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Short report

# Monetizing illness: The influence of disability assistance priming on how we evaluate the health symptoms of others

Rourke L. O'Brien[*]

*Harvard University, USA*

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## ABSTRACT

For low-income families in the United States disability assistance has emerged as a critical income support program in the post-welfare reform era. This article explores how this monetization of illness—tying receipt of government assistance to a physical or mental condition—influences how individuals evaluate the severity of another individual's health symptoms. Using data collected through a nationally representative survey experiment of adults in the United States ($n = 1005$) in May 2013, I find that respondents who are primed to consider the existence of disability assistance are less likely to rate the symptoms described in a hypothetical vignette as severe relative to the control group. I find evidence that this effect holds for both physical (back pain) and mental (depression) conditions for adults and behavioral conditions (ADHD) in children. Moreover, respondents in the experimental group were more likely to blame the individual for her health condition and this measure was found to partially mediate the effect of the disability assistance prime. These findings have important implications for researchers, policymakers and medical practitioners by illustrating how premising state assistance on a health condition may in turn shape how individuals evaluate the health symptoms of others.

In their 2014 article on stigma and the medicalization of poverty, Hansen et al. explore how increased reliance on disability assistance in the post-welfare reform era has changed the nature of what it means to be poor and receive government assistance in the United States. Using ethnographic methods, the authors demonstrate that tying receipt of government assistance to a medical diagnosis has profound implications for social exclusion, interpersonal relationships, and individual identity. As the authors note, this may be particularly problematic in the United States given the increasingly central role of disability assistance programs in the economic safety net for low-income families.

In discussing their results, the authors emphasize that growth in disability assistance has generated a significant “backlash stigma” (p. 82) against Supplemental Security Income (SSI) applicants and benefit recipients who, in the face of headlines highlighting the surge in SSI applications during the Great Recession, are increasingly being viewed as fraudulent (Blumberg, 2013; Fox News, 2012; Kristoff, 2013; New York Times, 2009; Ohlemacher, 2013; Whitman, 2012). A closer inspection of the media coverage finds this heightened skepticism is often aimed at individuals who receive SSI assistance for mental health issues, such as depression, which today account for approximately 60% of all SSI cases among those under age 65 (SSA, 2013). Moreover, increased attention is being paid to the growing number of families who receive assistance for a child's diagnosed disability, including developmental and intellectual disorders (such as ADHD). This news coverage has motivated calls for reforms to the program by policymakers, particularly among Republicans, as evidenced in recent congressional hearings (e.g. House Subcommittee Hearing on Human Resources, 10/27/2011).

Skepticism expressed towards recipients of disability assistance echoes attitudes towards beneficiaries of other government programs. Historically, provision of public assistance to the poor in the United States has consistently met with resistance among some segments of the population, with rules governing major assistance programs continually being reevaluated to ensure that aid only goes to those who are truly “deserving” (Katz, 1989). In the context of targeted cash welfare programs, the notion of deservingness is determined by assessments of morality and work ethic, with anti-welfare attitudes largely shaped by assumptions that those receiving assistance are “lazy” (Gilens, 1999). Deservingness is often judged by the degree to which the person's is to blame for his

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[*] Harvard Center for Population & Development Studies, 9 Bow Street, Cambridge, MA 02138, USA.

*E-mail address:* robrien@hsph.harvard.edu.

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or her economic position; support for cash welfare is lower when it is assumed the individual is responsible for not getting ahead, an assumption that is often shaped by racial stereotypes (Gilens, 1999; Luttmer, 2001).

Eligibility for disability assistance, however, is premised not only on economic status but also on the presence of a health condition that limits one's ability to work. Therefore evaluations of "deservingness" are likely to be at least in part function of the perceived legitimacy and severity of an individual's qualifying health condition (Willen, 2012; Garthwaite, 2011; Bambra and Smith, 2010; Stone, 1984). Indeed, one reason why disability assistance programs have historically been less divisive than targeted cash welfare is because benefits were limited to populations with severe physical disabilities that prevented them from participating in work, starting with veterans of the Civil War whose disability benefit was tied directly to the number of limbs lost in battle (Skocpol, 1995). Those injured on the battlefield or on the factory floor were seen as legitimate and deserving of assistance in part because they were not to blame for their condition (Stone, 1984).

As the definition of disability has expanded in the United States to incorporate more nuanced conceptions of physical—and later mental—conditions, the population of individuals theoretically eligible for disability assistance has also expanded (Stone, 1984). This evolving conception of disability has been met with increasing skepticism of the deservingness of the population for government funded assistance (Hansen et al., 2014). Yet given the nature of stigma and deservingness in health, this skepticism may not be uniform but instead conditioned on several factors, including the age, gender, race, work status of the individual and—the focus of this study—the nature of the health condition. For example, we might expect skepticism to be particularly strong for individuals seeking to qualify for disability assistance for mental health conditions, given the robust stigma associated with mental illness in the United States (Schomerus et al., 2012).

The prospect of financial assistance—particularly taxpayer funded financial assistance—may fundamentally alter the way one evaluates the health of another. Adding money to the equation wholly reshapes the relationship between the individual with a health condition and their evaluator—with the latter's assessment now infused with monetary value and therefore introducing questions of deservingness. This linking of government assistance to health may feel like an inappropriate monetary "match" (Zelizer, 1994, 2005) which may influence both the evaluation of health symptoms as well as assumptions about whether an individual is to blame for his or her condition.

This report seeks to explore whether and how tying income support to disability may influence the way respondents evaluate the health symptoms of others. Before turning to the data and methods, I first articulate a series of guiding hypotheses motivated by the literature cited above.

## 1. Guiding hypotheses

**H1**. Respondents primed with information that individuals with a work-limiting disability may be eligible to receive disability assistance will be harsher in their evaluations of individual health conditions, i.e., less likely to say a set of symptoms is disabling.

**H2**. Respondents primed with information on disability assistance for disability will be more likely to blame the individual for their health condition.

**H3**. Respondent assessment of the degree to which the individual is to blame for his/her health condition will mediate any observed differences in the evaluation of disability between the disability assistance condition and the control condition.

## 2. Data & methods

Respondents based in the United States were recruited via an online panel hosted by a major national survey research firm in May of 2013. Project was exempted by the IRB Committee at Princeton University. The analytic sample consisted of 1005 respondents and was designed to be nationally representative by income, age and gender. Respondents were randomly sorted into two groups, one experimental group ($n = 497$) and one control group ($n = 508$). All respondents were asked to read the following prompt:

> *Next you will be asked a series of questions about your own health. You will then be presented with short descriptions of individuals with health problems and asked a series of questions. We are particularly interested in the extent to which you think these people have a disability, that is, the degree to which they are limited in the kind or amount of work they can do.* ***[In the United States, individuals who have a disability may be eligible for financial assistance from the government of hundreds or thousands of dollars a month.]***

The prompt displayed to individuals in the experimental group included an additional sentence noting the existence of disability assistance for persons with disability (in brackets and bolded above). Respondents in the control group were not presented with this information. Following a series of questions where respondents were asked to rate their own health, respondents were then shown a series of vignettes that described an individual with a particular health condition. These vignettes were adapted from those used in the 2007 Health and Retirement Study (HRS) and employed by Kapteyn et al. (2007) in their studies of cross national differences in health and disability evaluation (see also Datta Gupta et al., 2010). The first vignette focused on back pain:

> *Lisa has pain in her back and legs, and the pain is present almost all the time. It gets worse while she is working. Although medication helps, she feels uncomfortable when moving around, holding and lifting things at work.*

Given the increasing utilization of disability assistance among individuals with mental health conditions, I also tested a second vignette that describes an individual with symptoms of depression:

> *Maria feels depressed most of the time. She weeps frequently at work and feels hopeless about the future. She feels that she has become a burden to her co-workers.*

After reading each vignette, respondents were asked to answer three questions. The first asked for an assessment of the degree to which the individual described in the vignette is limited in the amount or type of work they can do, with 5 response choices: not at all limited (1); mildly limited (2); moderately limited (3); severely limited (4); cannot do any work (5). The second question asked respondents to rate the individual's overall health, with a 5 point scale ranging from poor to excellent. Finally, I asked respondents to what degree they thought the individual in the vignette "is to blame for her condition," with a response scale ranging from "not at all" (1) to "a lot" (6).

The two vignettes outlined above focus on the physical and mental health issues of adults. Yet, as noted above, a significant