

# The Impacts of the COVID-19 Pandemic on the Lives of Disabled People: Disparities in Australia, Canada, the United Kingdom, and the United States



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ARTICLE

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## ABSTRACT

The 2019 pandemic was a global health crisis caused by the Covid-19 novel coronavirus. As of 3 October 2023, 676,609,955 cases and 6,881,955 deaths were reported internationally (John Hopkins University, 2023). Everyone has been affected to some extent by the Covid-19 pandemic regardless of their status and situation in life. This paper focuses on the extent and ways the Covid-19 pandemic affected disabled and able-bodied groups of people and those who are classified as having “other” identities. It presents results from an online survey which collected responses from 1325 participants living in 52 countries. This paper will focus more specifically on the 1059 participants residing in Australia, Canada, the United Kingdom and the United States of America.

The paper finds that a larger proportion of disabled participants were negatively impacted by Covid-19 than their able-bodied peers.

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The global outbreak of Covid-19 has not only presented an unprecedented health crisis but has also brought to the forefront various socioeconomic disparities and challenges faced by different segments of the population. This paper aims to comprehensively examine and compare the experiences of individuals belonging to diverse identity groups, with a particular focus on disabled individuals, able-bodied individuals, and those encompassing other identities.

A disabled person is typically defined as an individual with a physical, intellectual, psychiatric, sensory or neurological impairment which is often long-term and affects their ability to perform day-to-day functions (Disability Works Australia, n.d.; General Medical Council, n.d.). This definition includes a range of conditions including autoimmune diseases, mental health conditions and physical conditions such as motor neuron disease, cerebral palsy and chronic fatigue syndrome. It should be noted that the definition of disability is flexible and ever-changing among different communities. For example, some individuals with chronic illnesses, learning disabilities or autism spectrum disorder (ASD) may choose to identify as disabled, even if these conditions are not always legally or medically recognised as being disabilities. As a result of this grey definition, this paper includes an 'other' category in order to provide participants the autonomy to self-identify as disabled or other.

In this work, the term disabled people was used rather than persons with disability. Identity-first language places the individuals' identity first, for example 'disabled person', 'autistic person', 'deaf person'. On the other hand, person-first language places the word 'person' first, for example 'person with disability', 'person with autism'.

This paper uses identity-first language (IFL) as this is the widely preferred term among the disabled population, although individual preference may vary (Brown, 2011a; Dunn & Andrews, 2015; Kapitan, 2017; Lynch, 2019; National Association of the Deaf, n.d.; Schick, 2015; Theodosia, 2019). Multiple scholars and grey literature note that persons with disabilities such as autistic, deaf and blind individuals prefer IFL (Brown, 2011b; Dunn & Andrews, 2015; Liebowitz, 2015; Lynch, 2019; Schick, 2015; Sinclair, 1999; Theodosia, 2019). The preference for IFL is based on the social model of disabilities, whilst able-bodied people and the medical model of disabilities tend to use person-first language (PFL) (Collier, 2012a; Collier, 2012b; Dunn & Andrews, 2015; Egan, 2012 as cited in Ferrigon, 2019; Kenny et al., 2016; Theodosia, 2019).

Furthermore, person-first language (PFL) is often effectuated and advocated for by able-bodied people and is considered ableist and stigmatising in many disability spaces (Collier, 2012a; Collier, 2012b; Collier, 2012c; Gernsbacher, 2017; Ladau, 2015; Schick, 2015; Theodosia, 2019). PFL is 'co-opted by [able-bodied] people who believe they have the authority how persons with disabilities should declare their identity' (Sequenzia, 2016). There is a long history of ableism surrounding the use of person-first language (Collier, 2012a; Collier, 2012b; Schick, 2015; Sequenzia, 2016; Theodosia, 2019). Collier (2012a) argues that PFL may stigmatise 'words that were never considered derogatory or pejorative in the first place'.

## BACKGROUND AND SUPPORTING LITERATURE

### THE EMERGENCE OF COVID-19

On 31 December 2019, a cluster of pneumonia-like cases were reported in Wuhan, a major industrial city in central China. The illness, which soon became known as Covid-19, was identified as being caused by a novel coronavirus (WHO, 2020a). On 13 January 2020, the first case of Covid-19 outside of China was recorded in Thailand (WHO, 2020a). By March 2020, Covid-19 had rapidly spread across the globe, affecting countries like Australia, Canada, France, Italy, Japan, New Zealand, Spain, the United Kingdom (UK), the United States of America (US), and countless other countries (WHO, 2020b). The rapid spread and severity of the cases as well as the inaction of key stakeholders necessitated the declaration of Covid-19 by the Director-General of the World Health Organisation (WHO) as a global pandemic on 11 March 2020 (WHO, 2020c).

Disabled people make up around 15 to 20% of the global population at any time, although figures vary slightly by source (Australian Bureau of Statistics, 2019; Australian Institute of Health and Welfare, 2019; Australian Network on Disability, 2019; Campbell et al., 2009; Swanson & Campbell, n.d.; The World Bank, 2020; United Nations, n.d.; WHO, 2011). Disability prevalence varies by 'ethnicity, age, gender, income, education and location' (Campbell et al., 2009, para. 8).

The risks for disabled people during pandemics far exceed the heightened risk of contracting diseases compared to able bodied people (Australian Department of Health, 2020; United Nations Population Fund, 2020). This is because the Covid-19 pandemic has exacerbated disabled people's experience of 'discrimination, gender-based violence, and exclusion from services and decision-making' that they experience in regular circumstances (United Nations Population Fund, 2020, para. 1). The pandemic has also heightened the impacts of economic and social factors on disabled people (Bensadoun, 2020). Disabled people were disproportionately impacted by 'attitudinal, environmental, and institutional barriers' that have been reproduced 'in the Covid-19 response' (United Nations Office of the High Commissioner, 2020, p1).

Many disabled people rely on specialised support systems including multidisciplinary specialist teams, family members, support workers, and carers (Australian Department of Health, 2020). They also rely on wider mental health, medical, economic and social support systems (Australian Royal Commission, 2020; Swanson & Campbell, n.d.). Various literatures highlight a lack of consideration for disabled people living in congregate settings such as group homes, long-term care facilities or shared accommodation, and those dependent on both paid and unpaid caregivers and support workers (Bensadoun, 2020; Kavanagh, 2020; Parekh & Underwood, 2020; Swanson & Campbell, n.d.). Moreover, home-based disabled people often depend on local social services to provide their daily needs such as meals and hygiene (Human Rights Watch, 2020).

The Covid-19 pandemic has led to difficulties for disabled people in a wide range of areas including the accessibility of up-to-date information and educational resources, and a lack of disability-specific planning (Australian Human Rights Commission, 2020; Kavanagh, 2020; United Nations Office of the High Commissioner, 2020). During the pandemic, support workers and carers did not typically have access to sufficient personal protective equipment (PPE) to minimise the disabled persons' exposure to or spread of infection or mitigate the risk of care workers becoming infected themselves (Human Rights Watch, 2020). These barriers have been experienced by disabled people internationally, which have increased the impact of the pandemic on disabled people (Government of Canada, 2020; Hunt, 2020; United Nations, 2020; United Nations Office of the High Commissioner, 2020). Examples of inaccessible information include the Australian Government's failure to provide Auslan (sign language) interpreters in some of their communications (such as press conferences), the inaccurate captioning or transcripts (Kavanagh, 2020; Miers, 2020) and the lack of resources for people with partial vision or low literacy (Jackson, 2020). The National Work Group on Literacy recommends that resources should be 'written at [a] fifth-grade reading level and supplemented by non-written materials to be understood by populations with low literacy' (National Work Group as cited in Campbell et al., 2009). A lack of accessible resources strongly have impacted individuals with a variety of conditions including partial vision or blindness, partial hearing or deafness, intellectual, neurological and learning disabilities, and those with low literacy or individuals from culturally and linguistically diverse backgrounds.

Despite the presence of telehealth services, the closure of 'centre-based services... [posed] additional challenges for [disabled people], their support workers and carers' (Kavanagh, 2020, pp. 1). Some telehealth platforms have limited accessibility including a lack of closed captioning, high visibility text and incompatibility with Braille displays (Jackson, 2020). Another example is that partially-hearing or deaf individuals who depend heavily on lip-reading faced additional challenges due to the usage of face-masks. Accessibility is necessary in order for disabled people to receive accurate, up-to-date information during pandemics (European Disability Forum, 2020; International Disability Alliance, 2020).

Similar concerns were expressed by the Australian Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability (2020) and Bensadoun (2020), especially surrounding access to healthcare including preventative measures and treatment for Covid-19, essential support services for disabled people and their carers and support workers, accessible information, access to food and nutrition and employment, and income security. Furthermore, some hospitals and testing centres which had social distancing restrictions in place failed to accommodate disabled people by barring support workers and carers from entering the facilities (Jackson, 2020). This prevented disabled people who require assistance from support workers, carers, or family members from accessing Covid-19 testing and treatment (Jackson, 2020). Moreover, disabled people are four times more likely (32%) than able-bodied people (8%) to experience psychological distress during regular circumstances (Australian Institute of Health and Welfare, 2019). A combination of these factors have thus compounded the effects of Covid-19 on disabled people.

## EMERGENCY AND PANDEMIC PLANNING

Additionally, disabled people are often overlooked in emergency response, crisis and planning for natural disasters and pandemics (Bensadoun, 2020; Campbell et al., 2009; Jackson, 2020; Parekh & Underwood, 2020; Swanson & Campbell, n.d.; United Nations Population Fund, 2020). Existing academic and pandemic planning resources fail to address the experiences of disabled people in detail, which further increases the impact of risk factors on disabled people during pandemics and emergency situations (Campbell et al., 2009; Center for Disease Control and Prevention, 2006; Jackson, 2020; Swanson & Campbell, n.d.). The lack of disability-focused pandemic planning can create further barriers to accessing healthcare, mental health support, social support, which could lead to challenges in adapting to rapid societal changes such as lockdowns and social isolation measures. These barriers must be addressed urgently in order to support disabled people in attaining high standards of health (United Nations Department of Economic and Social Affairs, 2020; United Nations, 2020). Disabled people should be consulted when pandemic planning is occurring in order to ensure their viewpoints and actual experiences are carefully considered in emergency and pandemic planning (United Nations, 2020).

## RESEARCH GAP AND OBJECTIVES

Although some grey literature exists on the subject, no similar studies on the impacts of Covid-19 on disabled people could be found during the time of writing. This paper is a comparative analysis that seeks to identify common and contrasting experiences across Australia, Canada, the UK and the US. It aims to fill the gap in existing literature and highlight the experiences of disabled people to improve current health and social services. It also aims to provide evidence to encourage positive changes in pandemic planning, specifically surrounding the accessibility of resources across a range of sectors, in the future.

## HYPOTHESIS

The paper's hypothesis is that disabled individuals have borne a disproportionate burden of negative impacts as a result of the pandemic, compared to their able-bodied counterparts. Disabled people have experienced more widespread impacts as a result of the pandemic, in part due to a lack of pandemic/crisis planning and sufficient support systems. This paper aims to empirically test and validate this hypothesis through rigorous research and analysis.

The primary objective of this research is to investigate the multifaceted impacts of the Covid-19 pandemic across a range of critical dimensions, including economic and financial impacts, accessibility and quality of medical care, mental health impacts, education and employment.

To provide a comprehensive view, the study will concentrate on participants residing in four distinct countries: Australia, Canada, the US, and the UK. By including these geographies, we aim to capture a wide range of experiences and regional variations in responses to the pandemic.

### SAMPLING FRAMEWORK FOR THE ONLINE SURVEY

#### Recruitment Strategy

Participants for this study were recruited from various online sources. The recruitment process was entirely voluntary, and participants engaged in the survey of their own accord. A multifaceted approach was utilised to reach a diverse pool of respondents:

1. Recruitment efforts included online discussion and support groups, where individuals with shared interests and experiences congregate.
2. The survey was circulated across multiple social media platforms, with a particular focus on mental health and disability-specific support groups. To ensure a well-balanced representation, the survey was shared equally in general discussion, support, and survey-sharing groups on Facebook, Twitter, and LinkedIn.

#### Survey Content

The online survey was designed to collect relevant data to inform this research. Participants were asked to provide the following information:

1. Demographic information including age and their country of residence.
2. Self-Identity where participants were asked to identify themselves based on the following categories: able-bodied, disabled, or belonging to another identity category. The inclusion of an 'other' category allowed respondents to specify their unique identity, such as autistic, blind/low-vision, deaf/low-hearing, or chronically ill individuals. The question was asked in recognition of the personal nature of identities and the variability in self-identification,
3. Mental health information where participants had to indicate whether they had any mental health conditions and to specify the nature of their diagnoses. Distinctions were made between medically diagnosed and self-diagnosed mental health issues during data analysis to ensure accurate conclusions.

The questions for the survey were developed through clarifying the research objectives and hypothesis, scope of the survey (participants), and consideration of the desired output. The survey was developed in accordance with the procedure outlined by the Australian Bureau of Statistics (2020).

#### Qualitative Data

In the online survey, there was also the option for participants to provide qualitative responses in regard to their experiences during the Covid-19 pandemic. Many participants used the optional comments section to elaborate on their experiences during the pandemic. This provided valuable qualitative data which has been utilised to support the quantitative findings of this research.

### CONTROL VARIABLES

To mitigate potential confounding factors, participants were categorised by their country of residence. This approach allowed us to control for environmental factors such as access to healthcare, government assistance programs, legislation, political influences, and the severity of Covid-19 outbreaks and restrictions. However, it is acknowledged that some disparities may still exist within different regions.

#### Reliability & Standard Deviations

In order to ensure reliability within the study, a clear data collection period was set in accordance with periods of lockdowns across the various focus countries. Through maintaining the control variables, as well as ensuring the survey content stayed consistent between participants and conducting a split-half reliability test. The standard deviation of the quantitative aspects of the survey are indicative of a 'typical'/'normal' bell curve distribution, which is typically accepted as a standard variation of 34% on either side of the mean.

## Data Collection Period

The survey was conducted over a specific timeframe, running from 16 May 2020, to 23 June 2020. This duration was chosen to capture the Covid-19 pandemic experience as uniformly as possible across the focus countries and provide a snapshot of participants' experiences during that period.

## THE SURVEY SAMPLE

A total of 1,325 participants from 52 countries participated in the survey. The majority of the participants (1059) were located in the focus countries of Australia, Canada, the US, and the UK. [Table 1](#) shows participant distribution by focus country and identity (able-bodied, disabled, other) while [Table 2](#) shows participant distribution in non-focus countries and by identity.

	ABLE-BODIED		DISABLED		OTHER		TOTAL
Australia	118	61%	54	28%	20	10%	192
Canada	53	60%	17	19%	18	20%	88
USA	443	65%	148	22%	88	13%	679
UK	54	54%	25	25%	21	21%	100
<b>Total</b>	<b>668</b>	<b>63%</b>	<b>244</b>	<b>23%</b>	<b>147</b>	<b>14%</b>	<b>1059</b>

**Table 1** Participant Distribution in Focus Countries.

	ABLE-BODIED		DISABLED		OTHER		TOTAL
Algeria	1	100%	0	0%	0	0%	1
Argentina	2	100%	0	0%	0	%	2
Asia	1	100%	0	0%	0	%	1
Austria	2	100%	0	0%	0	%	2
Bangladesh	1	100%	0	0%	0	%	1
Brazil	7	88%	0	0%	1	13%	8
Bulgaria	2	67%	0	0%	1	33%	3
Chile	1	50%	0	0%	1	50%	2
Colombia	2	100%	0	0%	0	0%	2
Croatia	0	0%	0	0%	2	100%	2
Czech Republic	2	67%	0	0%	1	33%	3
Denmark	4	100%	0	0%	0	0%	4
Finland	1	100%	0	0%	0	0%	1
France	5	84%	1	17%	0	0%	6
Germany	6	86%	1	14%	0	0%	7
Greece	2	100%	0	0%	0	0%	2
Guatemala	0	0%	0	0%	1	100%	1
Hungary	0	0%	0	0%	3	100%	3
Iceland	2	67%	0	0%	1	33%	3
India	3	100%	0	0%	0	0%	3
Ireland	4	80%	1	20%	0	0%	5
Israel	2	100%	0	0%	0	0%	2
Italy	1	33%	0	0%	2	67%	3
Japan	0	0%	0	0%	1	100%	1
Kenya	1	100%	0	0%	0	0%	1
South Korea	0	0%	2	67%	1	33%	3

**Table 2** Participant distribution (non-focus countries).

	ABLE-BODIED		DISABLED		OTHER		TOTAL
Malta	1	100%	0	0%	0	0%	1
Mexico	5	83%	0	0%	1	17%	6
Netherlands	9	2%	0	0%	2	18%	11
North America	1	33%	1	33%	1	33%	3
Northern Ireland	4	80%	0	0%	1	20%	5
Norway	1	100%	0	0%	0	0%	1
Pakistan	1	100%	0	0%	0	0%	1
Panama	1	100%	0	0%	0	0%	1
Peru	1	100%	0	0%	0	0%	1
Philippines	5	83%	1	17%	0	0%	6
Poland	3	75%	0	0%	1	25%	4
Puerto Rico	2	100%	0	0%	0	0%	2
Russia	0	0%	1	100%	0	0%	1
Scotland	4	50%	4	50%	0	0%	8
Singapore	3	100%	0	0%	0	0%	3
South Africa	0	0%	0	0%	2	100%	2
Spain	1	50%	0	0%	1	50%	2
Sweden	2	100%	0	0%	0	0%	2
Taiwan	1	100%	0	0%	0	0%	1
Thailand	1	100%	0	0%	0	0%	1
Turkey	2	100%	0	0%	0	0%	2
Undisclosed	40	62%	12	18%	13	20%	65

These four focus countries were selected as comparators due to their similar social and economic models. They constitute a significant portion of the Anglosphere, characterised by close diplomatic, military, and cultural ties (Bennett, 2004). Nevertheless, it is essential to acknowledge key differences among these countries that were considered during the analysis. For instance, while Australia, Canada, and the UK have similar public healthcare models, the US predominantly relies on a privatised healthcare system.

The sample sizes were adequately sized, with over 1300 participants responding internationally. The sample was also proportional to the population distributions in the focus countries. The low margins of error highlight that the sample sizes are likely to represent the populations examined. Using a confidence level (CL) of 95% and a population proportion of 99.9%, the margin of error was calculated as 0.45% for Australia, 0.66% for Canada, 0.24% for the US and 0.62% for the UK.

The samples also took into consideration the population size differences amongst the focus countries. Overall, 63% of participants from the focus countries identified as able-bodied, 23% identified as disabled and 14% identified as other. This distribution aligns with current statistics on disability prevalence and affirms that the survey has captured a sample population which closely resembles the actual population.

## ETHICS STATEMENT

The ethics of this survey were discussed directly with a Humanities and Social Sciences Research Ethics Advisor from the researcher's undergraduate university. The advisor further discussed the survey with their team leader and the Director of Research Ethics & Integrity, who advised the data collection could be conducted without ethics approval if it was conducted independently (that is, without any affiliation with the university). The entirety of this paper consists of independent research and data collection and is not affiliated or endorsed by any organisation.



Participants gave consent through their participation in the research. There was an information and consent statement which stated that the survey responses may be used for journal publication or any other purpose as deemed appropriate by the researcher. Participation was voluntary and participants had the option to exit the survey at any time. There were mental health support services listed at the end of the survey for a variety of countries, as well as a link to an international list of mental health services. The researcher's email address was also provided at the beginning of the survey in case participants needed assistance in accessing additional resources.

Data collection was in the form of an online survey, which contained both open- and closed-ended questions. This was to ensure a mix of qualitative and quantitative data in order to allow more detailed conclusions. An online survey was used due to social distancing restrictions in place and the international focus of the paper. The online survey also used a large, easy to read font and was compatible with screen-reading devices to ensure accessibility for a wide range of participants.

The final data set used for the paper excluded any incomplete surveys and any responses from participants aged under 18 or over 64. It also excluded data from countries with relatively small sample sizes in order to allow for accurate comparisons. The Qualtrics software did not indicate which percentage of surveys were incomplete. Any incomplete or unsubmitted responses were not saved or included in the data set available for export from Qualtrics.

The researcher, who is a disabled person, disability representative and advocate, ensured that the survey was inclusive and accessible to disabled people and participants with a range of accessibility needs.

## DATA ANALYSIS

The data collected via the Qualtrics survey underwent analysis using Microsoft Excel. To ensure ethical compliance and consent, responses from individuals under the age of 18 were excluded from the final dataset. Quantitative data was analysed thoroughly, including through the calculation of the standard deviation to ensure variance was within acceptable parameters consistent with the typical bell curve distribution. The margin of error was also calculated using the various sample sizes to ensure that the observations made are reflective of the populations being commented on. Qualitative data was analysed through thematic analysis techniques to identify and interpret recurring patterns and themes raised by the participants.

## DATA ORGANISATION

The responses were systematically organised for analysis:

1. Initially, the responses were sorted based on country-based sorting. Responses were sorted into separate worksheets based on the participant's country of residence. This allowed for a structured examination of the data specific to each focus country, namely Australia, Canada, the US, and the UK.
2. Within each country-specific worksheet, identity-based segmentation was carried out to distinguish between respondents based on their self-identification. Participants were categorised into three primary identity groups: able-bodied, disabled, and other.

By segmenting the data in this manner, the analysis process could delve into the experiences and perspectives of each identity group within each focus country, facilitating comprehensive and meaningful insights.

## RESULTS & DISCUSSION

### IMPACTS OF COVID-19 ON FINANCIAL SITUATION, EMPLOYMENT, AND EDUCATION

The financial, education, and employment impacts of Covid-19 on the different groups sampled vary greatly between countries and identity groups. Quantitative data shows the predicted correlation between employment, education, and an individual's financial situation (See [Tables 3, 4 and 5](#)).



	NEGATIVE (%)			NO IMPACT (%)			POSITIVE (%)			UNSURE (%)		
	AB	D	O	AB	D	O	AB	D	O	AB	D	O
Aust	48	54	33	28	28	38	20	19	29	4	2	0
Can	49	22	39	34	56	28	15	22	33	2	0	0
USA	42	52	50	38	32	33	17	13	13	3	3	4
UK	47	42	41	35	35	50	18	19	5	0	4	5

	NEGATIVE (%)			NO IMPACT (%)			POSITIVE (%)			UNSURE (%)		
	AB	D	O	AB	D	O	AB	D	O	AB	D	O
Aust	48	44	45	39	43	35	7	9	10	6	4	10
Can	39	49	42	52	42	50	6	4	6	3	5	2
USA	44	48	57	54	52	43	0	0	0	2	0	0
UK	48	44	45	39	43	35	7	9	10	6	4	10

	NEGATIVE (%)			NO IMPACT (%)			POSITIVE (%)			UNSURE (%)		
	AB	D	O	AB	D	O	AB	D	O	AB	D	O
Aust	58	52	60	22	41	20	19	6	15	2	2	5
Can	57	57	57	28	31	30	14	10	8	2	2	6
USA	52	40	57	35	48	24	9	12	5	4	0	14
UK	58	52	60	22	41	20	19	6	15	2	2	5

**Table 3** Impacts of Covid-19 on Financial Situation.

Note: AB = Able-bodied; D = Disabled; O = Other identities.

**Table 4** Impacts of Covid-19 on Studies/Education.

Note: AB = Able-bodied; D = Disabled; O = Other identities.

**Table 5** Impacts of Covid-19 on Work/Employment.

Note: AB = Able-bodied; D = Disabled; O = Other identities.

In Australia, disabled individuals were notably more likely to report negative financial impacts compared to their able-bodied and other identity counterparts. Specifically, 54% of disabled Australians reported negative financial impacts, whereas the figures stood at 48% for able-bodied individuals and 35% for those with other identities. Despite similar proportions of all three groups reporting negative impacts on employment and/or education, disabled individuals expressed heightened concerns, including uncertainty about government support, increased anxiety regarding homelessness and housing insecurity, and reduced opportunities for high-risk individuals to earn income in customer-facing roles. Common factors contributing to financial and employment insecurity included reduced work availability, isolation due to lockdowns, and a perceived lack of government assistance.

An able-bodied participant stated that they were anxious surrounding the “lack of surety of support from the government and what will happen with assistance once we reach the end of the projected six months support.”

Another able-bodied Australian stated that:

*I've had no work shifts and usually I like going to work 1 to 2 times a week because it helps regulate things for me. I also lost my brother in November (2019) so not being able to see family or my friends has been so difficult. Luckily, I have an emotional support dog or I wouldn't be here.*

As a result of the lockdowns, many Australian universities shifted to 100% online education, although some institutions already offered online and distance-education options for some subjects and specialties to begin with. This made tertiary study more accessible to people living in regional, rural, and remote areas, as well as expanding the subjects available for study to disabled individuals, who may not be able to travel to campus.

The US exhibited similar trends, with 52% of disabled individuals and 50% of those with other identities experiencing negative financial impacts, compared to 41% of able-bodied individuals. Qualitative responses highlighted concerns about employment stability, particularly the absence of available personal/sick leave, precarious casual working arrangements, and

insufficient support for carers and parents. An able-bodied American participant cited reduced working hours, which had a flow-on effect to their financial position and ultimately, education – “... I don't make enough money to continue my education this coming fall.”

Conversely, in Canada, disabled individuals were less likely to experience negative financial impacts and more likely to experience positive ones compared to their able-bodied counterparts. A smaller proportion of disabled Canadians reported negative employment impacts. Qualitative data suggested that special arrangements made due to Covid-19 had a positive effect on disabled individuals. For instance, one disabled Canadian participant stated:

*Work has been able to finally provide me with the means to have video meetings (I had requested this numerous times before due to mobility issues with no result). They also were able to accommodate me working from home due to being high risk, though this had never been brought up before when I asked if there were options for me during (sick) days...*

A disabled Canadian participant also cited positive impacts due to special arrangements that have been extended to them by the Government, stating that “The government of Canada has increased educational grants for people with disabilities, enabling me to go back to school for free...”

Data from the UK indicated that disabled individuals were slightly less likely to experience negative financial impacts, with some even reporting no impact or positive effects. Disabled British individuals were less likely to report negative employment impacts, with 48% indicating that Covid-19 had no effect on their employment, and 12% mentioning a positive impact. Positive aspects included the ability to work from home, which proved beneficial for those with autism and social anxiety. Additionally, increased online social interactions were noted as a positive outcome, contributing to improved well-being.

A disabled participant described the positive impact of Covid-19 on their employment and social life:

*I am able to work from home full time at the moment and as I have autism and severe social anxiety the fact that I'm not needing to go into the office and mask (my symptoms) all the time has been really beneficial and it's actually helped me handle my other disabilities/symptoms a bit better. Lots more of my friends are hanging out online now so I am able to speak with them more frequently...*

Whilst another disabled participant highlighted the impact on their education: “(There is) less support and access to health services, (I am) unable to be around those who generally support me, (and) have to do university studies from home, whereas I had support in person.”

## **IMPACTS OF COVID-19 ON MEDICAL CARE AND MENTAL HEALTH**

An alarming number of participants reported negative impacts to accessing medical care, with 63% of disabled Australians reporting negative impacts on accessing medical care. This figure skyrocketed to 75% for the US, 88% for the UK, and 94% for Canadian disabled people. Similar trends were noticed, albeit to a lesser degree, among people with other identities. Able-bodied people were less likely to have experienced any impact on accessing medical care (See [Tables 6 and 7](#)).

A disabled Australian participant who suffers from mobility issues following extensive bowel cancer surgery had this to say:

*My physical disability has put me at (a) massive disadvantage when it comes to shopping. I do not have access to the DSP (Disability Support Pension) ... so (I) was not permitted to access special shopping hours or online shopping. Restrictions on loo paper, baby wipes, etc were very distressing as someone with a colostomy.*

This experience is not isolated, with many other disabled and chronically ill participants highlighting that their medical needs could not always be met if they were not registered for

	NEGATIVE (%)			NO IMPACT (%)			POSITIVE (%)			UNSURE (%)		
	AB	D	O	AB	D	O	AB	D	O	AB	D	O
Aust	35	63	67	58	30	29	5	9	5	2	0	0
Can	58	94	72	40	6	28	2	0	0	0	0	0
USA	47	75	62	48	20	23	2	1	4	4	4	11
UK	53	88	77	42	8	18	0	0	0	5	4	0

**Table 6** Impacts of Covid-19 on Accessing Medical Care.

Note: AB = Able-bodied; D = Disabled; O = Other identities.

	NEGATIVE (%)			NO IMPACT (%)			POSITIVE (%)			UNSURE (%)		
	AB	D	O	AB	D	O	AB	D	O	AB	D	O
Aust	23	43	24	69	52	52	4	4	5	4	4	19
Can	34	72	56	58	22	44	0	0	0	8	6	0
USA	28	53	36	61	36	45	2	2	2	9	9	38
UK	29	62	45	53	31	32	4	4	0	15	4	23

**Table 7** Impacts of Covid-19 on Quality of Medical Care.

Note: AB = Able-bodied; D = Disabled; O = Other identities.

the Disability Support Pension or other government initiatives and payments. These programs do not always consider individuals with chronic illnesses as being disabled.

Disabled people were also more likely to report negative impacts on the quality of medical care across all focus countries. A disabled participant from Australia commented that they lost access to physical therapy for their nerves as well as a loss of support systems for their pregnancy.

A hearing-impaired participant stated that:

*...Healthcare was already a joke pre-covid, but now doctors won't even bother speaking up when I tell them that I understand that they have to wear a mask; but I rely on lip reading and cannot hear them properly if they don't make direct eye contact and enunciate.*

A disabled participant from Canada also noted that they were no longer able to access their “physiotherapist, osteopath, psychologist, personal trainer or chiropractor” due to the lockdowns. Similar sentiments were expressed in the US and UK, where several participants commented on the impact of lockdowns and restrictions on accessing quality medical care.

## IMPACT OF COVID-19 ON MENTAL HEALTH

A large proportion of participants indicated that being disabled and having mental health conditions have worsened the impact of the Covid-19 pandemic on their lives. With a considerable number of people reporting worsening mental health and a negative impact on their social life, the impact of Covid-19 did not discriminate between the able-bodied and the disabled people. Able-bodied people, disabled people, and other individuals all reported similar rates of experiencing more negative mental health impacts due to the pandemic (See Tables 8 and 9).

	NEGATIVE (%)			NO IMPACT (%)			POSITIVE (%)			UNSURE (%)		
	AB	D	O	AB	D	O	AB	D	O	AB	D	O
Aust	34	52	24	53	37	57	5	7	10	8	6	10
Can	34	61	78	57	28	17	6	6	0	4	6	6
USA	44	53	52	44	35	31	5	7	7	8	5	10
UK	45	65	55	42	27	27	4	0	5	9	8	14

**Table 8** Impacts of Covid-19 on Accessing Mental Health Support.

Note: AB = Able-bodied; D = Disabled; O = Other identities.

	NEGATIVE (%)			NO IMPACT (%)			POSITIVE (%)			UNSURE (%)		
	AB	D	O	AB	D	O	AB	D	O	AB	D	O
Aust	82	72	80	8	19	15	6	4	5	4	6	0
Can	83	90	85	9	0	7	3	1	2	5	3	6
USA	80	84	90	13	0	5	4	16	0	4	0	5
UK	82	72	80	8	19	15	6	4	5	4	6	0

**Table 9** Impacts of Covid-19 on the Mental Health of Participants.

Note: AB = Able-bodied; D = Disabled; O = Other identities.

One American participant stated that:

*Being forced out of (university classes) should have reduced physical pain, but due to increased depression and feelings of isolation, helplessness, and apathy, it has increased and I am feeling more pain than I can ever remember experiencing before.*

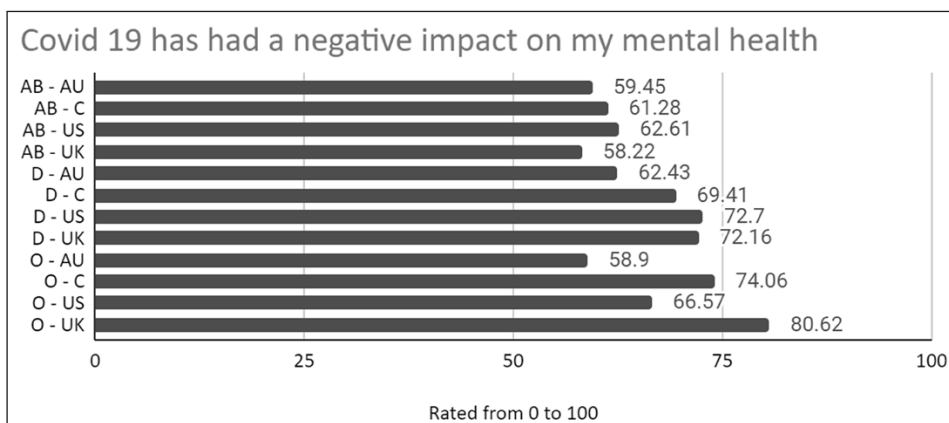
Participants from the other focus countries and study groups echo this sentiment, with some individuals citing challenges including eating disorder relapses, increased feelings of anxiety and depression, and suicidal ideation exacerbated by lockdowns and feelings of social isolation.

One disabled Australian participant highlighted the challenges they faced in seeking meaningful medical care:

*Mental health and medical appointments must all be done over the phone currently and many autistic people have significant anxiety around phone calls as it's harder to hear people and pick up social cues from body language and facial expressions, we can only rely on what's being said and the tone it's said in.*

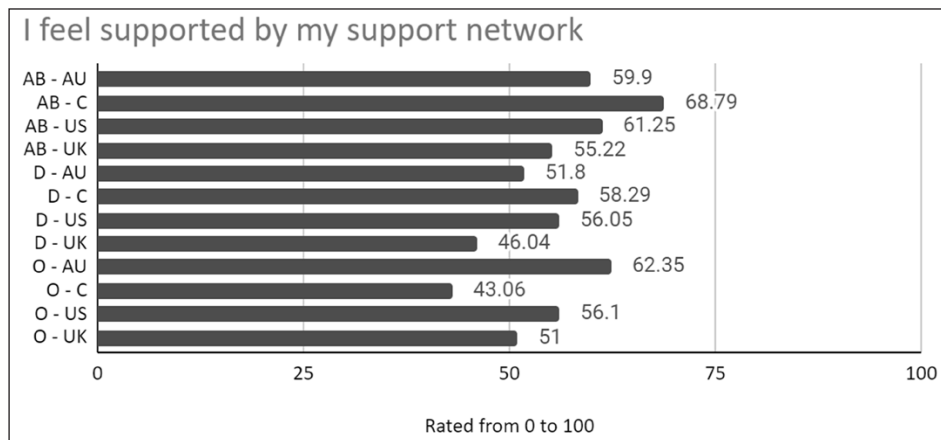
A participant from the UK ('other') stated that they were unsure whether their "poor mental health has made the time in quarantine worse or if the time in quarantine has made my mental health worse." A disabled American participant shared that "disabilities already make you feel isolated, but physical isolation on top of mental isolation is debilitating." This raises an interesting discussion point regarding causation vs correlation. Although individuals with existing disabilities and/or mental health issues can certainly have their condition exacerbated by social isolation, lockdowns and the other stressors seen during the pandemic (such as job losses, financial strain and difficulty accessing medical care); the experiences of many able-bodied individuals and individuals without pre-existing conditions point to the Covid-19 pandemic having brought on stressful situations and challenging experiences. This illustrates how the pandemic impacted the mental health of individuals who did not have mental health issues previously. However, this observation then raises the question of whether individuals with pre-existing mental health issues have a differing ability to cope due to existing support networks and strategies, which would require further research to establish.

Figure 1 helps visualise the stark contrast between the impact on mental health between the various study groups. Disabled people reported a notably higher impact of Covid-19 on their mental health, with many in the 'other' category also expressing impacts. It is vital to note that some participants who identified as able-bodied also experience mental health issues, which explains the ratings in the 50's and 60's by able-bodied participants.



**Figure 1** Average Participant Rating – Covid 19 Has Had a Negative Impact on My Mental Health.

Individuals across all groups in the focus countries indicated feeling moderately supported by their support network. As seen in Figure 2, disabled people were less likely to feel supported by their support networks than able-bodied participants from the same countries. However, the disabled and ‘other’ groups had higher scores than originally anticipated, highlighting that the majority of individuals did have some form of support from their support networks.



**Figure 2** Average Participant Rating – I Feel Supported by My Support Network.

This may be due to the shared nature of the lockdown experience, with some participants saying their “support network and friends have been more supportive than expected” (‘other’ participant from the UK). Chronically ill and disabled individuals, especially those with pain, fatigue, or mobility challenges, tended to rely on support groups, especially online/virtual ones which existed pre-pandemic on platforms such as Facebook and Discord. The presence of online support groups may have meant that disabled and other individuals were able to retain part of their support networks during the pandemic, thus slightly lessening the impact of lockdowns on their support networks.

For some, the lockdowns were a welcome break from the stressors and anxieties of pre-Covid 19 life, with one participant stating that “as an introvert, confinement has been a dream, (I am) very relieved to not have to see anyone or have to come up with excuses in order to not go somewhere” (able-bodied participant from Canada). This sentiment is also echoed in other responses, where individuals felt more supported by their workplaces and educational institutions due to remote/flexible working and study arrangements. One able-bodied American participant stated that they “have saved over \$3000 without having to pay for daycare for [their] child.” Being home has also made them to actually feel “more comfortable and safer.”

However, other participants expressed challenges with having to home-school their children and the unavailability of childcare services. “If I didn’t have kids, I don’t think it would impact me so greatly. Not having facilities available for my kids to run free and get massive amounts of energy out is frustrating” (American able-bodied participant). A chronically ill/‘other’ American participant shared that they “had several procedures for my back scheduled that had to be postponed due to closures. That greatly impacted (their) ability to care for (their) children.”

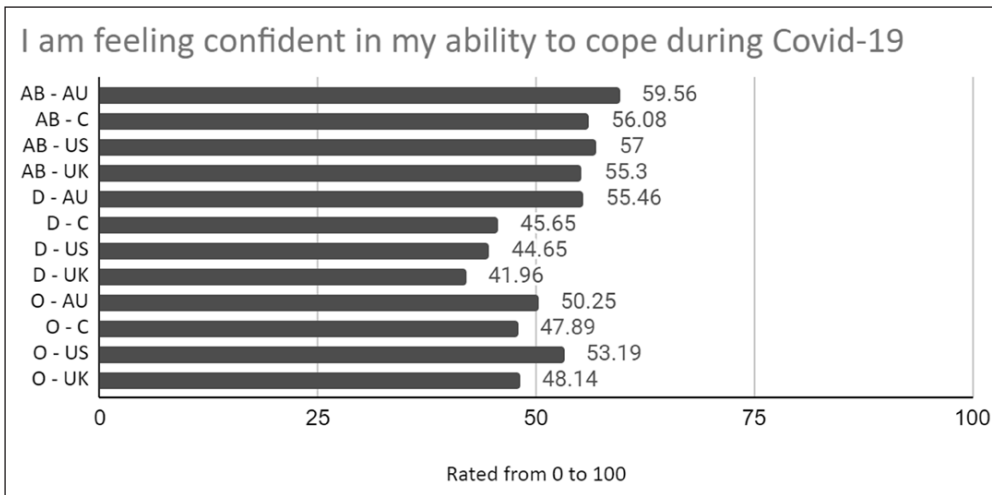
**PARTICIPANT ABILITY TO COPE DURING COVID-19**

High levels of uncertainty and anxiety may have contributed to individuals feeling a moderate to low level of confidence in their ability to cope during the Covid-19 pandemic.

The standard deviation of scores for participant-reported ability to cope during Covid-19 are indicative of ‘typical’ bell curve/distribution trends. Thus, it can be established that the distribution of responses is typical of what could be expected from a sample population.

Disabled participants were notably less confident in their ability to cope during the pandemic, with several participants highlighting factors such as difficulty in accessing adequate medical care, struggles communicating (in particular, vision and hearing-impaired participants), and difficulty in accessing supports such as carers and support staff (See Figure 3).

Interestingly, there is only a marginal difference between the self-reported ability to cope in the able-bodied groups by country. Additionally, in Australia, disabled participants reported



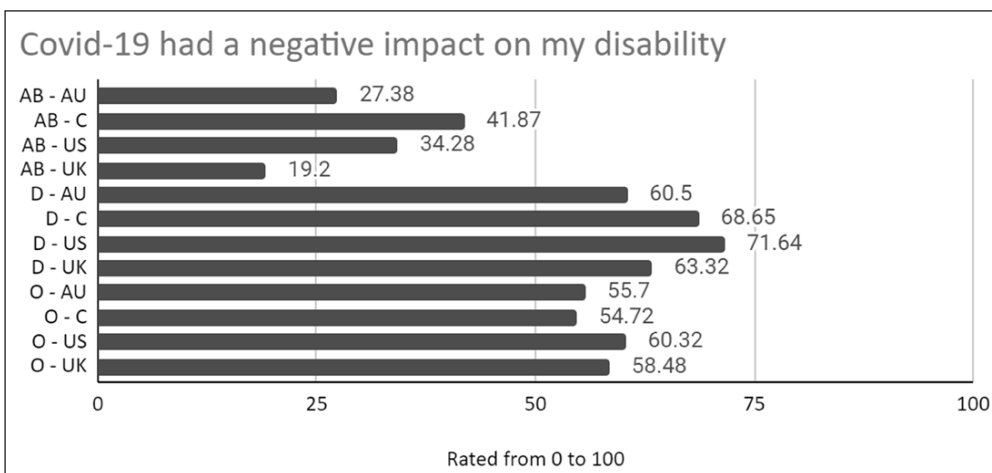
**Figure 3** Average Participant Rating – I am Feeling Confident in My Ability to Cope.

moderate ability to cope which was comparable to the corresponding able-bodied and other group. Conversely, in Canada, the US and the UK, disabled individuals were less confident in their ability to cope during the Covid-19 pandemic. The variation between countries may be explained by the disparities which exist in terms of access to healthcare and government support during Covid-19.

**PARTICIPANT-IDENTIFIED IMPACT ON DISABILITY**

Interestingly, in Canada, able-bodied people ranked Covid-19 as having a negative impact on their disability as 41.87 out of the 100 point scale. This may have occurred due to the prevalence of mental health issues and chronic illnesses amongst individuals who self-identified as being able-bodied. However, it is still observable that disabled and chronically ill/‘other’ individuals experienced measurable impacts on their conditions (See Figure 4).

Several participants cited a lack of medical care for conditions including hernias and necessary



**Figure 4** Average Participant Rating – Covid-19 had a Negative Impact on My Disability.

spinal surgery and difficulties in accessing essential supplies for their colostomy bag. Another participant (UK, disabled) stated that they didn't have adequate ergonomic seating at their home, rather, they were made to work from home and used their sofa, which exacerbated their EDS (Ehlers Danlos Syndrome).

Able-bodied participants still reported a negative impact, with some participants experiencing chronic illnesses and mental health issues, but not self-identifying as disabled. Nonetheless, the notable difference in impact between disabled and other participants compared to able-bodied participants can be clearly visualised.

Ultimately, the Covid-19 Pandemic has undeniably impacted disabled people and individuals with chronic illnesses to a more profound and enduring extent than able-bodied people. This is in line with the central hypothesis posed, which is that disabled people and individuals with chronic illnesses have been disproportionately burdened and impacted by the Covid-19 pandemic. The paper uncovered a multitude of factors which impacted disabled participants, ranging from insufficient or inaccessible government supports to a lack of childcare and social connections and financial instability.

However, it is essential to recognise that able-bodied people were also impacted by the pandemic, albeit to a lesser extent. This is evident in research that highlights the challenges faced by able-bodied individuals during the pandemic and as confirmed by this research. Several cited lack of childcare and having to home-school, with parents juggling their work-from-home responsibilities simultaneously to having to care for their children. Other factors explored include social isolation and financial uncertainty as contributing factors.

Through this research, it is evident that the Covid-19 pandemic has had a wide range of implications across several populations within society including disabled, chronically ill/‘other’ and able-bodied individuals. Disabled and chronically ill individuals faced a unique set of challenges and obstacles compared to their able-bodied counterparts. By identifying, recognising and addressing these disparities, governments, policy-makers and healthcare providers can work towards a more equitable pandemic and crisis plan to benefit all members of society moving forward.

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## COMPETING INTERESTS

The author has no competing interests to declare.

## AUTHOR INFORMATION

The author undertook this study when she was an undergraduate student at Macquarie University, Sydney, Australia. However, the entirety of this paper consists of independent research and data collection and is not affiliated with any organisation or institution.

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