noninstitutionalized population for whom poverty status is determined 2010–2014 American Community Survey 5-Year Estimates

[d]Percentage derived based on SSA data: Table 3

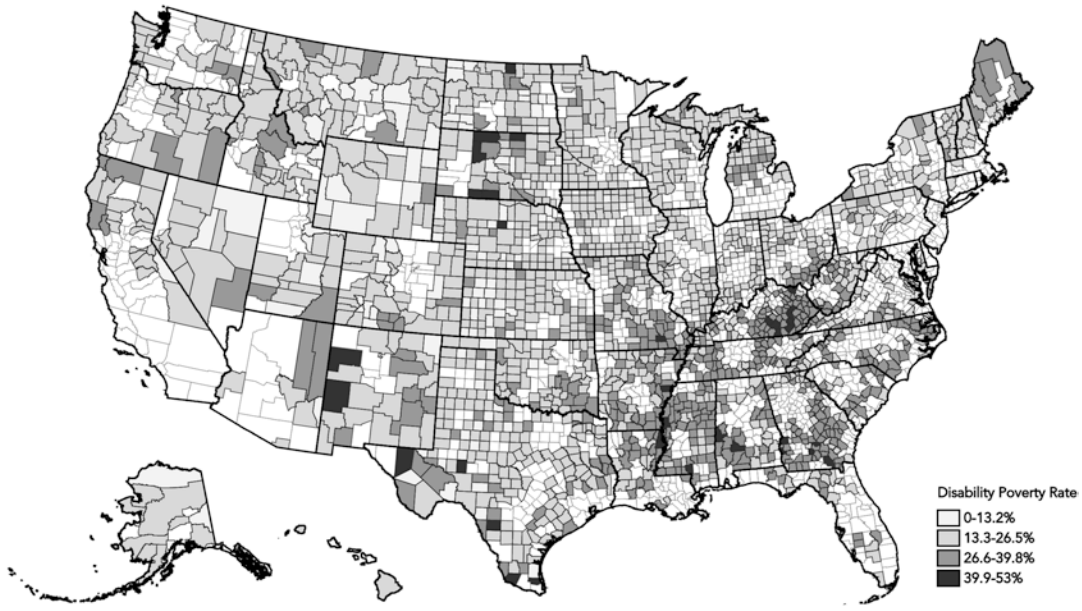

Fig. 2.3 Map of poverty rate for persons with disabilities of all ages in rural counties (Note: Data for urban counties is not included. Urban counties are left unshaded. Data source: Based on calculations on US Census table, C18130: Age by disability status by poverty status. Universe: Civilian noninstitutionalized population for whom poverty status is determined. Map produced by Michael Ward. 2010–2014 American Community Survey 5-Year Estimates)

serious limitations. However, given the fact that it is the measure used in most government programs, our discussion focuses on those official poverty measurement estimates. Individuals with disabilities in urban and rural micropolitan and noncore counties are over twice as likely (poverty rate ratio ranging 2.16–2.28) to be in poverty than their nondisabled peers, with over a quarter living below the poverty line. Again the situation for persons with disabilities living in persistently poor counties is far worse with over a third (37.1%) living in poverty.

It is interesting to note that the poverty rate ratio is actually lower for persistently poor counties at 1.65 times. This lower ratio is due to the much larger proportion of the comparison group, persons without disabilities, who are also impoverished. Persons ages 18–64 living in rural areas are slightly more likely to be receiving OASDI (disability) benefits than those living in urban counties, with rates ranging from 2.5% to 3.0%. However, working-age persons in the rural persistent poverty counties are over twice as likely to receive OASDI as those living elsewhere at 6.6%, or about one in 15 persons.

Figure 2.3 is a county-level map displaying poverty rates for individuals with disabilities for all rural counties and clearly shows the clustering of poverty. Again one of the most striking areas is in the southern Appalachian area, especially in the central Kentucky area with eight counties having nearly half of all persons with disabilities living below the poverty line and most of the remaining counties having over 25% poverty rates. Five rural counties in Georgia and five in South Dakota also have extremely high poverty rates with two out of five persons with disabilities living below the poverty line. More than one in four persons with disabilities are living in poverty in many rural counties located in the Deep South.

Related Factors: Educational Attainment, Employment, Age, Gender, and Race/Ethnicity

As noted above, data available from the Census Bureau county level tables at the county level is limited. The remainder of our tables use estimates from the ACS Public Use Microdata Sample (PUMS) to examine other topics of interest.

Table 2.3 Person and household and level estimates of working-age (18–64) persons living in predominantly rural areas by disability status

	Disability	No disability
Person-level estimates		
Poverty	32.3%	15.2%
Health insurance	86.0%	81.1%
Public insurance	59.9%	14.1%
Private insurance	37.8%	70.1%
Education attainment		
Less than high school	25.1%	11.6%
High school	40.7%	36.5%
Some college	27.1%	34.2%
Bachelor's degree or higher	7.1%	17.7%
Employment rate	27.2%	72.4%
Type of employment (occupation)		
Management, business, science, and arts	23.0%	29.3%
Service	20.9%	17.6%
Sales and office	19.6%	21.7%
Natural resources, construction, and maintenance	14.9%	12.9%
Production, transportation, and material moving	21.6%	18.4%
*Household-level estimates**		
Food stamps	35.1%	14.4%
Computer in house	75.5%	85.9%
Internet access	67.8%	77.9%
Median household income	$40,337	$63,530

Note: Predominantly rural areas are defined as Public Use Microdata Areas (PUMAs) with 70% or more of the population living in rural areas. Estimates based on analysis of the 2014 ACS PUMS data

*Households with one or more working-age (18–64) person(s). Disability: one or more working-age persons with a disability living in household. No disability: no working-age person with a disability in household

Because of data limitation noted previously, the remainder of the analysis is on "predominantly rural areas," defined as those with 70% or more of the total population living in rural areas. Table 2.3 examines the situation of persons living in predominantly rural areas and their households by disability status. Note that although the differences are not unique to rural areas, the estimates provided serve to further develop a sense of barriers and issues that working-age persons with disabilities and their households who live in rural areas face.

The poverty level of persons with disabilities living in predominantly rural areas is over twice that of persons without disabilities living in those areas. Although persons with disabilities are more likely to have health insurance, they are far less likely to have private health insurance than persons without disabilities. With regard to educational attainment, persons with a disability are much more likely to have less than a high school education than those without and less likely to have any postsecondary education. Only about one in four persons with disabilities are employed as compared to almost three out of four persons without disabilities. Of those that are working, many are employed in occupations that are typically lower paid relative to those without disabilities. Households with a working-age person with disability have a much lower median household income, a third less than households without working-age persons with a disability. Households with a working-age person with a disability were twice as likely to be receiving food stamps and much less likely to have a computer and Internet access.

Implications for Rehabilitation Counselors and Human Service Providers

Providing human and/or vocational rehabilitation services in rural America can be particularly challenging, as the array of issues presented in this book makes clear. In tracing poverty program development and implementation and its efficacy, this chapter has briefly discussed how provisions

shaped at the federal and state level to address poverty may not translate readily or neatly to the local level, where antipoverty policy actually plays out in people's lives in ways that heavily depend on local job markets and social networks. Approaches commonly used in urban areas often do not successfully translate to rural catchments. For example, in urban areas, programs and shelters can provide short-term solutions to address homelessness, while the rural homelessness issue affects areas in which population density may well not be sufficient to make this a sustainable alternative. Similarly, where efficiencies of service delivery may be gained with block grant funding in urban areas, such an approach may make delivering services more expensive in rural areas.

The rural poverty and employment statistics presented in this chapter suggest that individuals with disabilities in rural areas are disproportionately impacted by the economic, employment, housing, transportation, and health disparities which are endemic in rural areas for the population at large. We will here discuss some of the specific issues around program design and service coordination and their implications for service program administration, as well as service practitioner pre-service training and ongoing professional development.

Poverty, disability, and income are inextricably linked, and any attempt to address them in rural America must take into account the array of needed services and resources to systemically address interrelated issues. Programs are often administered by several departments (e.g., Agriculture, Treasury, Health and Human Services, Labor, Housing and Urban Dev.), each with its own eligibility criteria. To be successful, service providers and community planners need to work together to create a more holistically sound and integrated approach to these problems. Economic development, workforce development, and housing, transportation, and community planning interests need to be aligned both in intervention strategy design and ultimate implementation. Consortiums of service administrators and on-the-ground providers across all of these interests must be coalesced, similar to the workforce development consortium models now required by the Workforce Innovation and Opportunity Act requirements.[2]

Throughout all of this, it is imperative that grassroots input be included in the design to assure the relevance and effectiveness of the structure of services. Such input can be gathered by in-person community forums, via surveys conducted online or by mail, or by other means of outreach that elicit meaningful responses to the needs assessment and service design process. Input gathered from across a variety of sources and constituencies is a vital part of the design of useful services and service delivery systems that will meet the most critical needs of citizens and create enduring longer-term impacts.

Administrators of vocational rehabilitation, health, and other human service delivery programs cannot simply impose the same service structures that work in urban areas, but rather must equip service providers with the necessary tools for effective service delivery in rural environments. As described above, the defining feature of a rural region is its low population density and lack of an urban core that would serve as a physical center for program delivery. Inhabitants of these areas are geographically dispersed, making it difficult to reach clients. Service system designers must also recognize that intended service recipients might not have the ability to get to centralized service delivery locations due to lack of a transportation infrastructure to serve low-income residents and the inability to pay for private transportation. While many agencies are increasingly using email and websites to enhance their service delivery options, households with working-age persons with disabilities in predominantly rural areas are far less likely to have computers or Internet access. This limits their ability to become knowledgeable about services via the Web, or be reached by email to solicit applications, arrange appointments, or provide follow-along updates. There may also possibly be unwillingness to participate as a result of lack

[2] https://www.federalregister.gov/documents/2016/08/19/2016-15977/workforce-innovation-and-opportunity-act-joint-rule-for-unified-and-combined-state-plans-performance

of trust that governmental or service delivery structures will deliver if approached, due to past disappointing experiences.

Table 2.3 illustrates that the employment rate for both people with and without disabilities in rural counties is significantly lower than in urban areas. This has prompted a movement of younger population away from rural areas as they seek educational and job opportunities. As a result many people have lost the support of younger family or friends who could assist with transportation and communication concerns and provide social support and resources. At the same time, the consolidation of healthcare facilities and other services into metropolitan centers and the loss of healthcare and other providers at the local level means that the need for transportation and communication has increased.

Examples of service structures that can assist providers in dealing with these issues might be agency-sanctioned financial support of costs for the use of service provider mobile phones to reach clients or costs for transportation across large geographic areas to personally reach clients to establish relationships and directly deliver services. Also of importance, since time in the office will be less, is that caseload size reflects the time that service providers may need to travel to reach their clients. Service providers will need to be afforded the time to reach clients who will not be able to or will chose not to go into central location offices and may need face time to establish critical trust relationships which will heighten the likelihood of service uptake and follow-through.

Appropriate pre-service and post-service preparation of professionals to adequately equip them to work in rural areas is critical. Understanding differences in service delivery structures, availability of resources, and the importance of respect for and adaptability to local area norms and cultural differences is imperative. In a country that has such a large rural area, it would seem that these considerations in human service and vocational rehabilitation counselor training would be prevalent, but to date, they are not. Creating opportunities for learning about these differences in coursework and internship/practicum instructional experiences at the pre-service level in human service preparation is one part of addressing the gap in effective service delivery. Offering ongoing learning opportunities for the career development of professionals practicing in rural areas is also a necessary part of the quality service delivery equation. Having agencies and administrative infrastructures that recognize the importance of adequately prepared personnel and invest in professional development strategies that reach dispersed staff in a timely and cost-effective manner will be imperative. Creating complementary digital or e-communication structures and networks that afford dispersed staff an opportunity to do needed case consultation on particular issues and maintain a sense of team effort across distance will also be an important part of building a capable service delivery workforce which will be better prepared to provide high-quality services over time.

Summary

The focus in this chapter has been to discuss disability, income, and poverty using a review of related policy and poverty literature and to provide related statistics drawn from national survey and administrative data regarding the situation of persons with disabilities in rural areas. In addition, we discuss how the occurrence of poverty in one social, cultural, or economic dimension tends to interact with other dimensions such as income, health, or education investment. We described how poverty is defined in US policy and offered a broad overview of federal and state antipoverty public policy, statistics describing the current status of people with and without disabilities with regard to poverty and economic well-being, and factors that may be related to the high poverty rates among the rural population with disabilities.

We are focused on poverty and disability because the situation for persons with disabilities is particularly dire. Individuals with disabilities in the USA are 2.3 times more likely to be living in poverty than their nondisabled peers (Erickson

et al., 2016). Specific statistics about disability prevalence, economic conditions, and factors that may differentially impact economic opportunities of individuals with disabilities in rural areas are a critical first step to understand income inequality and the disability poverty gap and to subsequently design policy which addresses issues specific to rural areas.

Rural poverty's causes are diverse, but many are rooted in a combination of economic decline, neglect, or underdevelopment. The rural economy has been rooted historically in agriculture rather than emerging technologies and related industries, and the lack of opportunities that these growth areas afforded in rural communities has meant that young people often move away, leaving a widening education, economic and healthcare gap for the aging residents, and an even higher preponderance of those with disabilities and without employment in these communities.

Rural poverty has been discussed largely in terms of what benefits the poor receive, rather than the underlying social structures that put people on the benefit rolls. It has been considered a result of rural work culture, a lack of skills and preparation on the part of rural workers, and a lack of rural human capital. Changes in both the way poverty is defined and measured and in the policies and structures designed to alleviate poverty need to be undertaken, with a contemporary perspective of underlying causes and possible solutions. For example, current poverty level calculations do not take into account the changing structure of the economy. Although the US Census Bureau introduced the Supplemental Poverty Measure (SPM) in 2010, this measure is supplemental and has not replaced the official poverty measure for use in government programs and means-tested benefit eligibility. More permanent modernized measurements need to be imbedded in current policy and intervention approaches.

A focus on providing solutions that do more than provide a safety net of benefits is imperative. It is crucial that both workforce and economic development strategies be a part of any intervention to better ensure the desired longer-term changes needed. Isolation from institutions such as schools and the labor market has been a major contributing factor to rural poverty, and people with disabilities have been even more significantly disadvantaged by these disparities. Addressing ways to raise educational and vocational skill development levels among citizens in rural communities is critical, especially for those with disabilities. In addition, injecting into these communities employment opportunities with jobs affording higher pay and longer-term career growth is essential.

To take advantage of any infusion of workforce and economic development opportunities, communities need to develop the necessary infrastructure to support these initiatives so that residents can realize the potential benefits that education and employment opportunities can provide. Adequate infrastructure for housing, transportation, and healthcare that are equitably accessible to all across economic and social class lines will be a necessary part of democratizing opportunity. Growth industries such as technology which afford high-paying jobs with career advancement opportunities may also offer creative new solutions whereby citizens can access work without leaving their communities. It is time that we identify solutions whereby both communities and individual citizens in rural America can not only survive economically but thrive and build a promising future. A more comprehensive approach to poverty elimination beyond the traditional social net services is long overdue.

Resources

Disability Statistics. http://www.disabilitystatistics.org/

Online source of national and state level reports and data presenting the prevalence of disability and relative economic status of people with disabilities, from a variety of large public datasets.

Rural Poverty Research Institute. http://www.rupri.org/

The Rural Policy Research Institute (RUPRI) provides unbiased analysis and information on the challenges, needs, and opportunities facing rural America. RUPRI's aim is to spur public dialog and help policymakers under-

stand the rural impacts of public policies and programs.

The Housing Assistance Council. http://www.ruralhome.org/

A national nonprofit that helps local organizations build affordable homes. HAC also has developed a library of full-length research reports, research briefs, and other informational products that provide details and analysis on social, economic, and housing issues that affect the provision of affordable housing in rural America.

USDA ERS (US Department of Agriculture Economic Research Service). http://www.ers.usda.gov/topics/rural-economy-population/rural-poverty-well-being.aspx

ERS research focuses on the economic, social, spatial, and demographic factors that affect the income and poverty status of rural residents.

RHI Hub – the Rural Health Information Hub. https://www.ruralhealthinfo.org/topics/people-with-disabilities

The Rural Health Information Hub was formerly the Rural Assistance Center. It is funded by the Federal Office of Rural Health Policy as a national clearinghouse on rural health issues. It provides access to current and reliable resources and tools to help you learn about rural health needs and work to address them.

US Census Bureau American FactFinder. http://factfinder.census.gov/faces/nav/jsf/pages/index.xhtml

The Census Bureau's American Factfinder (AFF) website provides access to a wide variety of statistics, many based on the American Community Survey (ACS). AFF is a very useful source for poverty- and disability-related estimates especially for smaller, less populous areas including rural counties, villages, and cities as well as at the state and national level.

Instructional Features

Discussion Boxes

Discussion Box 2.1: Defining Disability

There is no single, universally accepted definition of disability. However, assessing the effectiveness of disability policy requires some measure of what disability is, and these different definitions affect our understanding of policy outcomes. Mashaw and Reno (1996) document over 20 definitions of disability used for purposes of entitlement to public or private income support programs, government services, or statistical analysis. Depending on the data sources used (and their disability definitions), estimates of disability prevalence and rates of employment and poverty can vary significantly.

The American Community Survey (ACS) uses a series of six questions that primarily focus on six specific functional or activity limitations. However, these six items do not capture everyone who might be considered to have a disability, such as those with mental illness or persons with upper body impairments, or other specific health conditions. The 2010 Survey of Income and Program Participation (SIPP) used a much broader definition of disability than the ACS and included many more items and conditions. For reference the 2010 ACS estimated that there were approximately 36.4 million persons of all ages with a disability (11.9% prevalence rate), whereas the 2010 SIPP estimates 56.7 million (18.7%).

Discussion Questions:

1. How might these different definitions affect the "official" number of people with disabilities?
2. What preconceived notions about disability are apparent from these definitions?
3. What might be some of the implications of using different definitions of disability? If they are broader? Narrower?

Discussion Box 2.2: Defining Poverty

The official US Government measure of poverty uses the US Census Bureau definition introduced in the 1960s, adjusted for inflation. This measure compares pretax cash income against a poverty threshold set at three times the cost of a minimum "grocery cart" of food.

Researchers have suggested that this measure has flaws: it does not reflect new expenses of living in modern society, it does not include sources of income such as noncash assistance, and it does not reflect the nature of twenty-first-century households. Others observe that the relationship between income, consumption, and possession of goods cannot be neatly specified.

The Census Bureau introduced the Supplemental Poverty Measure in 2010 to provide an alternative view of poverty that better reflects the twenty-first-century life. This measure supplements, but does not replace, the official poverty measure.

Many other countries use and suggested ways of measuring poverty include measurements of "relative" poverty, which express poverty in terms of relationship to the median income, or measurements of "material hardship," which track how difficult it is to acquire the housing, food, and medical care a family needs.

Proposed methods of measuring poverty can be described as "direct" methods, observing the lack of basic needs, and the "income" method, observing the flow of available cash. These methods are not just alternative measures, but alternative concepts of what poverty *is*.

Discussion Questions:

1. How has society changed since the introduction of the official poverty measure in 1963?
2. What differences might result from defining poverty based on income vs. defining it based on ability to meet household needs?
3. How might these definitions apply differently in rural areas vs. urban ones? In households composed of older individuals vs. households of predominantly younger people?

Research Box 2.1: See Iezzoni, Killeen, and O'Day (2006)

Objective or Research Question: To learn about the healthcare experiences of rural residents with disabilities.

Method: Interviews were conducted with 35 adults recruited from centers for independent living in rural Massachusetts and Virginia. Participants were people with sensory, physical, or psychiatric disabilities. Four focus groups were conducted.

Results: Interviewees confirmed experiencing many known barriers to accessing healthcare in rural America and reported that their disabilities made these barriers more difficult. Barriers included difficulty in finding healthcare practitioners well-versed in their disability, needing to educate practitioners about disability, difficulty finding medical practices that accept Medicaid and Medicare patients, and the need to travel long distances to regional medical centers in order to get specialty care. Physical access of healthcare facilities and access to transportation emerged as major concerns.

Conclusion: Improving healthcare access for rural people with disabilities requires not only ensuring availability of appropriately prepared healthcare practitioners but also addressing serious concerns around physical accessibility and transportation.

Questions:

1. What are some issues specific to healthcare providers that might be relevant to meeting the healthcare needs of people with disabilities in rural areas?
2. What are some non-healthcare issues that affect how people with disabilities might access healthcare in rural areas?

Research Box 2.2: See Neckerman et al. (2016)

Objective or Research Question: To better understand the links between income poverty, material hardship, and health.

Method: Researchers designed a survey, called the New York City Longitudinal Study of Wellbeing, or "Poverty Tracker," to gather data from approximately 2300 New York City residents on income poverty, material hardship, health, and well-being. Data was collected from the same sample over time, with interviews every 3 months over 2 years to provide a comprehensive picture of poverty and how it relates to material hardship and well-being. The tracker included not only the Census Bureau's new Supplemental Poverty Measure but also tracked the experience of hardship issues such as running out of money, utility cutoffs, food insecurity, unmet medical needs, and housing hardships. It also included an indicator of family health: whether the adult respondent reported a work-limiting disability or rated their own health as poor.

Results: Hardships were experienced more often by families that were also experiencing income poverty. Nearly half of families with children experienced "persistent" disadvantages over the survey period, and only one-third of families faced no hardships during that time. However, statistics on persistent poverty understate the level of sustained disadvantage – only 11% of families with children were "poor" at both time points.

Conclusion: Focusing on income poverty alone vastly underestimates the extent of disadvantage among families with children. Many families with incomes above the poverty line experience material hardship and/or health difficulties.

Questions:

1. This study used the presence of disability as a marker for family disadvantage. How might that affect attempts to study the relationship between poverty and disability?
2. This study took place in an urban setting. What additional or different factors might exist for families in rural areas that affect their experience of disadvantage?

Illustrative Case Study or Vignette or Profile of a Person with a Disability in a Rural Area

Bernice is a 37-year-old Black American woman with an intellectual disability living in Avera, GA. Bernice was born with Down syndrome, the last of 7 children in her family, and went to a special education class in the greater Jefferson County Unified School district up to the 8th grade. She left school before completing 8th grade, as her family wanted her to stay home to help with parental care. Her father was diabetic and had his leg amputated and had to leave his job as a janitor in the local school. The mother then had to become the family income earner and was driving to another town to work. Bernice was asked to stay at home with the father, who became increasingly ill and ultimately bed-ridden. Bernice's parents filed for Social Security Insurance benefits on Bernice's behalf and also became dependent on this as income to support the household as a whole. Both of Bernice's parents, now in their 70s, died in the past 18 months, and Bernice had been living alone as her siblings have all moved away in an effort to find employment. An aunt who lives nearby has occasionally been looking in after her but is concerned about Bernice's longer-term well-being and ability to support the costs of a household independently, as well live safely on her own over the longer term. The aunt made a referral for Bernice to both a local Social Service Agency and to vocational rehabilitation, to try to get help with finding a safe and affordable living place with supports and assistance for exploration of employment alternatives. As the rehabilitation counselor accepting this referral, how would you approach providing support to Bernice in this process? What vocational exploration approach might you

use? What is your role in residential and transportation issues that Bernice might be confronted with? What involvement would you see the family having? What other considerations might there be in moving forward with providing Bernice to identify meaningful community engagement and as much independence as possible within this setting?

Learning Exercises
Self-Check Questions

1. Why is the issue of disability and poverty an important one to focus on?
2. What are the consequences of poverty for individuals with disabilities in rural areas?
3. What are the factors that contribute to a disproportionate impact of poverty in rural areas?
4. How would you characterize the public policy poverty programs for people with disabilities?
5. Do you think that these programs are effective? Which features of these programs are the most effective?
6. What are the implications of rural poverty and individuals with disabilities for the functioning of rehabilitation and other human services designed to support these populations in rural areas?

Field-Based Experiential Assignments

1. What is the prevalence rate of people with disabilities in your state or regional/local geographic area?
   (a) Where would you go for information?
   (b) What geographic catchment area is viable and why?
   (c) How do these rates compare with national prevalence rates for this group?
2. What is the employment rate of individuals with disabilities in this state/regional or local catchment area?
   (a) How does that rate compare with people without disabilities in the same catchment area?
   (b) How does that participation rate compare to people without disabilities nationally?
3. What are the household income and poverty rates of individuals with disabilities in your state/regional/local area?
   (a) How are individuals with disabilities in rural areas of this catchment area faring in terms of comparative household income with their nondisabled peers?
   (b) How are individuals with disabilities in rural areas of this catchment area faring in terms of poverty rates with their nondisabled peers?

Multiple-Choice Questions

1. The poverty rate for working-age Americans with disabilities compared to their nondisabled peers is:
   (a) Approximately five times higher
   (b) Relatively the same rate
   (c) Over twice the rate
   (d) Significantly less than individuals without disabilities
2. Which of the following statements about poverty is false?
   (a) It is a function of poorly planned and implemented economic development.
   (b) The majority of the world's poor live in rural areas.
   (c) A greater percentage of the population is poor in rural areas.
   (d) The rural economy is largely concerned with food and commodity production.
3. Low wages and inadequate opportunities for youth, minorities, women, and the least educated are a result of:
   (a) The restructuring of US manufacturing base
   (b) The growing influence of resource-extraction firms in rural areas
   (c) The privatization of management of rural lands
   (d) All of the above
4. Compared to other wealthy nations globally, which of the following is true about the US situation related to poverty?

(a) The USA spends more on antipoverty programs than most other rich nations.
(b) The USA has higher poverty rates than most rich nations.
(c) The USA defines poverty at a much higher threshold.
(d) The USA spends more on public programs and less on private social expenditures.

5. Which of the following is true of the Supplemental Nutrition Assistance Program (SNAP)?
   (a) It is generally regarded as an effective US poverty alleviation policy program.
   (b) It is generally regarded as an ineffective US poverty alleviation policy program.
   (c) Its long-term benefits to low-income children have not been well documented.
   (d) It has not proven to respond to economic conditions as a true safety-net program.
6. Which of the following is *not* true about the Supplemental Poverty Measure (SPM)?
   (a) SPM indicates even greater differences in poverty rates between individuals with and without disabilities.
   (b) The measure has replaced the official poverty measure for use in government programs and means-tested benefit eligibility.
   (c) It takes into account the costs of owning vs. renting homes, as well as a wide array of necessary expenditures.
   (d) The definition of minimum needs is adjusted each year based on recent data.
7. Which of the following is true of county governments in the USA?
   (a) They are the fastest-growing general type of government.
   (b) They provide more services such as welfare, health, and housing than cities do.
   (c) They raise more of the funds themselves to address service needs.
   (d) All of the above.
8. Which of the following is *not* true about access to healthcare in rural areas?
   (a) Patients must travel greater distances to see doctors.
   (b) Medicaid and Medicare reimbursements to hospitals in rural areas appropriately cover the actual costs of care provided for these patients.
   (c) Patients are more likely to encounter barriers such as lack of transportation, severe weather, or bad roads.
   (d) There are significantly fewer physicians, specialists, and dentists.
9. Which of the following is *not* generally true of people with disabilities in rural areas?
   (a) Prevalence of disability is greater in rural areas.
   (b) The employment rate of people with disabilities is significantly less than those without disabilities.
   (c) A greater proportion of people with disabilities have private health insurance than public health insurance.
   (d) The poverty rates of people with disabilities are greater than those without.
10. Some ways of helping human and rehabilitation service providers be better equipped to provide quality services in rural areas are to:
   (a) Afford access to needed equipment (cell phones) and transportation support to readily reach clients who are dispersed throughout a large geographic area
   (b) Assign caseload sizes that take into account the requirements for significant out-of-office time to travel to outreach to service recipients and provide services
   (c) Provide a communication infrastructure for practitioners that enables case consultation and team coordination across a geographically dispersed area
   (d) All of the above

Key

1 – C
2 – A
3 – D
4 – B
5 – A
6 –B
7 – D
8 – B
9 – C
10 – D

References

Arnold, A., Crowley, S., Bravve, E., Brundage, S., & Biddlecombe, C. (2014). *Out of reach 2014: Twenty-five years later, the affordable housing crisis continues*. Washington, DC: National Low Income Housing Coalition. Retrieved from http://nlihc.org/sites/default/files/oor/2014OOR.pdf

Bradshaw, T. K. (2006). *Theories of poverty and anti-poverty programs in community development* (No. 06–05). Columbia, MO: Rural Poverty Research Center.

Braithwaite, J., & Mont, D. (2009). Disability and poverty: A survey of World Bank poverty assessments and implications. *ALTER – European Journal of Disability Research / Revue Européenne de Recherche Sur Le Handicap, 3*(3), 219–232. doi:10.1016/j.alter.2008.10.002.

Brucker, D. L., Houtenville, A. J., & Lauer, E. A. (2015). Using sensory, functional, and activity limitation Data to estimate employment outcomes for working-age persons with disabilities in the United States. *Journal of Disability Policy Studies.* Published online ahead of print. 10.1177/1044207315578949

Brucker, D. L., Mitra, S., Chaitoo, N., & Mauro, J. (2015). More likely to be poor whatever the measure: Working-age persons with disabilities in the United States. *Social Science Quarterly, 96*(1), 273–296. doi:10.1111/ssqu.12098.

Burton, L. M., Lichter, D. T., Baker, R. S., & Eason, J. M. (2013). Inequality, family processes, and health in the "new" rural America. *American Behavioral Scientist, 57*, 1128–1151. doi:10.1177/0002764213487348.

Caminada, K., & Martin, M. C. (2011). Differences in anti-poverty approaches in Europe and the United States: A cross-Atlantic descriptive policy analysis. *Poverty & Public Policy, 3*(2), 213–227. doi:10.2202/1944-2858.1153.

Center on Budget and Policy Priorities. (2014). *The war on poverty at 50: Section 3: Today's safety net cuts poverty nearly in half, provides health care to millions, and has long-term benefits for children*. Washington, DC: Center on Budget and Policy Priorities.

Council of Economic Advisors. (2014). *The war on poverty 50 years later: A progress report*. Washington, DC. Retrieved from https://www.whitehouse.gov/sites/default/files/docs/50th_anniversary_cea_report_-_final_post_embargo.pdf

Cromartie, J., & Bucholtz, S. (2008). Defining the "rural" in rural America. *Amber Waves*, *6*(3). Retrieved from http://webarchives.cdlib.org/sw1vh5dg3r/http:/ers.usda.gov/AmberWaves/June08/Features/RuralAmerica.htm

Dudenhefer, P. (1993). Poverty in the rural United States. *Focus, 15*(1), 37–46.

Duncan, C. M. (1994). Persistent poverty in rural america. *Contemporary Sociology, 23*(2), 264. doi:10.2307/2075238.

Dwyer, R. E., & Sanchez, D. (2016). Population distribution and poverty. In M. J. White (Ed.), *International handbook of migration and population distribution* (pp. 485–504). Dordrecht, The Netherlands: Springer Science & Business Media. doi:10.1007/978-94-017-7282-2.

Edelman, P. B. (2009). Changing the subject: From welfare to poverty to a living income. *Northwestern Journal of Law & Social Policy*, *4*(1). Retrieved from http://scholarlycommons.law.northwestern.edu/njlsp/vol4/iss1/2

Edelman, R. (2006, May–June). The war on poverty and subsequent federal programs: What worked, what didn't work, and why? Lessons for future programs. *Clearinghouse REVIEW Journal of Poverty Law and Policy*, 7–18. Retrieved from http://www.chn.org/wp-content/uploads/2012/08/edelman.pdf

Elwan, A. (1999). *Poverty and disability: A survey of the literature* (No. 9932).

Enders, A., Seekins, T., & Brandt, Z. (2005). *Update on the demography of rural disability part two: Nonmetropolitan and metropolitan*. Missoula, MT: The University of Montana.

Erickson, W. (2012, December). *A guide to disability statistics from the American community survey (2008 forward).* Ithaca, NY: Cornell University. http://digitalcommons.ilr.cornell.edu/edicollect/1290

Erickson, W., Lee, C., & von Schrader, S. (2016). *2014 disability status report: United States*. Ithaca, NY: Cornell University Yang Tan Institute on Employment and Disability (YTI). www.disabilitystatistics.org

Fisher, G. (1992). The development and history of the poverty thresholds. *Social Security Bulletin, 55*(4). https://www.ssa.gov/history/fisheronpoverty.html

Food Research and Action Center. (2012). *Replacing the thrifty food plan in order to provide adequate allotments for SNAP beneficiaries*. Washington, DC: Author.

Fremstad, S. (2009). *Half in ten: Why taking disability into account is essential to reducing income poverty and expanding economic inclusion*. Washington, DC. Retrieved from http://www.cepr.net/documents/publications/poverty-disability-2009-09.pdf

Givon, L. (2016). The poor and economically vulnerable in public and safety net healthcare institutions: Outcomes and attitudes. In R. Parakh & W. Childs (Eds.), *Stigma and prejudice: Touchstones in understanding diversity in healthcare*. Geneva, Switzerland: Springer Publishing.

Glasgow, N., & Brown, D. L. (2012). Rural ageing in the United States: Trends and contexts. *Journal of Rural Studies, 28*(4), 422–431. doi:10.1016/j.jrurstud.2012.01.002.

Gurley, L. (2015, October 22). Why the left isn't talking about rural American poverty. *In These Times*, 1–5. Retrieved from http://inthesetimes.com/rural-america/entry/18526/why-the-left-isnt-talking-about-rural-american-poverty

Housing Assistance Council. (2011). Poverty continues to be high in rural America. In *Poverty in rural America*. Washington, DC: Housing Assistance Council. Retrieved from http://www.ruralhome.org/storage/documents/info_sheets/povertyamerica.pdf.

Housing Assistance Council. (2012, June). Poverty in rural America. In *Rural research brie*f. Washington, DC: Author. Retrieved from http://www.ruralhome.org/storage/research_notes/rrn_poverty.pdf

Housing Assistance Council. (2014). *Housing an aging rural America: Rural seniors and their homes*. Washington, DC: Housing Assistance Council. Retrieved from http://www.ruralhome.org/sct-information/mn-hac-research/mn-rrr/1035-rrr-rural-seniors-2014.

Houtenville, A. J., & Brucker, D. L. (2014). Participation in safety-net programs and the utilization of employment services among working-age persons with disabilities. *Journal of Disability Policy Studies, 25*(2), 91–105. doi:10.1177/1044207312474308.

Iezzoni, L. I., Lillen, M. B., & O'Day, B. L. (2006). Rural residents with disabilities confront substantial barriers to obtaining primary care. *Health Services Research*, *41*(4 I), 1258–1275. 10.1111/j.1475-6773.2006.00534.x.

Ingram, D. & Franco, S. (2013). NCHS urban–rural classification scheme for counties. National Center for Health Statistics. *Vital Health Stat, 2*(166), 2014.

Institute for Research on Poverty. (2014a). *How is poverty measured in the United States?*. Retrieved from http://www.irp.wisc.edu/faqs/faq2.html.

Institute for Research on Poverty. (2014b). What are poverty thresholds and poverty guidelines? Madison, WI: Author. Retrieved from http://www.irp.wisc.edu/faqs/faq1.htm.

Joint Economic Committee. (2014). *Keeping rural communities healthy*. Washington, DC: Joint Economic Committee, United States Congress.

Kearney, M. S., & Harris, B. H. (2014). *Policies to address poverty in America*. Washington, DC: The Hamilton Project, Brookings Institute.

Kurre, J. A. (2003). Is the cost of living less in rural areas. *International Regional Science Review, 26*(1), 86–116. doi:10.1177/0160017602238987.

Lobao, L., Jeanty, P. W., Partridge, M., & Kraybill, D. (2012). Poverty and place across the United States: Do county governments matter to the distribution of economic disparities? *International Regional Science Review, 35*(2), 158–187. doi:10.1177/0160017611435356.

Lynn, K. (2005, September). *Disaster and the cycle of poverty: Understanding urban, rural, and gender aspects of social vulnerability*. Retrieved from http://www.gdnonline.org/resources/lynn_disasters_poverty_9_20_05.pdf

Martin, M. C., & Caminada, K. (2011). Welfare reform in the U.S.: A policy overview analysis. *Poverty & Public Policy, 3*(1), 67–104. doi:10.2202/1944-2858.1087.

Meyer, B. D., & Sullivan, J. X. (2012). Winning the war: Poverty from the great society to the great recession. *Brookings Papers on Economic Activity*, *0*(0), 133–183. doi:10.1353/eca.2012.0019.

Neckerman, K. M., Garfinkel, I., Teitler, J. O., Waldfogel, J., & Wimer, C. (2016). Beyond income poverty: Measuring disadvantage in terms of material hardship and health. *Academic Pediatrics, 16*(3), S52–S59. doi:10.1016/j.acap.2016.01.015.

Newkirk, V. R., & Damico, A. (2014, May). The affordable care act and insurance coverage in rural areas extending health rural areas the impact of ACA coverage expansions in rural areas. *The Kaiser Family Foundation*.

Nord, M. (2000). Does it cost more to live in rural areas? Evidence from new data on food security and hunger. *Rural Sociology, 65*(1), 104–125.

Racine, A. D. (2016). Child poverty and the health care system. *Academic Pediatrics, 16*(3), S83–S89. doi:10.1016/j.acap.2015.12.002.

Sachs, J. D. (2016). High US child poverty: Explanations and solutions. *Academic Pediatrics, 16*(3), S8–S12. doi:10.1016/j.acap.2016.02.009.

Smeeding, T. M. (2008). Poorer by comparison. *Pathways*, 3–5. Retrieved from http://www.motif.stanford.com/group/scspi/_media/pdf/pathways/winter_2008/Smeeding.pdf

Smeeding, T., & Thévenot, C. (2016). Addressing child poverty: How does the United States compare with other nations? Academic Pediatrics, 16(3), S67–S75. https://doi.org/10.1016/j.acap.2016.01.011

Stanford Center on Poverty and Inequality. (2015). *State of the states: The poverty and inequality report, 2015*. Stanford, CA: Pathways. Retrieved from http://www.inequality.com.

Stauber, K. N. (2001). Why invest in rural America – And how? A critical public policy question for the 21st century. *Federal Reserve Bank of Kansas City, 2001*(Q2), 33–63.

Tickamyer, A. R., & Duncan, C. M. (1990). Poverty and opportunity structure in rural America. *Annual Review of Sociology, 16*(1), 67–86. doi:10.1146/annurev.soc.16.1.67.

U. S. Department of Agriculture. (2014). *Rural America at a glance: 2014 edition*. Washington, DC: USDA-ERS. Retrieved from http://www.ers.usda.gov/media/1697681/eb26.pdf

U. S. Department of Agriculture. (2016). *Rural poverty and well-being: Overview: A note about data sources*. Retrieved from the USDA-ERS website: http://www.ers.usda.gov/topics/rural-economy-population/rural-poverty-well-being/poverty-overview.aspx

U.S. Department of Health and Human Services (2015, November). *HRSA: Defining rural population*. Retrieved from the HRSA website: http://www.hrsa.gov/ruralhealth/aboutus/definition.html

U.S. House of Representatives Committee on the Budget. (2014). *The war on poverty: 50 years later*. Washington, DC: U.S. House of Representatives. doi:10.1002/pam.21846.

von Reichert, C., & Myers, A. (2014). *The geography of disability in America: On rural- urban differences in impairment rates* (Independent Living and Community Participation No. 7). University of Montana. Retrieved from http://scholarworks.umt.edu/ruralinst_independent_living_community_participation/7

Weber, B., Jensen, L., Miller, K., Mosley, J., & Fisher, M. (2005). *A critical review of rural poverty literature: Is there truly a rural effect?* (No. 1309–05). Madison, WI: Institute for Research on Poverty. doi:10.1177/0003122410363563.

Weber, B. A. (2007). Rural poverty: Why should states care and what can state policy do? *Journal of Regional Analysis & Policy, 37*(1), 48–52.