Adults with disabilities in the United States have worse self-reported physical and mental health status, lower employment rates, and higher rates of chronic illness, poverty, and material hardship than adults without disabilities (BLS 2023; Krahn, Walker, and Correa-De-Araujo 2015; Mitra et al. 2022; Vallas et al. 2022). Despite important federal antidiscrimination protections, disabled people also continue to experience discrimination and unfair treatment in health care settings, workplaces, and when applying for public benefits (Domzal, Houtenville, and Sharma, 2008; Gasper, Palan, and Muz 2020; Iezzoni et al. 2021; Lagu et al. 2022; McDaniel et al. 2023; Pratt et al. 2023).

Experiences of unfair treatment in these settings can reinforce health and economic disparities by limiting access to employment opportunities and services that are essential for meeting basic needs. Efforts to improve the health and well-being of people with disabilities will, therefore, require addressing unequal treatment and ableism—a set of biases and institutional practices rooted in the belief that people with disabilities are inferior (Lindsay et al. 2022; 2023).

In this brief, we used nationally representative survey data to better understand the extent to which adults experience differential treatment because of their disabilities and other personal characteristics, such as race, ethnicity, and income, and the impact of such treatment on their well-being. Drawing on December 2022 data from the Urban Institute’s Well-Being and Basic Needs Survey, we examined self-reported rates at which adults ages 18 to 64 with and without disabilities felt they were treated or judged unfairly in the past year in three settings: at doctors’ offices, clinics, or hospitals.
(hereafter referred to as health care settings); at work; and when applying for public benefits (which we also refer to as social service settings). Our measure of disability conforms to federal data collection standards for surveys and is defined as having difficulties with one or more of the following: hearing; seeing; concentrating, remembering, or making decisions; walking or climbing stairs; dressing or bathing; doing errands alone; and communicating in one’s own language (see the data and methods appendix on page 15 for more information).

Our key findings include the following:

- In December 2022, 4 in 10 adults with disabilities (40 percent) reported experiencing unfair treatment in health care settings, at work, or when applying for public benefits because of their disabilities or other personal characteristics in the previous year. Adults with disabilities were more than twice as likely as adults without disabilities to report unfair treatment in one or more of these settings (40 percent versus 18 percent).
  - Disabled adults were more likely than adults without disabilities to report unfair treatment in each of the three settings: 32 percent versus 10 percent in health care settings, 18 percent versus 11 percent at work, and 14 percent versus 3 percent when applying for public benefits.

- Many disabled adults reported experiencing unfair treatment because of their disabilities or health conditions in the prior year: 14 percent in health care settings, 9 percent at work, and 6 percent when applying for benefits.

- Among disabled adults, Black and Hispanic/Latinx adults were more likely than white adults to report unfair treatment or judgment in each of the three settings because of their race, ethnicity, country of origin, or primary language.

- Disabled adults frequently reported adverse consequences after experiencing unfair treatment, in many cases at rates higher than those of adults without disabilities.
  - About 71 percent of disabled adults who experienced unfair treatment in health care settings reported a disruption to care after such treatment, including delaying (54 percent) or not getting (50 percent) needed care.
  - Almost half (46 percent) of disabled adults who experienced unfair treatment in workplaces reported looking for a new job because of the way they were treated.
  - About 71 percent of disabled adults who experienced unfair treatment in social service settings had difficulty receiving public benefits, including delaying (45 percent) or not getting (57 percent) benefits.

Although we were not able to determine the specific nature of the interactions with health care providers, employers, coworkers, benefits administrators, or others that were perceived as unfair treatment, these findings show that experiences of unfair treatment were common among people with disabilities, causing disruptions in health care and employment and delays in accessing public benefits to help them meet their basic needs. Experiences of unfair treatment could also take a mental and physical
health toll on people with disabilities, given past research linking discrimination to higher levels of stress and the close link between stress and physiological responses (APA 2016; Namkung and Carr 2020). The barriers and discrimination that disabled people face in these settings because of their disability are compounded among those who are also marginalized based on other characteristics, such as race, ethnicity, or primary language (Crenshaw 1989; Crossley 2022; Goodman, Morris, and Boston 2019; Yee et al. 2017). Understanding and addressing experiences of unfair treatment among people with disabilities is necessary for ensuring they have equitable access to health care, employment opportunities, and economic support.

Background

Disabled people face greater barriers to access, service quality, and equitable treatment in many settings, and experiences of unfair treatment can take various forms. Barriers to health care include limited access to sign language interpreters or other supports to facilitate communication with providers and office staff and widespread use of scales, examination tables, and other diagnostic equipment that were not designed for people with disabilities (Peacock, Iezzoni, and Harkin. 2015). Health care provider bias can directly manifest in the provision of lower quality care for people with disabilities, including lower rates of preventive screenings because of assumptions that people with disabilities do not require certain types of care or explicit denial of care because of provider perceptions that treating people with disabilities is too cumbersome (de Vries McClintock et al. 2016; Iezzoni et al. 2021; Lagu et al. 2022; Lindsay et al. 2022; VanPuymbrouck, Friedman, and Feldner 2020).

People with disabilities also face barriers to becoming or staying employed because of a lack of support, accommodations, and enforcement of antidiscrimination protections designed to promote workplace equity. For example, employers may hesitate to hire disabled job seekers who are qualified for open positions if they perceive the cost of providing reasonable accommodations—required under the Americans with Disabilities Act—would be too high or if they incorrectly believe disabled employees will not be able to perform job duties (Domzal, Houtenville, and Sharma, 2008; Gaspar, Palan, and Muz 2020). Employed people with disabilities may also face overt and subtle forms of discrimination because of their disability, such as microaggressions and exclusion from meetings because of a lack of accessibility support for employees with vision, hearing, mobility, or other disabilities (Graham et al. 2019; Namkung and Carr 2019; Schur et al. 2017). Further, disabilities are not always visible, as can be the case with hearing difficulties, chronic physical health conditions, or disabilities related to mental health conditions such as depression. Employed people with disabilities may choose not to disclose their disability to employers for fear of being stigmatized or otherwise treated differently, which can result in disabled employees not requesting reasonable accommodations they need and eventually lead them to leave their jobs (Schur et al. 2017).

Such barriers to working can lead to higher unemployment rates, food insecurity, and economic insecurity among disabled people (Altiraifi 2019; Heflin, Altman, and Rodriguez 2019; Vallas et al. 2022). This increased financial precarity contributes to the need for public assistance programs that pose barriers disproportionately affecting disabled people. For example, administrative burdens, such
as complicated paperwork and documentation requirements or in-person appointment requirements, are well-established factors in complicating access to public benefits (Moynihan, Herd, and Harvey 2015). These administrative barriers can become more challenging for people with disabilities if, for example, online benefit applications are not available in multiple formats to meet the needs of people with disabilities (Musumeci et al. 2022). In the Social Security Disability Insurance and Supplemental Security Income (SSI) programs, applicants face burdensome medical paperwork requirements to prove their disability and lengthy application processes that often end in denial of benefits (Schweitzer et al. 2022). SSI applicants also face asset tests that require them to have resources below a very low threshold.

Unequal treatment persists despite federal protections against discrimination based on disability status in health care, social service, employment, and other settings, including the following:

- the Americans with Disabilities Act, which prohibits discrimination based on disability in employment, state and local government activities, public transportation, public accommodations, commercial facilities, and telecommunications
- the Rehabilitation Act, which prohibits discrimination based on disability in programs and activities funded by the federal government and in the employment practices of federal agencies and contractors
- the Affordable Care Act, which prohibits discrimination on the basis of disability in federally funded health care programs and services and includes other provisions that are important for disabled patients, such as protections against denying coverage or charging higher premiums to patients with preexisting health conditions

In the following section, we assess reported experiences with unfair treatment or judgment in health care, employment, and social service settings for people with and without disabilities. We close with a discussion highlighting steps that could help produce better experiences and outcomes for people with disabilities.

Results

In December 2022, 4 in 10 adults with disabilities reported experiencing unfair treatment in health care settings, at work, or when applying for public benefits because of their disabilities or other personal characteristics in the previous year. Adults with disabilities were more than twice as likely as adults without disabilities to report unfair treatment in one or more of these settings.

Forty percent of adults with disabilities reported they were treated or judged unfairly in health care settings, at work, or when applying for public benefits because of their personal characteristics in the past year, a rate that was over twice as high as that for adults without disabilities (18 percent; figure 1). About 17 percent of people with disabilities reported unfair treatment in two or more settings (data not shown). People with disabilities reported higher rates of unfair treatment in all three situations: health
care settings (32 versus 10 percent), at work (18 versus 11 percent), and when applying for public benefits (14 versus 3 percent).

**FIGURE 1**
Share of Adults Reporting Unfair Treatment or Judgment in Health Care Settings, at Work, and When Applying for Public Benefits in the past 12 Months, by Disability Status, December 2022

![Bar chart showing unfair treatment or judgment rates by disability status.]

**Source:** Well-Being and Basic Needs Survey, December 2022.

**Notes:** Adults are ages 18 to 64. Health care settings include a doctor’s office, clinic, or hospital. Respondents could have reported unfair treatment or judgment because of one or more of the following characteristics: race, ethnicity, gender, gender identity or sexual orientation, country of origin or primary language, health insurance coverage type (only asked for health care settings), disability or health condition, weight, income or education, or some other reason. Disability is defined as difficulties with one or more of the following: hearing; seeing; concentrating, remembering, or making decisions; walking or climbing stairs; dressing or bathing; doing errands alone; and communicating in one’s own language.

*** Estimate differs significantly from that for adults with a disability at the 0.10/0.05/0.01 level, using two-tailed tests.

One in seven adults with disabilities (14 percent) reported unfair treatment or judgment in health care settings because of their disability or a health condition, and the same share reported unfair treatment because of their weight (table 1). Nearly as many reported feeling they were treated or judged unfairly because of their health insurance coverage type (12 percent). Because of structural factors that limit their employment opportunities and incomes, disabled people have less access to private health insurance and disproportionately rely on Medicaid and other public programs for coverage (Altiraifi 2019; Musumeci and Orgera 2020; Vallas et al. 2022). Prior research has shown that publicly insured adults are more likely than those with private insurance to report being treated or judged unfairly because of their type of health insurance coverage (Gonzalez et al. 2022). This could reflect negative attitudes toward Medicaid among providers because of the program’s lower reimbursement rates, more cumbersome prior authorization and billing processes, and the greater cost of treating patients who are more likely to have complex medical needs, as well as providers’ or staff
members’ implicit or explicit biases toward publicly insured patients (Alexander and Schnell 2019; Dunn et al. 2021; Grimm 2023; Polsky et al. 2015).

Just under 1 in 10 adults with disabilities (9 percent) experienced unfair treatment at work because of a disability or health condition; these adults were almost as likely to report unfair treatment for other reasons such as their gender, gender identity, or sexual orientation (8 percent) and their race, ethnicity, country of origin, or language (8 percent).

Six percent of disabled adults reported unfair treatment because of a disability or health condition when applying for public benefits, similar to the share reporting they were treated or judged unfairly because of their income or education (7 percent) or their race, ethnicity, country of origin, or language (7 percent). Relatively few adults without disabilities reported unfair treatment when applying for public benefits for any of the reasons shown in table 1.

### TABLE 1
Share of Adults Reporting Unfair Treatment or Judgment in Health Care Settings, at Work, and When Applying for Public Benefits in the past 12 Months, by Disability Status and Reason for Unfair Treatment, December 2022

<table>
<thead>
<tr>
<th>Share reporting unfair treatment or judgment because of:</th>
<th>In Health Care Settings</th>
<th>At Work</th>
<th>When Applying for Public Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Adults with a disability</td>
<td>Adults without a disability</td>
<td>Adults with a disability</td>
</tr>
<tr>
<td>Disability or health condition</td>
<td>14%</td>
<td>1%***</td>
<td>9%</td>
</tr>
<tr>
<td>Weight</td>
<td>14%</td>
<td>3%***</td>
<td>5%</td>
</tr>
<tr>
<td>Health insurance coverage type</td>
<td>12%</td>
<td>3%***</td>
<td>-</td>
</tr>
<tr>
<td>Gender, gender identity, or sexual orientation</td>
<td>11%</td>
<td>3%***</td>
<td>8%</td>
</tr>
<tr>
<td>Race, ethnicity, country of origin, or primary language</td>
<td>10%</td>
<td>4%***</td>
<td>8%</td>
</tr>
<tr>
<td>Income or education</td>
<td>9%</td>
<td>2%***</td>
<td>5%</td>
</tr>
</tbody>
</table>

**Source:** Well-Being and Basic Needs Survey, December 2022.

**Notes:** Adults are ages 18 to 64. Health care settings include a doctor’s office, clinic, or hospital. Respondents were not asked whether they were treated unfairly at work or when applying for public benefits because of their health insurance coverage type. Disability is defined as difficulties with one or more of the following: hearing; seeing; concentrating, remembering, or making decisions; walking or climbing stairs; dressing or bathing; doing errands alone; and communicating in one’s own language. Respondents could report multiple reasons for unfair treatment or judgment. Sample sizes for adults with a disability and adults without a disability are 2,194 and 5,687, respectively.

*/*/*** Estimate differs significantly from that for adults with a disability at the 0.10/0.05/0.01 level, using two-tailed tests.
Among disabled adults, Black and Hispanic/Latinx adults were more likely than white adults to report unfair treatment or judgment in each of the three settings because of their race, ethnicity, country of origin, or primary language.

Table 2 shows the share of Black, Hispanic/Latinx, and white adults with disabilities who reported experiencing unfair treatment in each setting and the reasons they felt they were treated or judged unfairly (estimates are not shown for other racial/ethnic groups because of sample size limitations). In each racial/ethnic group shown in the table, about 4 in 10 adults reported unfair treatment in at least one setting. Black adults with disabilities were likelier than white adults with disabilities to report unfair treatment in two or more settings (21 versus 16 percent; data not shown).

We observed differences by race/ethnicity when assessing rates of unfair treatment in each setting that were related to specific characteristics. Black adults with disabilities were nearly six times as likely as white adults with disabilities to report unfair treatment in health care settings because of their race, ethnicity, country of origin, or primary language (23 percent versus 4 percent). Hispanic/Latinx adults reported unfair treatment for these reasons at three times the rate of white adults (12 percent versus 4 percent).

Disabled Black and Hispanic/Latinx adults were also more likely than disabled white adults to report unfair treatment because of their race, ethnicity, country of origin, or primary language in the workplace (15 percent and 10 percent versus 4 percent) and when applying for public benefits (11 percent and 8 percent versus 5 percent).

In addition, Black and Hispanic/Latinx adults with disabilities were generally more likely than white adults with disabilities to report unfair treatment because of their income or education. For example, 11 percent of Black and Hispanic/Latinx adults with disabilities reported unfair treatment because of their income or education in health care settings, compared with 6 percent of white adults with disabilities.
<table>
<thead>
<tr>
<th>Share reporting unfair treatment or judgment in any setting</th>
<th>Black</th>
<th>Hispanic/Latinx</th>
<th>White</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>40%</td>
<td>37%</td>
<td>39%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Share reporting unfair treatment or judgment in health care settings because of:</th>
<th>Black</th>
<th>Hispanic/Latinx</th>
<th>White</th>
</tr>
</thead>
<tbody>
<tr>
<td>Any reason</td>
<td>34%</td>
<td>29%</td>
<td>29%</td>
</tr>
<tr>
<td>Disability or health condition</td>
<td>15%</td>
<td>12%</td>
<td>14%</td>
</tr>
<tr>
<td>Weight</td>
<td>17%</td>
<td>13%</td>
<td>13%</td>
</tr>
<tr>
<td>Health insurance coverage type</td>
<td>12%</td>
<td>12%</td>
<td>11%</td>
</tr>
<tr>
<td>Gender, gender identity, or sexual orientation</td>
<td>12%</td>
<td>9%</td>
<td>9%</td>
</tr>
<tr>
<td>Race, ethnicity, country of origin, or primary language</td>
<td>23%</td>
<td>12%***</td>
<td>4%***/++</td>
</tr>
<tr>
<td>Income or education</td>
<td>11%</td>
<td>11%</td>
<td>6%**/+</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Share reporting unfair treatment or judgment at work because of:</th>
<th>Black</th>
<th>Hispanic/Latinx</th>
<th>White</th>
</tr>
</thead>
<tbody>
<tr>
<td>Any reason</td>
<td>20%</td>
<td>17%</td>
<td>16%</td>
</tr>
<tr>
<td>Disability or health condition</td>
<td>9%</td>
<td>8%</td>
<td>8%</td>
</tr>
<tr>
<td>Weight</td>
<td>7%</td>
<td>6%</td>
<td>4%**</td>
</tr>
<tr>
<td>Gender, gender identity, or sexual orientation</td>
<td>10%</td>
<td>8%</td>
<td>8%</td>
</tr>
<tr>
<td>Race, ethnicity, country of origin, or primary language</td>
<td>15%</td>
<td>10%*</td>
<td>4%***/++</td>
</tr>
<tr>
<td>Income or education</td>
<td>6%</td>
<td>8%</td>
<td>3%/***</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Share reporting unfair treatment or judgment when applying for public benefits because of:</th>
<th>Black</th>
<th>Hispanic/Latinx</th>
<th>White</th>
</tr>
</thead>
<tbody>
<tr>
<td>Any reason</td>
<td>15%</td>
<td>15%</td>
<td>12%</td>
</tr>
<tr>
<td>Disability or health condition</td>
<td>8%</td>
<td>7%</td>
<td>5%</td>
</tr>
<tr>
<td>Weight</td>
<td>4%</td>
<td>7%</td>
<td>3%**+</td>
</tr>
<tr>
<td>Gender, gender identity, or sexual orientation</td>
<td>6%</td>
<td>7%</td>
<td>4%**+</td>
</tr>
<tr>
<td>Race, ethnicity, country of origin, or primary language</td>
<td>11%</td>
<td>8%</td>
<td>5%***/+</td>
</tr>
<tr>
<td>Income or education</td>
<td>9%</td>
<td>6%</td>
<td>6%</td>
</tr>
</tbody>
</table>


Notes: Adults are ages 18 to 64. Estimates for adults who are Black or white refer to those who are not Hispanic/Latinx. Estimates for non-Hispanic/Latinx adults of additional races are not shown because of small sample sizes. Health care settings include a doctor’s office, clinic, or hospital. Disability is defined as difficulties with one or more of the following: hearing; seeing; concentrating, remembering, or making decisions; walking or climbing stairs; dressing or bathing; doing errands alone; and communicating in one’s own language. Respondents could report multiple reasons for unfair treatment or judgment.

*/++/*** Estimate differs significantly from that for Black adults with a disability at the 0.10/0.05/0.01 level, using two-tailed tests. 
/+/**/+ Estimate differs significantly from that for Hispanic/Latinx adults with a disability at the 0.10/0.05/0.01 level, using two-tailed tests.
Disabled adults frequently reported adverse consequences after experiencing unfair treatment, in many cases at rates higher than those of adults without disabilities.

CONSEQUENCES OF UNFAIR TREATMENT IN HEALTH CARE SETTINGS

Overall, about 7 in 10 adults with disabilities (71 percent) who experienced unfair treatment in health care settings reported a disruption to care because of how they were treated, compared with about 6 in 10 adults without disabilities (61 percent; figure 2). Disruptions to care among people with disabilities included looking for a new health care provider (47 percent), delaying needed care (54 percent), not getting needed care (50 percent), and not following the doctor’s or provider’s recommendations (31 percent). Adults with disabilities were more likely than those without disabilities to report each of these disruptions.

Over 1 in 3 adults with disabilities (36 percent) who experienced unfair treatment in health care settings took some action to express dissatisfaction with the treatment they received, compared with just under 1 in 4 adults without disabilities (23 percent) who experienced unfair treatment. About one-quarter of adults with disabilities (26 percent) spoke to the provider about how they were treated, 16 percent filed a complaint, and 14 percent wrote a review or shared their experience on social media.

FIGURE 2
Disruptions to Care and Actions Taken in Response to Unfair Treatment or Judgment in Health Care Settings in the past 12 Months, by Disability Status, December 2022

<table>
<thead>
<tr>
<th>Disruption to Care / Action Taken</th>
<th>Adults with a disability</th>
<th>Adults without a disability</th>
</tr>
</thead>
<tbody>
<tr>
<td>Any disruption to care</td>
<td>71%</td>
<td>61%***</td>
</tr>
<tr>
<td>Looked for a new health care provider</td>
<td>36%***</td>
<td>47%</td>
</tr>
<tr>
<td>Delayed getting needed care</td>
<td>41%***</td>
<td>54%</td>
</tr>
<tr>
<td>Did not get needed care</td>
<td>31%***</td>
<td>50%</td>
</tr>
<tr>
<td>Did not follow the doctor or provider’s recommendations</td>
<td>18%***</td>
<td>31%</td>
</tr>
<tr>
<td>Any action to express dissatisfaction with treatment</td>
<td>36%***</td>
<td>23%***</td>
</tr>
<tr>
<td>Spoke to the doctor or provider about the way they were treated</td>
<td>26%**</td>
<td>15%**</td>
</tr>
<tr>
<td>Filed a complaint</td>
<td>16%**</td>
<td>9%**</td>
</tr>
<tr>
<td>Wrote a review or shared on social media</td>
<td>14%**</td>
<td>8%**</td>
</tr>
</tbody>
</table>


Notes: Adults are ages 18 to 64. Health care settings include a doctor’s office, clinic, or hospital. Respondents could have reported unfair treatment or judgment because of one or more of the following characteristics: race, ethnicity, gender, gender identity or sexual orientation, country of origin or primary language, health insurance coverage type, disability or health condition, weight, income or education, or some other reason. Disability is defined as difficulties with one or more of the following: hearing; seeing; concentrating, remembering, or making decisions; walking or climbing stairs; dressing or bathing; doing errands alone; and communicating in one’s own language. Respondents could report multiple actions in response to unfair treatment or judgment. */**/*** Estimate differs significantly from that for adults with a disability at the 0.10/0.05/0.01 level, using two-tailed tests.
CONSEQUENCES OF UNFAIR TREATMENT AT WORK

Almost half (46 percent) of disabled adults who experienced unfair treatment in workplaces reported looking for a new job because of the unfair treatment they experienced, a share that was 11 percentage points higher than that for adults without disabilities (35 percent; figure 3). About 4 in 10 adults with disabilities (41 percent) spoke to a manager or supervisor about how they were treated, and just under 1 in 5 (19 percent) filed a complaint after the perceived unfair treatment at work.

FIGURE 3
Actions Taken in Response to Unfair Treatment or Judgment at Work in the past 12 Months, by Disability Status December 2022

<table>
<thead>
<tr>
<th>Action</th>
<th>Adults with a disability</th>
<th>Adults without a disability</th>
</tr>
</thead>
<tbody>
<tr>
<td>Looked for a new job</td>
<td>46%</td>
<td>35%**</td>
</tr>
<tr>
<td>Spoke to a manager or supervisor about the way they were treated</td>
<td>41%</td>
<td>35%</td>
</tr>
<tr>
<td>Filed a complaint</td>
<td>19%</td>
<td>13%*</td>
</tr>
</tbody>
</table>


Notes: Adults are ages 18 to 64. Respondents could have reported unfair treatment or judgment because of one or more of the following characteristics: race, ethnicity, gender, gender identity or sexual orientation, country of origin or primary language, disability or health condition, weight, income or education, or some other reason. Disability is defined as difficulties with one or more of the following: hearing; seeing; concentrating, remembering, or making decisions; walking or climbing stairs; dressing or bathing; doing errands alone; and communicating in one’s own language. Respondents could report multiple actions in response to unfair treatment or judgment.

*/**/*** Estimate differs significantly from that for adults with a disability at the 0.10/0.05/0.01 level, using two-tailed tests.

CONSEQUENCES OF UNFAIR TREATMENT WHEN APPLYING FOR PUBLIC BENEFITS

Just over 7 in 10 adults with disabilities (71 percent) who experienced unfair treatment when applying for public benefits reported a problem receiving benefits because of how they were treated (figure 4). This included delaying getting benefits (45 percent), not getting needed benefits (57 percent), and looking for other ways to apply for benefits (49 percent).
Some adults with disabilities took steps to express dissatisfaction with the treatment they received when applying for benefits, including 21 percent who spoke to the benefits provider about the way they were treated and 11 percent who filed a complaint. Figure 4 does not show estimates for adults without disabilities because of small sample sizes.

**FIGURE 4**
Problems Getting Public Benefits and Actions Taken in Response to Unfair Treatment or Judgment When Applying for Public Benefits in the past 12 Months among Adults with Disabilities, December 2022

<table>
<thead>
<tr>
<th>Problem</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Any difficulty getting benefits</td>
<td>71%</td>
</tr>
<tr>
<td>Did not get needed benefits</td>
<td>57%</td>
</tr>
<tr>
<td>Looked for other ways to apply for benefits</td>
<td>49%</td>
</tr>
<tr>
<td>Delayed getting benefits</td>
<td>45%</td>
</tr>
<tr>
<td>Any action to express dissatisfaction</td>
<td>23%</td>
</tr>
<tr>
<td>Spoke to the benefits provider about the way they were treated</td>
<td>21%</td>
</tr>
<tr>
<td>Filed a complaint</td>
<td>11%</td>
</tr>
</tbody>
</table>


Notes: Adults are ages 18 to 64. Respondents could have reported unfair treatment or judgment because of one or more of the following characteristics: race, ethnicity, gender, gender identity or sexual orientation, country of origin or primary language, disability or health condition, weight, income or education, or some other reason. Estimates for adults without disabilities are not shown because of small sample sizes. Disability is defined as difficulties with one or more of the following: hearing; seeing; concentrating, remembering, or making decisions; walking or climbing stairs; dressing or bathing; doing errands alone; and communicating in one’s own language. Respondents could report multiple actions in response to unfair treatment or judgment.

Discussion

Four in 10 nonelderly adults with disabilities reported they were treated or judged unfairly because of their personal characteristics in health care settings, at work, or when applying for public benefits in 2022, a share over twice as high as that for people without disabilities. Disabled adults’ greater average health care use and likelihood of receiving benefits may have contributed to the higher rate at which they experienced unfair treatment in health care and social service settings by exposing them to more frequent interactions. However, previous research suggests this would only account for part of the
higher rates of unfair treatment reported by disabled adults in these settings, and notwithstanding that, our findings indicate that disabled individuals are encountering unfair treatment in health care and social service settings at high rates over the course of a year (McDaniel et al. 2023). In addition, disabled adults were more likely to experience unfair treatment in the workplace despite having a lower employment rate than adults without disabilities, suggesting there are even wider disparities in unfair treatment among disabled and nondisabled workers.

The negative consequences of perceived unfair treatment also fell disproportionately on adults with disabilities. For instance, about 7 in 10 adults with disabilities who reported unfair treatment in health care settings experienced disruptions in their health care, such as delayed or forgone care, which could compromise their health and well-being. Many adults with disabilities also experienced problems receiving benefits because of the unfair treatment they received, such as delayed receipt of or not getting needed benefits, which puts them at greater risk of experiencing material hardships, stress, or having unmet health needs. In addition, repeated exposure to discriminatory treatment and marginalization have been found to have negative psychological and physiological consequences, which could contribute to worse health outcomes for people with disabilities who routinely experience unfair treatment (APA 2016; Namkung and Carr 2020).

Among those with disabilities, Black and Hispanic/Latinx adults were more likely than white adults to report unfair treatment in each setting because of their race, ethnicity, country of origin, or primary language. Our previous analyses have found that, within the overall nonelderly adult population, Black and Hispanic/Latinx adults were more likely to report unfair treatment in health care and other settings (Gonzalez et al. 2021a; 2021b). These findings underscore the role of intersectionality: in addition to bearing the stress of biases related to ableism, people of color with disabilities also encounter racism, classism, and other forms of discrimination based on social status, which compound to intensify adverse consequences of unfair treatment and mistrust in the health care system (Crenshaw 1989; Crossley 2022; Horner-Johnson 2020).

Promoting equity in health care, employment, and social service settings will require multifaceted efforts to reduce the unfair treatment of people with disabilities, including bolstering enforcement of existing antidiscrimination protections; improving disability awareness and competency training for health care providers, employers, and benefits administrators; and improving accessibility of workplaces and services.

ENFORCING ANTIDISCRIMINATION PROTECTIONS
Stronger enforcement of existing civil rights laws is a key strategy to protect people with disabilities from inequitable treatment. For instance, a recently proposed rule seeks to reinstate and bolster protections under Section 1557 of the Affordable Care Act that were weakened under the previous administration. Proposed changes include holding providers accountable for discrimination that may arise from reliance on biased clinical algorithms to drive decisionmaking in health care settings and requiring providers to ensure that their services and platforms through telehealth are accessible to people with disabilities (Obermeyer et al. 2019). President Biden’s executive order on advancing racial
equity and support for underserved communities is another potential lever for building on enforcement, as it concerns promoting equity for people with disabilities.\textsuperscript{11}

Expanded access to free legal aid could also ensure greater accountability and compliance with antidiscrimination laws (Schweitzer et al. 2022). Increased education about Protection and Advocacy Systems, a network of agencies that provide legal representation and advocacy for people with disabilities, could further help ensure that the legal rights of disabled people are protected and enforced.\textsuperscript{12}

\section*{IMPROVING DISABILITY AWARENESS AND TRAINING}
Efforts to educate health care and social service providers and employers about their responsibilities under the Americans with Disabilities Act and other relevant laws and to promote disability competency training will also be needed. For example, enhancing disability curricula in medical education programs could improve physicians’ understanding of disabled patients’ needs (Iezzoni 2016; Meeks, Stergiopoulos, and Petersen 2022; Kaundinya and Schroth 2022). Increasing the number of disabled physicians could also lead to greater awareness of changes that address physical accessibility and communication barriers within health care settings for patients with disabilities (Iezzoni 2016).

\section*{HOLDING SYSTEMS ACCOUNTABLE}
Health care systems, health insurance programs, social service agencies, and employers can monitor patterns of discrimination and unfair treatment through anonymous surveys of patients, clients, and employees.\textsuperscript{13} For instance, in health care settings, payers could use such information to hold health care providers and their staff accountable for reducing inequitable treatment and fostering a culture of quality improvement. In addition, building on examples of platforms where birthing people of color share reviews about their patient care experiences with and the perceived cultural competency of their health care providers, mobile applications could be developed to allow people with disabilities to provide feedback about their experiences that can help inform the choices of other patients with disabilities.\textsuperscript{14}

\section*{ENHANCING PEER SUPPORT FOR NAVIGATING COMPLEX SYSTEMS}
Peer-to-peer support could help disabled people access resources to address unfair treatment. In health care settings, for example, parent-mentor intervention programs connect parents with experience navigating health care for children with certain medical needs to other parents with children in similar situations. These programs have been successful in helping parents of color meet their children’s health care needs and improving satisfaction with their children’s care (Flores et al. 2018). Similar models could be leveraged to provide more disabled people with peer mentors who can help patients and public benefit applicants successfully navigate administrative barriers that arise in health care and social service settings and the complex systems and processes for filing applications and appeals.

\section*{IMPROVING ACCESSIBILITY}
Steps to implement universal design, which entails designing environments to be “accessed, understood, and used to the greatest extent possible by all people regardless of their age, size, ability, or disability,”\textsuperscript{15}
would make them more inclusive for people with disabilities. Such changes can include greater use of ergonomic tools and furniture that would benefit people with mobility difficulties and information sharing in multiple forms (i.e., visual, auditory, and written) that would benefit people with cognitive or communication difficulties in the workplace.¹⁶ In health care settings, requiring the adoption of federal criteria developed in 2017 for accessible diagnostic medical equipment (which physicians are not currently required to implement) would further improve accessibility in these settings (US Architectural and Transportation Barriers Compliance Board 2017; National Council on Disability 2021).¹⁷ A recent US Department of Health and Human Services proposed rule to further strengthen the protections in Section 504 of the Rehabilitation Act would establish enforceable standards for ensuring health care providers use accessible medical diagnostic equipment.¹⁸

In social service settings, streamlining application processes could make programs easier to apply for and navigate. Recent federal efforts calling on public benefit programs to be fair, reduce administrative burden, and better understand customers’ needs and constraints (as reflected in President Biden’s executive order on improving customer service experiences in government programs) could also lead to changes that improve experiences of people with disabilities and ensure that they receive public benefits for which they are eligible.¹⁹

This study has documented that many disabled adults experience unfair treatment in multiple domains in ways that undermine the continuity and quality of their health care, employment, and access to public benefits that could help them meet their basic needs. Addressing structural barriers and biases at the root of the health and well-being of disabled people will require intentional and sustained public and private sector responses developed in partnership with people with disabilities.

Appendix: Data and Methods

Data

This brief draws on data from a nationally representative sample of 7,881 adults ages 18 to 64 who participated in the Urban Institute’s December 2022 Well-Being and Basic Needs Survey (WBNS). The WBNS is an internet-based survey designed to monitor changes in individual and family well-being as policymakers consider changes to federal safety-net programs. For each round of the WBNS, we draw a stratified random sample (including a large oversample of adults in low-income households) from the KnowledgePanel, a probability-based internet panel maintained by Ipsos that includes households with and without internet access. Survey weights adjust for unequal selection probabilities and are poststratified to the characteristics of nonelderly adults based on benchmarks from the Current Population Survey and American Community Survey. Participants can complete the survey in English or Spanish. For further information on the survey design and content, see Karpman, Zuckerman, and Gonzalez (2018).²⁰
Measures

DISABILITY
We measured disability status using six questions based on minimum data collection standards for disability established by the US Department of Health and Human Services and used in the American Community Survey and several other federal surveys. We also draw on another question about communication difficulties from the Washington Group Short Set on Functioning. We consider people as having a disability if they reported “yes” to one or more of the following questions about whether they have difficulties doing certain activities because of a health problem:

- Are you deaf or do you have serious difficulty hearing?
- Are you blind or do you have serious difficulty seeing, even when wearing glasses?
- Because of a physical, mental, or emotional condition, do you have serious difficulty concentrating, remembering, or making decisions?
- Do you have serious difficulty walking or climbing stairs?
- Do you have difficulty dressing or bathing?
- Because of a physical, mental, or emotional condition, do you have difficulty doing errands alone such as visiting a doctor’s office or shopping?
- Using your usual language, do you have difficulty communicating (for example, understanding or being understood)?

EXPERIENCES OF UNFAIR TREATMENT
We asked respondents whether there was a time in the past 12 months when they felt they were treated or judged unfairly in health care settings, at work, or when applying for public benefits because of any of the following: their race, ethnicity, gender, gender identity or sexual orientation, country of origin or primary language, a disability or health condition, weight, income or education, or some other reason (with an option to provide a written response). For experiences in health care settings, we also asked about unfair treatment because of health insurance coverage type.

CONSEQUENCES OF UNFAIR TREATMENT
People reporting unfair treatment in health care were asked if they took any of the following actions:

- Looked for a new health care provider
- Delayed getting care you needed
- Did not get care you needed
- Spoke to the doctor or provider about the way you were treated
- Filed a complaint
- Did not follow the doctor or provider’s recommendations
- Wrote a review or shared on social media
- Other (specify)

For people reporting unfair treatment at work, we asked if they did any of the following because of the treatment they received:

- Looked for a new job
- Spoke to a manager or supervisor about the way you were treated
- Filed a complaint
- Other (specify)

For people reporting unfair treatment when applying for benefits, we asked if they did any of the following because of the treatment they received:

- Looked for other ways to apply for benefits
- Delayed getting benefits
- Did not get needed benefits
- Spoke to the benefits provider about the way you were treated
- Filed a complaint
- Other (specify)

Limitations

The WBNS has several limitations, including a low cumulative response rate, and the survey weights mitigate, but do not eliminate, potential nonresponse bias. The sampling frame for the WBNS also excludes or underrepresents certain groups of adults, including those who are homeless, have low literacy levels, and are not proficient in English or Spanish. Additionally, some people with disabilities are likely underrepresented in the survey sample, including people with visual, cognitive, and certain physical impairments. The sample also excludes adults with disabilities living in institutional settings, those ages 65 and older, and children under 18. Our questions on disability status do not fully capture the population of adults with all types of disabilities, such as those related to mental health (Hall et al. 2022). We also asked about fewer actions taken in response to or consequences resulting from the unfair treatment people reported at work; other actions or consequences, such as seeking legal help, mental health impacts, or leaving the workforce, could be relevant to people with disabilities.

Further, our measure of unfair treatment is subject to limitations. We are limited in our ability to characterize experiences of unfair treatment given that these are fully self-reported perceptions, and we cannot complement these with measures of provider or employer behavior or intent. We also cannot determine whether respondents were seeking care or benefits for themselves or someone else (e.g., a child) when they were treated or judged unfairly for the measures on unfair treatment in health care.
settings and when applying for public benefits. Our estimates did not account for differences in health care use, benefit program participation, and employment that could have contributed to differences by disability status in rates of unfair treatment by exposing disabled adults to more frequent interactions in health care and social service settings and fewer interactions in employment settings. Additionally, our estimates are subject to underreporting because we asked respondents to report experiences of unfair treatment or judgment in the past 12 months, so we do not capture the experiences of people who may have experienced unfair treatment in a longer time frame or who did not see a health care provider, were not employed, or did not apply for benefits in the past 12 months, respectively. We may also be underreporting experiences of unfair treatment or judgment because respondents may not know the reason they were treated unfairly or may hesitate to classify their negative experience as discrimination without evidence (McDaniel et al. 2021).

Notes

1 When referring to their disability, people have different preferences. Some see their disability as an essential part of who they are and prefer to be identified with their disability first—called identity-first language—but others prefer person-first language. In recognition of the variation in preferences, for this study, we use “people with disabilities” and “disabled people” interchangeably.

2 Throughout this brief, references to adults who are Black or white are limited to those who are not Hispanic/Latinx. We capitalize Black to denote the unique Black experience as one characteristic of a diverse group of people, ethnicities, and cultures. The authors have not capitalized “white,” a term and label for a range of historically grouped ethnicities used to delineate a contrast with people of color. See Margaret Simms, “Say African American or Black, but First Acknowledge the Persistence of Structural Racism,” Urban Wire (blog), Urban Institute, February 8, 2018, https://www.urban.org/urban-wire/say-african-american-or-black-first-acknowledge-persistence-structural-racism. We use the term “Hispanic/Latinx” to reflect the different ways people with Latin American ancestry self-identify. Many see “Latinx” as more inclusive; unlike “Latino/a,” it is not gender specific. The term used in the Well-Being and Basic Needs Survey is “Hispanic or Latino.”


8 The June 2022 round of the Urban Institute’s Health Reform Monitoring Survey (HRMS) included similar questions on disability status and unfair treatment in health care settings as those that were asked in the December 2022 WBNS. The HRMS also asked about health care use in the past 12 months, including whether respondents had a routine checkup, saw or talked to their personal health care provider or any other doctors or providers, or had a telehealth visit. Our analysis of the June 2022 HRMS found that disabled adults who sought care in the past 12 months were more likely than those without disabilities who sought care to report unfair treatment because of their race, ethnicity, gender, gender identity, sexual orientation, country of origin, primary
language, health insurance coverage type, disability, health condition, weight, or income (29 percent versus 10 percent; data not shown).


20 To access the WBNS instruments, see https://www.urban.org/research/publication/well-being-and-basic-needs-survey.


References


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Acknowledgments

This brief was funded by the Robert Wood Johnson Foundation. We are grateful to them and to all our funders, who make it possible for Urban to advance its mission. The views expressed do not necessarily reflect the views of the Foundation.

The views expressed are those of the authors and should not be attributed to the Urban Institute, its trustees, or its funders. Funders do not determine research findings or the insights and recommendations of Urban experts. Further information on the Urban Institute’s funding principles is available at https://www.urban.org/about/our-funding.

We thank Tara Oakman, Susan J. Popkin, and Shereese Rhodes for helpful comments on earlier drafts of this brief. The authors are also grateful to Crystal Evans, Whitney Lee, Shereese Rhodes, and Marsha Ruggeri and other members of a community advisory board overseen by Kimá Joy Taylor and Myriam Hernandez-Jennings of the Urban Institute for their input on this study and for past insights on disability issues that informed our thinking. Finally, we thank Sarah LaCorte for assistance with editing.

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