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Original Article

COVID-19 disproportionately impacts access to basic needs among households with disabled members



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ABSTRACT

Background: The COVID-19 pandemic has disproportionately impacted disabled people, especially those who are members of marginalized communities that were already denied access to the resources and opportunities necessary to ensure health equity before the pandemic.

Objective: Compare COVID-19 impact on basic needs access among households with and without disabled adults.

Methods: An online survey was distributed to households with children enrolled in one of 30 socially vulnerable elementary or middle schools in San Diego County, California. We measured disability using the single-item Global Activities Limitations Indicator. We measured pandemic impacts on basic needs access using the RADx-UP common data elements toolkit. We then assessed number of impact items reported by household disability using multivariable linear regression, adjusting for household income, household size, education, parent gender, and child's ethnicity.

Results: Of 304 participants, 41% had at least one disabled household member. Participants reporting a disabled household member were more likely to report challenges accessing basic needs, such as food, housing, healthcare, transportation, medication, and stable income during the pandemic (all $p < 0.05$). Difficulty accessing basic needs was significantly associated with household income and parent gender in the final regression model.

Conclusions: Households with a disabled member were significantly more likely to experience difficulty accessing basic needs during the COVID-19 pandemic. This has important implications for the disproportionate impact of COVID-19 on disabled people, especially those from low-income communities that already face barriers to accessing resources. To improve COVID-19 outcomes for disabled people, we must focus on meeting their basic needs.

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Introduction

The COVID-19 pandemic has included high rates of mortality and overall disproportionate impact among disabled people.¹ Low socioeconomic status, inability to socially distance from caregivers, and difficulty accessing basic needs, such as food, are all risk factors for COVID-19 which are common among disabled people.^{2,3} Disabled people have also had difficulty accessing COVID-19

testing and vaccination throughout the pandemic, leading to lower vaccination rates among disabled people than among non-disabled adults.⁴ Disabled people have experienced inequality in treatment for COVID-19, with medical triage sometimes resulting in denied care due to ableist assumptions about the quality of life.⁵ Not only has COVID-19 disproportionately impacted disabled individuals, but it has also impacted other members of their households. People with disabled household members often already served as informal caregivers before the pandemic, especially in low-income households with limited access to trained caregivers.⁶ In these contexts, most caregivers are women.⁶ During the COVID-19 pandemic, people with disabled household members often took on even more care duties (e.g., increasing precautions to avoid infection or caring for disabled household members who

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contracted COVID-19) in addition to trying to meet their own basic needs.⁷

Before the COVID-19 pandemic, disabled people already faced significant health disparities including higher prevalence of chronic health conditions.⁸ Disabled people also experience medical mistreatment, ranging from historical practices of forced sterilization and institutionalization to contemporary medical discrimination.⁹ Although disabled people often require more frequent medical care than non-disabled people, mistreatment and other structural barriers, such as lack of transportation and adequate health insurance, have led to reduced healthcare access and poorer health outcomes for these populations.⁹ While COVID-19 has clearly exacerbated existing health inequities, it has been especially harmful for disabled Black, Indigenous, and Hispanic/Latinx people.¹⁰ Black, Indigenous, and Hispanic/Latinx people in the USA are more likely than non-Hispanic White people to be disabled, denied access to wealth and opportunities, live in crowded housing that makes social distancing difficult, and face significant barriers to healthcare access.¹¹ Disabled people of all races and ethnicities are also more likely to face barriers to education that can impact their ability to earn sufficient income.⁹ Employment discrimination, transportation difficulties, and inadequate provision of disability benefits are additional factors that result in low incomes for disabled people.⁹ The well-established association between health outcomes and factors, such as racism, education, and income, highlights the importance of including these factors in our examinations of health disparities and disability.

While previous research has documented the prevalence of social risk factors among disabled people, as well as worse access to biomedical prevention, treatment, and care, more information is needed to understand how the pandemic has specifically affected disabled people and their households. A study from 2021 suggested that it is important to prioritize the collection of disability data to address health inequities that disabled people have faced during COVID-19.³ Documenting the effects of COVID-19 on health disparities is important to ensure that disabled people are not left further behind as COVID-19 policies shift from acute to long-term strategies. In this article, we examine the impact of the COVID-19 pandemic on access to basic needs within households with at least one disabled member in socially vulnerable areas of San Diego County, California.

Table 1
Sociodemographic factors by household disability status.

	Full sample (n = 304)		No disabled household members (n = 178)		Any disabled household members (n = 126)	
	n	%	n	%	n	%
Education^a						
Some high school	48	15.8	20	11.2	28	22.2
High school grad or GED	165	54.3	99	56.6	66	52.4
Bachelor's degree	69	22.7	47	26.4	22	17.5
Graduate degree (Masters, PhD, MD, etc.)	22	7.2	12	6.7	10	7.9
Child's ethnicity						
Hispanic/Latinx	231	84.0	134	83.8	97	84.3
Non-Hispanic/Latinx White	44	16.0	26	16.3	18	15.7
2019 household income^a						
Less than \$15,000	47	15.5	25	14.0	22	17.5
\$15,000–\$19,999	23	7.6	14	7.9	9	7.1
\$20,000–\$24,999	37	12.2	20	11.2	17	13.5
\$25,000–\$34,999	46	15.1	17	9.6	29	23.0
\$35,000–\$49,999	53	17.4	34	19.1	19	15.1
\$50,000–\$74,999	51	16.8	35	19.7	16	12.7
\$75,000–\$99,999	26	8.6	16	9.0	10	7.9
\$100,000 and above	21	6.9	17	9.6	4	3.2
Parent/guardian gender						
Female	267	87.83	159	89.3	108	85.7
Male	37	12.2	19	10.7	18	14.3
	Mean	SD	Mean	SD	Mean	SD
Household size	4.94	1.62	4.93	1.68	4.96	1.55

^a Significant difference between households with and without a disabled member in bivariate tests at $p \leq 0.05$.

Methods

Setting and sample

To understand how the COVID-19 pandemic impacted households with at least one disabled member, we conducted a secondary analysis of data collected as part of the Safer at School Early Alert (SASEA) project. SASEA utilized SARS-CoV-2 environmental surveillance to track rates of COVID-19 infection in elementary and middle schools in San Diego County that were identified as socially vulnerable according to the California Healthy Places Index (HPI).¹² The HPI analyzes social indicators of health by geographic location, including socioeconomic data, information on community racial/ethnic composition, investigations of local healthcare infrastructure, and other factors that contribute to racial health disparities.¹² The sample consisted of 30 elementary and middle schools across four San Diego County school districts. Every month three classrooms were randomly selected from each site, and students were given flyers to take home inviting their parent/guardian to participate in a self-administered online survey, which took an average of 8 min to complete. Parents/guardians were incentivized to participate with a raffle for a \$250 gift card. Students were incentivized to participate with a \$100 pizza gift card to the class with the highest response rate. Surveys and flyers were available in English and Spanish. Parents were provided with a phone number to call if they preferred to complete the survey over the phone with a trained, bilingual (English/Spanish) research assistant. All participants provided signed or verbal consent, and all research procedures were reviewed and cleared by the [ANONYMIZED FOR REVIEW] Institutional Review Board (IRB). Survey data were collected between February 7 and April 8, 2022.

Measures

Demographics and potential confounders

Participants were asked to report their total household income based on an ordinal scale (Table 1). Participant education was also measured with an ordinal item. Household size was measured by allowing participants to respond to the question “How many people live in your household?” using a numeric text box. Respondents

were also asked to identify their gender as male, female, or “prefer not to answer.” Parents/guardians were asked to report their child’s racial/ethnic identity based on the common data element (CDE) set for the National Institutes of Health Rapid Acceleration of Diagnostics among Underserved Populations (RADx-UP) project.¹³ Respondents who indicated that their children were Black or African American, American Indian or Alaskan Native, or Asian represented less than 4% of our sample and were thus excluded from statistical analysis due to small sample sizes. Because most participants indicated that their child’s race was White and their ethnicity was Hispanic/Latinx, and because there is good evidence for the disproportionate impact of COVID-19 on Hispanic/Latinx communities,¹⁰ we created a binary ethnicity variable for the purpose of our analysis indicating whether these children were Hispanic/Latinx (1) or non-Hispanic/Latinx White (0). This binary variable for examining ethnicity also reflects the overall ethnic composition of the San Diego region, where the two largest ethnic groups are non-Hispanic White (45.6%) and Hispanic (33.7%).¹⁴ Parents/guardians who indicated that their children did not fit into one of these categories were excluded from the analysis.

Primary outcome – basic needs index

Participants were asked to report whether, in the previous six months, the pandemic had impacted their access to basic needs, such as (1) physical and mental healthcare, (2) housing, (3) food, (4) medicine, (5) transportation (“getting to where I need to go”), and (6) earning a stable income (Table 2). These items are part of the NIH RADx-UP CDE measures.¹³ Responses to each item were coded from 0 to 2, with 0 = no difficulty, 1 = a little difficulty, and 2 = major difficulty. We then created a single basic needs index by summing participant response to all six items with possible values ranging from 0 (no difficulty for all six items) to 12 (major difficulty for all six items).

Table 2
Challenges accessing basic needs during the pandemic by household disability status.

Basic needs challenge	Full sample		No disabled household member		Disabled household member	
	n	%	n	%	n	%
Getting the health care I need (including for mental health)^a						
Not a challenge	181	59.5	121	68.0	60	47.6
Minor challenge	80	26.3	40	22.5	40	31.7
Major challenge	43	14.1	17	9.6	26	20.6
Having a place to stay/live^a						
Not a challenge	242	79.6	159	89.3	83	65.9
Minor challenge	40	13.2	14	7.9	26	20.6
Major challenge	22	7.2	5	2.8	17	13.5
Getting enough food to eat^a						
Not a challenge	206	67.8	138	77.5	68	54.0
Minor challenge	71	23.4	36	20.2	35	27.8
Major challenge	27	8.9	4	2.2	23	18.3
Getting the medicine I need^a						
Not a challenge	210	69.1	142	79.8	68	54.0
Minor challenge	80	26.3	33	18.5	47	37.3
Major challenge	14	4.6	3	1.7	11	8.7
Getting to where I need to go^a						
Not a challenge	228	75.0	151	84.8	77	61.1
Minor challenge	51	16.8	21	11.8	30	23.8
Major challenge	25	8.2	6	3.4	19	15.1
Earning a stable income^a						
Not a challenge	152	50.0	115	64.6	37	29.4
Minor challenge	95	31.3	50	28.1	45	35.7
Major challenge	57	18.8	13	7.3	44	34.9
Basic needs index score^a	Mean	SD	Mean	SD	Mean	SD
	2.6	3.0	1.6	2.3	4.0	3.3

^a Significant difference between households with and without a disabled member in bivariate tests at p ≤ 0.001.

Primary predictor – household disability status

We asked participants to report household members’ disability using the Global Activities Limitations Indicator (GALI),¹⁵ a validated single survey item that asks participants to self-report: “For at least the past 6 months, to what extent have you or someone in your household been limited because of a health problem in the activities people usually do? Severely limited? Limited but not severely? Or not limited at all?” Participants who indicated any limitation were then asked to indicate whether the individual with limited ability was themselves, a child under age 18, an adult aged 18–65, or an adult over age 65. We created a binary variable to analyze household disability, wherein the categories of “severely limited” or “limited but not severely” were combined and coded as “disabled household member” (1), and the category “not limited at all” was coded as “no disabled household member” (0). We also assessed whether and to what degree households reporting a disabled household member had trouble accessing basic needs during the COVID-19 pandemic.

Statistical analyses

We first conducted chi-square analyses to determine if there were differences in parent gender, child’s ethnicity, household size, education, or household income between households with and without a disabled member. We used t-tests to identify statistically significant associations between household disability status and each of the six items on the basic needs index. We then performed a t-test to look at associations between household disability status and the overall basic needs index score as well as a one-way ANOVA test to determine whether the basic needs index score differed according to which household member was disabled.

We performed linear regression analyses to examine the relationship between household disability status and each of the six basic needs index categories using unadjusted models, then repeated these regression analyses adjusting for demographic factors. Finally, we constructed a multivariable model using ordinary least squares (OLS) regression to examine the effect of having a disabled household member on basic needs access, adjusting for potential demographic confounders. Global model fit was assessed using Akaike Information Criterion (AIC) and Bayesian Information Criterion (BIC). All statistical analyses were performed using Stata 17 statistical software.

Results

Descriptive results

Our sample consisted of 304 parents/guardians from participating SASEA schools, with 275 participants completing all survey items. Missing data were treated as missing at random.¹⁶ Forty-one percent of participants reported having at least one disabled household member. Of those with a disabled household member, 48% identified themselves as disabled, 16% identified another adult age 65 or older as disabled, 18% identified another adult age 18–64 as disabled, and 18% identified a child as disabled. Overall, 88% of respondents were female. Eighty-four percent of participants were considered “low-income” for the San Diego region.¹⁷ Fifty-four percent of all participants reported their highest level of education as high school graduate or GED holder (versus 87.4% of adults in San Diego County), and 23% reported holding a Bachelors’ degree (versus 23.8% of adults in San Diego County).¹⁴ Mean household size for the entire sample was 4.94. Sociodemographic characteristics of participants by household disability status are shown in Table 1.

Households with a disabled member reported more minor or major difficulties accessing basic needs during the pandemic

compared to households without a disabled member (Table 2). Across the six basic needs index items, participants with a disabled household member reported that earning a stable income was the greatest challenge (70.6% reported a major or minor challenge), followed by access to healthcare (52.3% reported a major or minor challenge). Overall, the basic needs index ranged from 0 to 12, with a mean score of 2.6.

Bivariate results

In chi-square analyses, individuals without a disabled household member were more likely to report a higher household income (p = 0.02). Participants without a disabled household member were also more likely to report higher educational attainment (p = 0.04). There were no statistically significant associations between household disability status and parent gender (p = 0.34), household size (p = 0.15), or child’s ethnicity (p = 0.89) (Table 1).

In t-tests, individuals with at least one disabled household member were more likely to report challenges in all six basic needs challenge areas than individuals who did not report a household member with a disability (p<0.001 for all items). Additionally, the mean basic needs index score for households with a disabled member was 4.0, significantly higher than the mean index score for households that did not report a disabled member (1.6, p<0.001) (Table 2). One-way ANOVA showed that there was no statistically significant difference in pandemic impacts on basic needs access according to which household member was reported to be disabled (p = 0.93).

Multivariable analysis results

Linear regression analyses showed that each of the six basic needs index categories remained significantly associated with household disability status in unadjusted models as well as models that adjusted for demographic factors (Table 3). Using multivariable linear regression analysis to adjust for education, parent gender, household size, child’s ethnicity, and household income, we found that having a disabled household member remained associated with 2.21 additional points on the basic needs index compared to

Table 3
Association between basic needs index categories and household disability status in unadjusted and adjusted^a linear regression models.

Basic needs index item	Unadjusted model		Adjusted model	
	b	95% CI	b	95% CI
Physical & mental healthcare	0.31	(0.15–0.48)	0.31	(0.14–0.48)
Housing	0.34	(0.21–0.47)	0.31	(0.17–0.44)
Food	0.40	(0.25–0.54)	0.39	(0.24–0.53)
Medicine	0.33	(0.20–0.45)	0.29	(0.16–0.42)
Transportation	0.35	(0.22–0.49)	0.31	(0.17–0.45)
Income	0.63	(0.47–0.79)	0.62	(0.46–0.78)

All p-values <0.001.

^a Model adjusted for household disability status, household income, parent/guardian gender, parent/guardian education, child’s ethnicity, and household size.

Table 4
Multivariable analysis of factors associated with basic needs index score among households in San Diego County.

R ²	0.2390		
Variable	b	95% CI	p-value
Disability (ref = no disabled household members)	2.22	(1.59–2.85)	<0.001
Household income (ref = <\$15,000)	-0.34	(-0.51 to -0.17)	<0.001
Parent/guardian gender (ref = female)	1.28	(0.34–2.22)	0.008
Parent/Guardian Education (ref = some high school)	0.22	(-0.23 to 0.68)	0.335
Child’s Ethnicity (ref = white, non-Hispanic)	0.19	(-0.71 to 1.08)	0.679
Household Size (ref = 2)	0.11	(-0.78 to 0.31)	0.242

not having a disabled household member (p<0.001) (Table 4). In our model, household income was inversely associated with the basic needs index score (p<0.001) where the basic needs score decreased by 0.34 points for each level increase in household income. Parent gender was also associated with the basic needs index score, with male respondents having a mean score that was 1.28 points higher than female respondents (p = 0.008). Education level, household size, and child’s ethnicity were not associated with any significant difference in basic needs index scores in the regression model.

Discussion

Our results suggest that households with a disabled member are more likely to experience difficulty accessing basic needs, such as food, housing, transportation, medicine, healthcare, and stable income, during COVID-19. Higher household income was associated with greater access to basic needs. We found an association between parent/guardian gender and basic needs index scores in the final regression model, with male parents/guardians reporting more pandemic-related challenges to meeting their basic needs. Previous research suggests that heterosexual men more frequently take on caregiving duties when they have a sick, disabled, or absent female partner who is unable to assist with care.¹⁸ In this case, male caregivers would be disadvantaged over female caregivers who may be receiving additional support from a partner. Prior research also suggests that men perceive greater challenges and burdens associated with caregiving due to the persistence of gendered expectations surrounding care and their lack of social preparation for undertaking caregiving duties, which may cause them to report their challenges more readily.¹⁹ While the current study cannot fully explain why parent/guardian gender may be associated with more challenges meeting basic needs for individuals with a disabled household member, it does suggest that further research into household caregiving dynamics and gendered patterns of social and structural support is needed to better understand these issues.

Individuals with a disabled household member were twice as likely to report challenges getting enough food to eat compared to those without a disabled household member. Food insecurity has been associated with poor health outcomes as it may result in lack of access to nutritionally valuable foods and difficulty adhering to medically necessary diets.²⁰ Food insecurity can also be a significant source of stress, which can negatively impact health, especially when experiences of stress are chronic.²⁰ Previous research has shown high rates of food insecurity among disabled people, and access to food has become even more difficult for disabled people during the COVID-19 pandemic.³ This increasing food insecurity is likely one factor contributing to worse health outcomes for disabled people during COVID-19.

Transportation was also an issue for households with a disabled member, with 38.9% of participants who had a disabled household member reporting difficulty getting where they needed to go, versus 15.2% of individuals who did not report a disabled household

member. Transportation issues contribute to health disparities because they prevent people from accessing medical care and from maintaining the employment necessary to pay for that care.²¹ Lack of access to transportation also has implications for access to testing and booster shots during the COVID-19 pandemic. As there are already substantial disparities in access to COVID-19 testing and vaccination among disabled people, transportation assistance is needed to ameliorate these inequities.⁴

Access to stable housing was also a problem for households with a disabled member, who were three times more likely than those without a disabled household member to report housing instability. Different forms of housing instability, from difficulty paying rent to homelessness, have been associated with poor physical and mental health outcomes for the general population.²² Disabled people often experience high rates of housing instability due to their lower incomes and housing discrimination, and this housing instability is inadequately addressed by existing social support infrastructures.²³ These housing issues lead to increased stress and negatively impact the mental and physical health of disabled individuals and their families.²³ The COVID-19 pandemic has intensified the existing housing crisis in the USA due to widespread job losses and evictions.²⁴ At the same time, issues, such as overcrowding and poor quality ventilation in housing, have led to increases in COVID-19 case rates.²⁵ This relationship between housing instability and worse COVID-19 outcomes adds to existing housing and health disparities among disabled people.

Inability to earn a stable income during the COVID-19 pandemic was also identified as a major problem by households with a disabled member. Before the COVID-19 pandemic, disabled people already faced high rates of poverty and unemployment due to factors, such as work-limiting symptoms, educational inequity, low pay, and occupational segregation.²⁶ While disability benefit programs exist in the USA, these programs rely upon the disabled person's ability to navigate complex and restrictive bureaucratic systems to receive benefits.²⁷ Even when disability benefits are obtained, disabled people are often subject to surveillance to maintain benefits and are trapped in poverty by disability program asset limitations.²⁸ This leads to a perpetual cycle of poverty, decreased healthcare access, and worsening health outcomes for disabled people.²⁹ Between 2020 and 2021, rates of unemployment fell for both disabled and non-disabled people. However, the gap between unemployment rates of disabled (10.1%) and non-disabled (5.1%) people increased by 0.4% points during this time, indicating a general increase in employment disparities for disabled people.³⁰ Among those who were employed, disabled people were more likely to hold only part-time employment.³⁰ Additionally, disabled people were more likely to hold jobs as essential workers during the pandemic, putting them at higher risk for exposure to COVID-19.³⁰

Participants who reported having a disabled household member also had difficulty accessing healthcare during the COVID-19 pandemic. Inequitable access to healthcare due to structural barriers already resulted in worse health outcomes for disabled people before the pandemic, particularly for people whose disabilities require they receive more frequent medical care.⁹ With medical systems overwhelmed by the COVID-19 pandemic, disabled people who rely upon routine access to care have faced particular difficulties due to medical rationing.³¹ Healthcare access in the USA is often reliant upon employment and socioeconomic status; however, disabled people are more likely to lack access to employment opportunities that can provide them with reliable access to healthcare.²⁹ High rates of unemployment for disabled people during COVID-19 have undoubtedly contributed to additional difficulties accessing healthcare for these populations.³⁰ Finally, disabled people have often experience medical mistreatment, resulting in reduced trust in healthcare systems that may prevent

them from accessing care.⁹ This reduced trust may have been exacerbated by practices of medical triage during COVID-19 that have devalued the lives of disabled people, producing additional pandemic-related barriers to healthcare access.³² These are only a few examples of the many ways that pre-existing healthcare access issues for disabled people have been compounded by the COVID-19 pandemic.

Limitations

Because of our small sample size, geographic limitation to San Diego County, and majority of female respondents, the generalizability of our results is limited. Additionally, our sample had lower education levels in comparison with San Diego County as a whole, which could limit our ability to make broader comparisons. However, our work provides valuable insights into basic needs access for people with disabled household members during the COVID-19 pandemic. Furthermore, this project provides us with a greater understanding of pandemic-related difficulties experienced by disabled people and their household members who live in areas of high social vulnerability according to the HPI.¹² It is vital to understand the impact of COVID-19 on these communities to ensure that the pandemic response does not further entrench longstanding health inequities.

Our sample consisted of parents/guardians with a young child at home, which may have affected basic needs access during COVID-19. A comparative analysis of households with disabled members that do and do not include young children would provide greater insight into how household dynamics and caregiving affect basic needs access during health emergencies. Because of the lack of consensus among researchers on how to measure disability and the fact that disability was not the focus of our survey, we could not go into greater detail on the severity of limitations or types of disabilities experienced.³³ More information is needed to determine how various types of disability (e.g., physical, intellectual) may lead to different health outcomes.³⁴ Additionally, our survey did not capture information about people who may have become disabled by "long COVID" or whose existing disabilities were exacerbated after contracting COVID-19. As COVID-19 can lead to the development and exacerbation of longer-term disability, future research should examine how disability status is impacted by the SARS-CoV-2 virus.³⁵

Our measure of ethnicity relied upon the parent/guardian's determination of their child's ethnicity, which may not reflect the ethnicity of all household members. Counter to our expectations, we also did not find a significant association between child's ethnicity and disability status or pandemic-related challenges in access to basic needs in our study. This may be an effect of our relatively small sample size. Additionally, our sample was predominantly Hispanic/Latinx with a smaller number of non-Hispanic/Latinx White participants, making a more robust comparison difficult. However, it is well established that many Hispanic/Latinx disabled people experience intersectional oppression, including ableism and racism, which are associated with inequitable health outcomes.¹⁰ Thus, further research including more racially and ethnically diverse communities is warranted. Finally, this work is cross-sectional, and as such we could not determine whether difficulty accessing basic needs was the cause or the effect of household disability status. Additional longitudinal studies could determine whether disability status is a predictor of future difficulties in accessing basic needs during health emergencies.

Implications for interventions and advocacy

Disabled people have frequently been left behind in emergency response scenarios, and the COVID-19 pandemic is no exception.³²

However, there are clear areas of intervention to improve health outcomes for disabled people. For instance, disabled people would benefit from services, such as meal deliveries, which have already been shown to improve mental and physical health outcomes and quality of life for disabled and low-income older adults.³⁶ While some interventions have focused on training disabled individuals to navigate public transit, more advocacy for disability inclusive improvements to transportation infrastructure is needed to promote equitable access to healthcare and employment.³⁷ In terms of housing instability, programs which improve access to Supplemental Security Income (SSI) and Social Security Disability Insurance (SSDI) can lead to increased economic stability for disabled people at risk for homelessness which may help them to acquire more stable housing.³⁸ Additionally, policy change is needed to ensure greater collaboration between the Department of Housing and Urban Development (HUD) and the Social Security Administration to ensure that disabled people receiving SSI/SSDI benefits are able to make use of all housing resources available to them.³⁹ While the USA has anti-discrimination legislation in place with regard to hiring disabled people, these anti-discrimination approaches have not been as effective at reducing employment disparities for disabled people as employee quotas, which have been shown to reduce employment gaps in various other countries.⁴⁰ Further advocacy is needed to promote these kinds of evidence-based recruitment and retention policies for disabled workers in the USA. The COVID-19 pandemic has also offered an opportunity to reexamine work practices and introduce more inclusive virtual and hybrid work options for disabled people which can improve socioeconomic outcomes.⁴¹ As far as direct COVID-19 response is concerned, the expansion of home visitation and community health worker programs for testing and vaccine delivery is needed to address issues of poor access which disproportionately impact the most marginalized disabled people.⁴

Conclusion

Participants who reported having a disabled household member were more likely to have trouble accessing their basic needs during the COVID-19 pandemic. This has important implications for the disproportionate impact of COVID-19 on disabled people, especially those living in low-income households. Future research should consider not only disability status in designing effective pandemic responses but also other forms of marginalization experienced by disabled people, such as low socioeconomic status. Struggles with access to resources during COVID-19 also greatly impact the household members of disabled people; thus, building strong social and structural responses that center the needs of disabled people could result in solutions that also benefit their households and extended social networks.

Disclosure statement

The authors report no disclosures.

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Conflicts of interest

The authors report no conflicts of interest.

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