

**UNITED STATES AND EUROPEAN SCHOOL-AGED DISABILITY PREVALENCE:  
AN INVESTIGATIVE STUDY TO ELABORATE DIFFERENCES**

**A Report Prepared for the  
Organization for Economic Co-operation and Development**

Barbara W. LeRoy, Ph.D. (Consultant)  
Developmental Disabilities Institute  
Wayne State University  
Detroit, Michigan USA

Peter Evans, Ph.D., FBPsS  
OECD/OCDE

Marcella Deluca, MSc  
OECD/OCDE

Through funding from  
Office of Special Education Programs  
U.S. Department of Education

December 2000

## UNITED STATES AND EUROPEAN SCHOOL-AGED DISABILITY PREVALENCE: AN INVESTIGATIVE STUDY TO ELABORATE IDENTIFIED DIFFERENCES

### Introduction

1. In 1995 the OECD published the first comprehensive set of data intended to provide a comparative review of the educational provision for students with disabilities and disadvantages in OECD countries. That study found that although there were technical difficulties in making comparisons due to definitional differences among countries, sufficiently large differences did appear to exist among the countries to indicate the occurrence of substantial variations in provision. In an attempt to reduce some of the technical difficulties in the first study and to further define the provision of services to students with disabilities and disadvantages, a second study was implemented. This second study (OECD, 2000) defined special needs education as that which is “supported by additional public and/or private resources”(p. 8). This definition resulted in the delineation of three cross-national categories of educational needs, as follows:

2. *Category A:* the educational needs of students for whom there is substantial normative agreement as to the presence of a disability-such as blind and partially sighted, deaf and partially hearing, severe and profound mental handicap, and multiple handicaps. These conditions affect students from all social classes and occupations. Typically, adequate measuring instruments and agreed criteria are available to accurately identify students who have these disabilities. In medical terms, these conditions are considered to be organic disorders attributable to organic pathologies (e.g., in relation to sensory, motor or neurological defects).

3. *Category B:* the educational needs of students who have difficulties in learning which do not appear to be directly or primarily attributable to factors which would lead to categorisation as either A or C.

4. *Category C:* the educational needs of students whose difficulties are considered to arise primarily from socio-economic, cultural and/or linguistic factors. These students have some form of disadvantaged or atypical background for which education seeks to compensate.

5. Twenty-three OECD member countries: Austria, Belgium (Flemish Community), Canada (New Brunswick), the Czech Republic, Denmark, France, Finland, Germany, Greece, Hungary, Italy, Ireland, Korea, Mexico, the Netherlands, Portugal, New Zealand, Spain, Sweden, Switzerland, Turkey, the United Kingdom, and the United States participated in the study. Data were collected from each country as to the allocation of students with disabilities, difficulties, and disadvantage to each of the above categories. As a second step in the study, each country identified the number of primary and lower secondary students (ages 5 – 15 years) between and within each of their national categories. Prevalence rates by category, disability, and country were calculated using category counts divided by student population counts. Subsequently, cross-national comparisons of disability, difficulties, and disadvantage labels and categories were made.

6. While there were many useful and interesting findings in this second study, one particularly curious finding emerged. The prevalence data for disability groups within Category A indicated that the United States had a rate more than twice as high as that of Western European countries. Specifically, the United States Category A prevalence rate was 5.62%, as compared to European rates of: 1.33% for Austria, 2.53% for France, 1.45% for Germany, 2.57% for Ireland, 2.13% for Italy, 1.77% for the Netherlands, 2.56% for Spain, and 1.62% for Switzerland. These rates emerged after taking account of differences in national definitions of the concept of special education (Ibid, p. 76). These statistics are

useful in establishing baselines for national and cross-national comparisons. However, statistics, alone, cannot provide further insight into what underlies the reported differences in disability prevalence rates.

7. In order to provide additional insight into these reported differences and to explore the policy potential in linking disability prevalence with social indicators of child well being, an exploratory and investigative study was implemented with the co-operation of selected OECD countries. The conditions of funding and availability of the lead researcher necessitated that this study be implemented within a three-month period. Therefore, study countries were selected based on their prevalence rates, data availability, ease of access to data gathering, ease of travel, and willingness to participate in the study. The study countries were: the United States, Ireland, Italy, and Switzerland.

## **Study Methodology**

### *Research questions*

8. This investigative and exploratory study was directed by the following four research questions:
1. What factors appear to contribute to the reported differences in disability prevalence rates between the United States and selected European countries? How can differences within and between countries be explained?
  2. How comprehensive are the reported disability prevalence rates across education settings and countries?
  3. What are the study countries' ratings on selected social indicators that have been linked with disability in the United States?
  4. What is the perceived potential for a research methodology that links social indicators of child well being with disability prevalence in the study countries?

### *Procedure*

9. A two-phase procedure was implemented to address the research questions. Phase one was an investigative process addressing the first two research questions. In this phase existing SEN Category A statistics for the study countries were examined using an analytic methodology. This methodology implemented a five-step iterative process. First, the SEN Category A disability labels were divided into two groups. Group one (common core) was composed of those disabilities in which there was agreement among countries. Group two (disparate core) was composed of those remaining disabilities in which there was not common agreement among countries. Second, comparisons were made among disability rates on the common core. Third, the extant data on the prevalence rates for the common core were examined to rule out potential technical errors in data entry and data analysis. Fourth, the disparate core was delineated and the prevalence rates and/or disability label determination by country were identified. As with the common core data, the extant data on the disparate core were examined for technical errors. Finally, data on procedural factors, (e.g., data age cohorts, comprehensiveness of the reported data, and classification definitions and student identification procedures) were examined to determine the potential contribution of these factors to rate differences. This data was gathered through direct interviews with in-country education, health, and social welfare experts.

10. Phase two of the study was an exploratory process, addressing the last two research questions. This phase was designed to be hypothesis generating in preparation for potential future research studies. In this phase the relationship between a variety of social indicators of child well being and types and prevalence of various disabilities was examined. Initially, the relationship between these two sets of variables was examined for the United States, only. A Pearson Correlation matrix was generated to examine the relationship between 10 social indicators from the Kids Count data (Annie B. Casey Foundation, 2000) and disability prevalence data from the US Department of Education, Office of Special Education and Rehabilitative Services (1999). To develop the matrix, state-level social indicator data were correlated with state-level disability prevalence data. Subsequently, descriptive data, on the significant social indicators of child well being, were gathered for each of the study countries, where available, from a variety of international databases. That data was subsequently checked for accuracy and viability with the in-country experts through qualitative discussions. Finally, the country informants were queried as to their opinions about the utility of a research methodology which would link social indicators of child well being with disability prevalence.

### ***Instrument***

11. In order to gather quantitative and qualitative data from the study countries, an interview questionnaire and data tables were used. The interview questionnaire sought to gather and/or clarify data related to the definitions of disability labels within SEN Category A, the identification of children (0-8 years old) with those disability labels, and data on social indicators of child well being. To explore the potential for future research studies on social indicators and disability, open-ended questions were used. The questionnaire for each study country was uniquely designed to build on extant data and responses in the two previous OECD studies.

#### Study Timeframe

12. Data were collected and analyzed over a three-month period in the Autumn of 2000.

#### Study Countries and Participating Representatives

13. The countries that participated in this study were Ireland, Italy, Switzerland<sup>1</sup>, and the United States. As stated in the introduction, these countries constituted a convenience sample, drawn for ease of data collection, and the limitations of time and travel associated with the study. For each country, data gathering activities were carried out with representatives of the national ministries of education, health, and social welfare, as well as with research experts in these same disciplines from local universities. To further elaborate data, qualitative discussions were held in both Ireland and Italy with the aforementioned ministry representatives.

## **Findings - Phase One**

### **Common Core of Disability Labels**

14. In SEN Category A, each study country includes a diverse number of distinct disabilities, as follows: Ireland - 9, Italy - 7, Switzerland - 10, and the United States - 10. From this universe of potential disability labels, the study countries were found to have five disability labels in common. This common

---

<sup>1</sup> The full data report for Switzerland is still pending and will be included in the final version of this document.

core includes intellectual disability, visual impairment, physical disability, multiple disabilities, and hearing impairment. Each of these five disabilities is, generally speaking, attributable to an organic etiology and is recognizable by lay and professional personnel, alike. Table 1 presents the education prevalence rates by country for this common core of disabilities.

**Table 1: Education Prevalence Rates for the Common Core of Disability Labels by Study Countries**

Disability Category	Country			
	CH	IR	IT	USA
<b>Intellectual Disability*</b>	.98	1.49	1.80	1.13
<b>Visual Impairment</b>	.02	.07	.04	.05
<b>Physical Disability</b>	.09	.26	.18**	.13
<b>Multiple Disabilities</b>	.08	.01	.02	.19
<b>Hearing Impairment</b>	.13	.18	.09	.14
<b>Prevalence Rate Totals</b>	<b>1.30</b>	<b>2.01</b>	<b>2.13</b>	<b>1.64</b>

\*Intellectual Disability classifications within all countries were combined, i.e., mild, moderate and severe mental handicap were added together to equal one prevalence rate per country for intellectual disability

\*\*Physical disability prevalence rate for Italy combines mild and severe physical handicap

15. The alignment of these disabilities labels from SEN Category A resulted in very similar prevalence rates across the study countries, with intellectual disability accounting for the highest prevalence rate in each country. When only taking into account this common core of disability categories, the disability prevalence rate for the United States is lower than that of both Ireland and Italy, and only slightly higher than that of Switzerland.

16. Findings from the technical review of the data for accuracy indicated that the extant data for Switzerland, Italy, and Ireland were accurate, as reported and recorded. Data for four out of five categories of disability for the United States were accurate, as reported and recorded. Data for the category of multiple disabilities, however, was seriously under reported to OECD. The reported prevalence for this disability was .01, whereas a review of the past 20 reports to the United States Congress indicated that the actual prevalence rate consistently ranges between .17 - .21. For the year under investigation (1996), the reported rate to the United States Congress for this category was .19. Therefore, Table 1 reflects the revised prevalence rate for multiple disabilities for the United States. Even, in light of this revised data, the United States ranks third in prevalence for these five common disability labels.

### **Disparate Core of Disability Labels**

17. While there is not universal agreement across study countries on the inclusion of other disability labels in SEN Category A, there are an additional seven disabilities that are variously identified by the study countries as being included in this Category. This disparate core of disabilities includes speech/language impairment, health impairment, deaf/blind, autism, emotional/behavioral impairment, learning disability (normal intelligence), and traumatic brain injury. Among educators and psychologists, many of these disability labels are not considered to have an organic etiology and their identification is considered to be more subjective in nature. Table 2 presents this disparate core of remaining disabilities and each study country's education prevalence rate for that label (if it is considered a Category A disability

by the country) or the country’s determination of that disability level (different SEN Category, no formal recognition of the label).

**Table 2: Country Determinations and Education Prevalence Rates for the Disparate Core of Remaining Disability Labels by Study Countries**

Disability Category	Country CH	IR	IT	USA
Speech/Language	.13	.24	d	2.28
Health Impairment	B	d	d	.34
Deaf/Blind	D	d	d	.00*
Autism	D	d	d	.07
Emotional Impairment	.65	B	d	B
Learning Disability (normal intelligence)	B	.37	d	B
Traumatic Brain Injury	D	d	d	.02
<b>TOTALS</b>	<b>.78</b>	<b>.61</b>	<b>-</b>	<b>2.71</b>

d – Country does not differentiate this Disability Label - students are serving within existing Category A classifications

B – Disability Label is assigned to SEN Category B

\*Note: this figure is not a true zero, but less than .01.

18. As indicated in Table 2, Switzerland and Ireland, each, identify two additional disability labels within SEN Category A (albeit not the same labels); the United States identifies five additional disability labels; and Italy has no additional disability labels within Category A. However, the mere difference in the quantity of disability labels that are assigned to Category A within the study countries does not, itself, account for the differences in prevalence rates. The extreme outlier in this disparate core, across all countries and labels, appears to be speech and language disability for the United States. If this label were held separately, the additional prevalence rates for Switzerland, Ireland, and the United States would be similar. Therefore, it appears that the speech and language label is driving the prevalence rate difference between the countries. As with the common core, the prevalence data for these disability labels were also re-examined to ensure that the reported statistics were accurate. Findings from that procedure indicated that the data for speech and language for the United States, as reported to OECD, was higher than that reported to the United States Congress for the same period. To be consistent throughout this report, the prevalence data reported to Congress was therefore used in this table, as well, thus reducing the category prevalence from 2.81 (as reported) to 2.28. Similarly, the prevalence rates for the remaining four labels under the United States Category A were taken from the same Report to the US Congress.

19. Table 3 presents the revised education prevalence rates for SEN Category A by study countries. The Table indicates that the United States continues to have a prevalence rate twice as high as that of the other countries. Again, if speech and language disability were held separate from the equation, the prevalence rates across countries would be very similar (United States – 2.07).

**Table 3: Revised Education Prevalence Rates for SEN Category A Study Countries**

Prevalence Rates	Country CH	IR	IT	USA
Common Core	1.30	2.01	2.13	1.64
Additional Disabilities	.78	.61	0.00	2.71

<b>Revised Totals</b>	<b>2.08</b>	<b>2.62</b>	<b>2.13</b>	<b>4.35</b>
-----------------------	-------------	-------------	-------------	-------------

***Procedural Factors***

20. Qualitative discussions with study country experts determined that, overall, procedural factors might explain some of the variance in prevalence rates between the United States and the European study countries, particularly related to the disability classification of speech and language impairment. However, the first procedural factor, *data age cohorts*, does not appear to be contributing to the rate differences. Each country provided data on only those students who were within the specified age range of the study (5-15 years of age). While each country has data on students on both sides of this cohort range, the specific age group under study was isolated from the other data.

21. The second procedural factor, the *comprehensiveness of the reported data*, may explain some of the variance in prevalence rates, albeit its contribution would be small. Specifically, discussions with both Ireland and Italy indicated that there was under counting of children, particularly with regard to children with more severe disabilities.

22. In Ireland, experts in both health and education indicated that the data provided to the OECD represented only children who are within the public education system. Their specific example of under counting of children with severe disabilities was indicative of the potential problem. In Ireland, the Ministry of Health maintains a birth to death database on citizens with intellectual disability. That database reports the existence of approximately 1200 school age students with severe intellectual disability. The Ministry of Education data reports approximately 800 students with that level of disability. The Ministry of Education concurs that the Health data captures the entire population, whereas the Education data only counts those young people who are served by the public education system. While the Ministry of Education is confident that its data reflects the population of students with mild disabilities, it believes there is under counting in the other areas.

23. A similar counting problem exists in Italy, however, to a much lesser degree. In general comments from various Ministry experts, the consensus was that there is an under counting of students with disabilities, although no estimate of the degree of under counting was given. As with Ireland, the Italian experts believe that the majority of under counting also represents students with the most severe disabilities.

24. As for the United States data, experts at the Department of Education and local school districts are confident that the data reported captures the entire population of students who have disabilities within the study age cohort. The data reports students who are in public (regular classrooms, separate classrooms, separate schools), private (served by public special education), home schools, and residential (hospitals, juvenile justice) settings. Therefore, it appears that some of the difference in rates may be due to under counting by the European countries. However, since the under counting seems to be primarily limited to categories of severe impairment, which by their very nature are inherently small, this under counting would not likely make a significant difference in the overall prevalence rates.

25. The third procedural factor, *classification definitions and student identification*, appears to explain some of the variance in prevalence rates in a very specific way. First, generally speaking, the entire population of students with disabilities does appear to be captured by all countries within their respective schema, taking into account individual differences in the number and type of disabilities listed by countries in SEN Category A. For example, whereas the United States delineates several classifications by the etiology of the disability (e.g., traumatic brain injury), those same students are, nevertheless,

counted within the other study countries. However, in the European countries, these students are more often classified according to the manifestation of their disability versus its etiology (e.g., students with traumatic brain injury would be classified as physically handicapped or mild mental handicap in Ireland).

26. Specifically turning to the classification of speech and language impairment, in which the greatest difference in prevalence rates seem to occur, it appears that the classification of students in this disability group is much broader in the United States than in the European study countries. According to the United States Department of Education, a speech or language impairment is *a communication disorder, such as stuttering, impaired articulation, a language impairment, or a voice impairment, that adversely affects a child's educational performance* (34 Code of Federal Regulations, 300.7). There is no mention of level of intelligence or degree of impairment. In discussions with speech and language specialists in the United States, it appears that the students in this classification may have diverse cognitive abilities, may have English as a second language, or may have language difficulties which are manifested as the result of some psychological condition. The identification and placement of students into this classification appears to be very subjective and non-standardized across districts and states. This classification appears to serve a very broad range of students with diverse language needs.

27. In Ireland this classification is limited to students whose non-verbal ability is in the average band or higher and whose skill in understanding or expressing themselves through the medium of spoken language is severely impaired (Special Education Review Committee, 1993). Students who may experience speech and language difficulties as the result of hearing impairment, learning difficulties (cognitive impairment), or emotional and/or behavioral concerns would not be included in the speech and language disorder classification, but in the broader category of specific learning disability. The key here is that the student must have average or higher non-verbal intelligence and have no other identifiable cause for his/her speech and language difficulty.

28. In Italy the classification of speech and language impairment is not differentiated as a distinct disability. Discussions with education and health experts in Italy indicated that these children would be served under some other classification (e.g., hearing impairment) if their needs were so great as to require additional equipment or supports to benefit from their educational programs. These students are part of the regular classroom and are educated by the regular classroom teacher. Additionally, these students benefit from the existence of support teachers and trained volunteers in the regular classroom.

29. Therefore, it appears that the large prevalence rate for the classification of speech and language impairment in the United States versus that of the European countries reflects cross national differences in definitions and student identification. However, further intense study at the district level in the United States would be needed to determine to what degree definition and identification are driving the prevalence rate differences. In particular, such a study would need to identify the characteristics of students who are served under this classification, to determine if they are, indeed, significantly different than those served in other countries.

## **Phase Two**

### **United States Correlations**

30. Table 4 presents the results of the examination of the relationship between social indicators of child well being and disability prevalence for the United States. Ten social indicators were examined as follows: low birth weight, infant mortality, child death, teen death, teen birth, high school dropout, teens out of school and/or work, children living in homes with less than fully employed parents, children living in poverty, and children in single parent households. Disability classifications that were examined

included mental retardation, emotional impairment, and a composite category of all SEN categories A and B disabilities. Mental retardation (intellectual disability) was positively correlated with five social indicators. Four out of these five indicators are primarily related to health issues, while the fifth indicator measures child poverty.

31. Emotional impairment was negatively correlated with seven out of ten of the social indicators. This negative correlation indicates that as the identification of students with emotional impairment increases, child outcomes improve. The assumption here is that identification of emotional and/or behavioral impairments leads to intervention services, which, in turn improve social outcomes for these students, as measured by the indicators. For example, states such as Minnesota and New Hampshire have relatively high identification rates for emotional impairment and low rates of poor child outcomes. Conversely, for states such as Alabama and Mississippi, where the identification of students with emotional impairment is relatively low compared to other states, those same states have high rates of poor child outcomes. (While these correlations are compelling, these researchers acknowledge that much more research is needed to fully understand what these figures mean).

32. There was no significant correlation for the composite disability category and the social indicators.

**Table 4: Significant Correlations between Social Indicators and Disability Prevalence in the United States**

Social Indicator	Disability Labels	
	MR	EI
Low birth weight babies	.43**	
Infant mortality rate	.59**	-.29*
Child death rate	.34*	-.43**
Teen death rate		-.44**
Teen birth rate	.29*	-.42**
High school dropout		-.32*
Teens out of school and/or work		-.39**
Less than fully employed parents		
Children living in poverty	.35*	-.33*
Children in single parent homes		

\* = alpha of .05; \*\* = alpha of .01, based on two-tail test with a sample of 51 States and DC

### Descriptive Data on Indicators for Study Countries

33. Experts in the study countries supported the premise that a potential correlation does exist between social indicators of child well being and disability prevalence. In particular, experts in Ireland indicated that they have observed a high rate of disability in areas of their country that also have high rates of socioeconomic disadvantage. However, they emphasized that they have not ruled out the important role that test bias (disability identification issues relate to the potential difficulties that students with low socioeconomic status may have with language comprehension) may contribute to the high disability rates. They indicated that a majority of students in some impoverished areas have been identified as having a wide range of educational needs, spanning Categories A-C in the SEN schema. Professionals in education, health, and social welfare, all indicated a high interest in pursuing a research study on the relationship of social indicators and disability prevalence.

34. Similarly, experts in Italy supported the premise that there is a relationship between social indicators of child well being and disability prevalence. However, there was some debate as to the direction of the relationship (e.g., did social disadvantage trigger disability or disability trigger social disadvantage). Officials from both health and education agreed that there are regional trends related to these variables in Italy. They indicated that Southern Italy has both lower socioeconomic status and higher disability rates. For example in the South, there are twice as many students with multiple disabilities as in the North. Italy has just begun a two year study (funded by social affairs) to examine the “life process” for persons with disabilities. They indicated that a research study on social indicators and disability would complement the work they are implementing and therefore expressed strong support for a collaborative study.

35. Both Ireland and Italy have data structures in place that will facilitate the study of social indicators and disability. Both countries have life span data for persons with disabilities, which is maintained at the local (health) and national (education) levels.

**Research Potential – Economic Implications**

36. Table 5 provided the basis for the last series of exploratory questions on the potential utility and benefits of a social indicator-disability study. Table 5 presents data on the percentage of gross domestic product that is spent on health, education, and social welfare, and poverty and disability rates for selected OECD countries (study countries, as well as selected others). Data is based on a recent study by the United Nations Children’s Fund (Innocenti Research Centre, 2000) in which they found that the rate of child poverty is affected by the level of state benefits to workless and low paid parents. Specifically, they found that no country with a high rate of gross social expenditures (e.g., unemployment benefit, family allowances and services, disability and sickness benefits, housing benefits, and other forms of social assistance) had a high rate of child poverty (e.g., Finland compared to the United States).

37. While poverty is a multidimensional construct, it appears that at least one factor, social expenditure, can have a mitigating effect on it. Recalling that the previous correlation matrix indicated that poverty is linked with disability, at least in the United States, further inquiry with the study countries examined the logic of extending this line of thinking to disability prevalence. Specifically, discussions focused on their perceptions of the potential effect that spending in health and education may have on mitigating the effects on disability prevalence. Results of these exploratory questions indicated that there would be strong support for linking demography, disability and economic implications. Experts across countries agreed that the examination of prevalence rates (as in Phase One of this study), in isolation of social and economic factors and relationships, fail to move national disability policies and agendas forward. Support was expressed for a multinational study that would examine disability prevalence from a multivariate, interagency perspective. Experts believe that such an approach would help policymakers to understand the often hidden reality that, while disability prevalence rates remain flat among children living in families above the poverty line, the prevalence rate among specific sectors of the population (e.g., poor, disadvantaged) is increasing at unprecedented rates (Fujiura, 2000). Recognizing that economic sectors within countries are becoming increasingly polarized, the study countries expressed interest in determining the implications of the disadvantage/disability increase and in the potential for intervention success.

**Table 5: Percentage of Gross Domestic Product Spent on Health, Education, and Social Welfare and Poverty and Disability Rates in Selected OECD Countries**

Country	GDP Percentages			Prevalence Rates		
	Health	Education	Social Welfare	% Total	Poverty*	Disability

<b>CH</b>	10.3	5.4		<b>M</b>	<b>M</b>	2.08
<b>IR</b>	6.3	4.5	9.1	19.9	16.8	2.62
<b>IT</b>	7.6	4.6	4.5	16.7	20.5	2.13
<b>USA</b>	13.9	5.2	3.1	22.2	22.4	4.35
<b>FIN</b>	7.4	6.3	15.4	29.1	4.3	1.04
<b>DEU</b>	10.7	5.7	8.4	24.8	10.7	1.45
<b>NL</b>	8.5	4.3	12.6	25.4	7.7	1.65

\*Poverty is defined as those whose resources (materials, cultural, and social) are so limited as to exclude them from the minimum acceptable way of life in the Member States in which they live”, in other words, relative poverty. In practical terms this definition is interpreted as “those whose incomes fall below half of the average income (as measured by the median) for the nation in which they live”. (United Nations Children’s Fund, pg. 6).

## Discussion and Conclusion

38. This two phase study investigated the OECD-reported differences in disability prevalence rates between the United States and selected western European countries, and explored the potential for future research which would address the relationship between a variety of social indicators of child well being and disability. Findings from phase one of the study indicated that the difference in disability prevalence rates was primarily attributable to a difference in the definition of one specific disability classification. No difference existed among countries on the common core of disability classifications. Nor did the higher number of disability classifications within the United States Category A, over that of other countries, contribute to the higher prevalence rates. All countries appear to recognize the same universe of students and disabilities within their current systems. While the other countries did acknowledge some under counting of students with disabilities within their national education data, as compared to the United States, the under counting appeared to be limited to students with the most severe disabilities. Given that this classification is inherently small, such under counting did not contribute to the prevalence rate differences. Finally, it was found that the specific classification of speech and language impairment explained the difference in prevalence rates. Within the classification of speech and language impairment, the United States prevalence rate is more than double the rates of western European countries. This larger prevalence rate appears to be primarily driven by a broader definition of the classification within the education system in the United States. In European countries students who experience speech and language difficulties as the result of hearing impairment, learning difficulties, or emotional and/or behavioral concerns would not be included in the speech and language impairment classification, but rather be identified under the broader classification of specific learning disability. The United States does not appear to restrict the speech and language classification by these conditions. However, more intense study at the district level within the United States would be needed to determine exactly which students are served under this classification.

39. Findings from Phase Two of this study indicated that disability correlated with a number of health and social indicators, within the United States. Qualitative discussions with education and health experts in the other study countries acknowledged similar patterns. Further the discussants indicated that, like that in the United States, the face of disability among industrialized countries is changing.

40. While disability prevalence rates remain flat for children at or above the poverty line, rates among children below the poverty line are increasing dramatically (Fujiura, 2000). Study countries agreed that disability covaries with a number of social indicators such as low birth weight, parents education, parental employment, teen birth rate, violence and abuse, and poverty. They further acknowledged that disability is costly, consuming an increasing proportion of education, health, and social welfare budgets. Finally, all study participants agreed that disability must be examined in relationship to the complex influence and interaction effects of social and economic variables. Disability is no longer a narrow disciplinary or national issue, but rather it exists at the intersection of rights-based mandates, child health, and social welfare. Concerns which were historically allocated to the sole domain of special education

now transcend that narrow program niche. Emerging data argue for the need to investigate disability and disability prevalence from an interdisciplinary, multinational perspective.

## REFERENCES

- Annie E. Casey Foundation. (1999). Kids Count Data Book. Baltimore, MD: Author.
- Fujiura, G.T. & Yamaki, K. (2000). Trends in demography of childhood poverty and disability. Exceptional Children, 66(2), 187-199.
- Office of Special Education Programs. (1998). 20th Report to Congress. Washington, D.C.: U.S. Department of Education.
- Organization for Economic Co-Operation and Development. (1995). Integrating students with special needs into mainstream schools. Paris: Author.
- Organization for Economic Co-Operation and Development. (2000). Special Needs Education: Statistics and Indicators. Paris: author.
- Seelman, K. & Sweeney, S. (1995). The changing universe of disability. American Rehabilitation, 21, 2-13.
- Special Education Review Committee. (1993). Report of the Special Education Review Committee (Tuairisc an Choiste Athbhreithnithe ar an Oideaschas Speisialta). Dublin: Government of Ireland.
- United Nations Children's Fund. (June 2000). Child Poverty in Rich Nations. Florence: Innocenti Research Centre.
- Westat. (November 1999). OSEP IDEA, Part B Data Dictionary. Rockville, MD: Author.