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“Visible Enough to Qualify?" Diagnostic Objectivity and Access to Disability Assistance

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ABSTRACT

Disability assistance programs in the United States, such as Supplemental Security Income (SSI) and welfare benefits, are vital safety nets for individuals unable to work due to disabling conditions. However, eligibility for these programs often hinges on objective medical evidence, which can disadvantage individuals with conditions that rely on subjective assessment, like chronic pain, psychiatric disorders, or cognitive impairments. This study, using data from the 2023 American Community Survey, examined how disability type—categorized as “objective,” “subjective,” or “both”—shapes access to SSI and welfare benefits among adults aged 18–64 reporting functional difficulties. Findings present that individuals with cognitive and independent living impairments face the highest odds of receiving benefits, while those with both subjective and objective disabilities have the lowest predicted probability of receipt. Regression analyses and predictive modeling suggest that disability programs systematically favor certain functional profiles, particularly those that are more easily recognized or validated through existing administrative frameworks. These patterns persist even after I adjust for sociodemographic and employment-related factors. The findings highlight critical limitations in current disability eligibility criteria, revealing how reliance on diagnostic objectivity can obscure real functional needs.

INTRODUCTION

Disparities in access to disability assistance programs, including Supplemental Security Income (SSI), have historically been influenced by the underlying medical and administrative paradigms employed to determine eligibility criteria. A core dichotomy exists between objective medical conditions—characterized by visible, quantifiable biomarkers—and subjective conditions, such as chronic pain syndromes or mental health disorders, which predominantly depend on self-reported symptoms and clinical judgment. This dichotomy has considerable repercussions for notions of fairness and equity in the allocation of aid.

A growing body of research suggests that disabilities with clear, objective diagnostic criteria, such as vision or hearing loss, are more easily validated within program guidelines. By contrast, conditions with more subjective or less easily measurable impacts–such as cognitive or independent living

difficulties–can be more challenging to assess, leading to inconsistent recognition in policy and practice. Yet the relationship between disability type, economic vulnerability, and program access remains poorly understood, particularly when multiple functional limitations overlap. Understanding how these distinctions shape access to SSI and welfare is critical for addressing inequities in benefit receipt and ensuring that safety net programs effectively reach those with the greatest need.

This study addresses this gap by examining how disability type—categorized as objective-only, subjective-only, or both—influences economic outcomes and participation in income-based support programs. Using data from the 2023 American Community Survey, I link descriptive statistics on income, poverty, and insurance coverage with logistic regression models predicting SSI and welfare receipt.

Findings reveal a stark disconnect: individuals with both objective and subjective disabilities experience the greatest economic hardship but do not receive proportionately greater assistance. These results suggest that current eligibility frameworks systematically disadvantage individuals with complex or less visible impairments—not because they are less impaired, but because the system privileges diagnostic objectivity. This emphasizes the need for a more inclusive, equity-oriented model of disability assessment that better reflects the full range of disabling experiences.

BACKGROUND

Disability assistance programs in the United States, such as Social Security Disability Insurance (SSDI) and Supplemental Security Income (SSI), provide financial support to individuals who can no longer work due to a "medically determinable impairment." While these programs are associated with improved long-term health and economic outcomes (SSA, 2023), access remains contingent on the presence of objective diagnostic evidence. This requirement raises critical questions about fairness and accessibility for individuals with disabling conditions that do not present with measurable biomarkers.

U.S. disability policy has long prioritized conditions with visible or quantifiable signs, often verified through imaging, lab tests, or standardized clinical tools. The Social Security Administration's "Listing of Impairments" reflects this preference, favoring diseases with predictable progression and clear diagnostic benchmarks (SSA, 2023). Consequently, applicants with spinal cord injuries or advanced cancer often encounter fewer barriers to approval (Jenkins & Rigg, 2004), while those with chronic pain, psychiatric conditions, or myalgic encephalomyelitis/chronic fatigue syndrome (ME/CFS) face heightened scrutiny. These applicants must often document their impairments through a patchwork of functional assessments, pain journals, and provider notes—an unrealistic burden for many (Disability Benefits Group, n.d.).

Several legal and policy analyses underscore this structural inequity. A 2014 SSA commission report acknowledged the systemic disadvantage faced by applicants with subjective conditions and called for the

consideration of new listing categories for pain-related impairments (SSA, 2014). Despite such recommendations, current adjudication practices continue to disadvantage applicants with less visible or fluctuating conditions. Studies have shown that symptoms without corresponding objective markers are often dismissed, regardless of severity, delaying benefit access and exacerbating financial hardship (Timmermans & Buchbinder, 2013; Liebert, 2021).

The preference for objective medical documentation—justified by administrative efficiency and fraud prevention—frequently undermines the legitimacy of self-reported symptoms and the clinical judgment of treating physicians. Applicants with fibromyalgia, chronic fatigue, or psychiatric disorders are more likely to face disbelief, prolonged appeals, and higher denial rates (Rottenberg et al., 2018). These challenges are often compounded by systemic inequities. For instance, lower-income and rural applicants may have limited access to specialists who can produce the documentation required by SSA guidelines, even when functional limitations are severe (Hoffman et al., 2022; Davenport et al., 2014). As a result, applicants from marginalized racial or geographic communities may be disproportionately penalized due to both structural and evidentiary barriers.

While prior research has begun to explore disparities in disability approval based on race, socioeconomic status, and condition-specific stigma, few studies offer a comparative, cross-condition analysis of how diagnostic objectivity affects access to public disability programs. Most literature is siloed—examining single conditions such as PTSD, bipolar disorder, or fibromyalgia—without evaluating broader patterns across diagnostic categories. Moreover, limited work has connected these diagnostic dynamics with economic outcomes and program access at a population level.

This study addresses these gaps by systematically analyzing how disability type—categorized by the presence of objective vs. subjective diagnostic criteria—shapes approval rates for SSI and welfare benefits. Using a nationally representative sample, we assess not only access to income support programs but also the economic positioning of individuals across diagnostic categories. By analyzing how diagnostic classification intersects with benefit access and socioeconomic disadvantage, this research bridges clinical, administrative, and economic perspectives. It highlights how current program structures may unintentionally reproduce inequities—and contributes to ongoing debates about fairness and reform in disability policy.

METHODS AND DATA

I drew my analytic sample from the 2023 American Community Survey (ACS) Public Use Microdata Sample (PUMS), a nationally representative survey conducted annually by the U.S. Census Bureau. The ACS is designed to capture detailed demographic, social, economic, and housing characteristics of the U.S. population, and it plays a critical role in shaping federal resource allocation and policy decisions. Among its many objectives, the ACS includes a validated six-item set to measure functional disability status across several domains: vision, hearing, ambulatory, cognitive, self-care, and independent living.

These questions are based on the Department of Health and Human Services standard for disability surveillance and are widely used in federal research and administrative planning.

This dataset is especially well-suited to our research inquiry for several reasons. First, the large sample size and nationally representative design allow us to compare subpopulations with different types of disabilities while preserving statistical power. Second, the ACS includes detailed income and program participation data, enabling us to observe actual receipt of means-tested benefits like Supplemental Security Income (SSI). Third, the survey's disability indicators are phrased in terms of self-reported functional limitations rather than specific diagnoses, which aligns well with our interest in examining the relationship between disability type (i.e., objective vs. subjective) and benefit access, rather than condition-specific pathways.

To investigate potential inequities tied to the "objectivity" of disability evidence, I categorized disability types into objective and subjective groupings based on how the ACS functional limitation variables are structured. Objective disabilities include vision, hearing, and ambulatory difficulties. These are conditions that can be typically verified through clinical tests or direct observation (e.g., eye exams, audiometric results, mobility assessments). Subjective disabilities include cognitive, self-care, and independent living difficulties, which rely more heavily on self-report or contextual judgment and importantly, may fluctuate or be less visible. Within this framework, mental health-related impairments (such as depression or anxiety) are primarily captured under the cognitive difficulty domain, which asks whether the respondent experiences "serious difficulty concentrating, remembering, or making decisions" due to a physical, mental, or emotional condition. Likewise, selfcare and independent living limitations refer to challenges in basic daily activities such as bathing, dressing, shopping, or managing bills. Respondents who reported at least one disability from each group were classified as having both types. Those reporting only objective or subjective limitations were assigned to the respective "objective-only" or "subjective-only" categories. This typology was developed specifically for this analysis and is not an official classification used by the Social Security Administration (SSA). However, it reflects distinctions discussed in existing literature on disability adjudication, where programs often place greater emphasis on impairments supported by measurable diagnostic evidence while scrutinizing conditions that rely more on subjective reporting. I defined program receipt based on respondents' self-reported income sources, flagging individuals who received Supplemental Security Income, welfare/TANF, or Social Security benefits during the past year.

My analytical approach began with weighted summary tables that compared demographic characteristics, educational attainment, employment status, income distribution, poverty rates, and benefit receipt across the three disability-type groups. I used chi-square tests on raw cross-tabulations for unadjusted comparisons to highlight basic differences in assistance rates. I then estimated a series of nested logistic regression models predicting the likelihood of receiving Supplemental Security Income. The first model included only the objective and subjective disability indicators; subsequent models sequentially adjusted for age (and its square), gender, marital status, race/ethnicity, education level, and labor-force status. From these models, I reported odds ratios to convey relative likelihoods and calculated average changes in predicted receipt probabilities to illustrate absolute differences.

To explore heterogeneity further, I repeated similar regressions for each of the six individual disability difficulties—first without covariate adjustment, then with the full set of demographic and socioeconomic controls—to assess whether certain conditions exhibited especially high or low program participation. Additionally, I ran parallel models using welfare receipt as the outcome. Throughout, I adhered to best practices for survey data by applying design-based weights in descriptive analyses and carefully handling missing or top-coded income values. All results were compiled into publication-quality tables and figures, and I archived my analytic scripts and output artifacts to ensure full reproducibility.

RESULTS

The analytic sample, consisting of 1,348,404 unweighted cases, was grouped by disability type: objective-only, subjective-only, or both types of conditions. The findings revealed significant disparities in income and government assistance among these groups. For instance, individuals with objective-only conditions were the oldest on average (49.2 years), followed closely by those with both types (48.9 years), while the subjective-only group was notably younger (37.1 years). Women comprised 52.5% of the 'both types' group compared to approximately 49% in the other groups. Marriage rates varied considerably, with 48.6% of the objective-only group married versus 34.2% of the 'both types' group and 24.9% of the subjective-only group. Educational attainment was lowest among those with both types of conditions—64.6% had less than a high school education compared to 54.2% in the objective-only group and 60.2% in the subjective-only group. Employment rates revealed stark differences across groups. Only 22.0% of individuals with both types of conditions were employed, compared to 58.4% in the objective-only group and 44.3% in the subjective-only group. Correspondingly, 74.3% of those with both condition types were not in the labor force, suggesting potential long-term work disability. Income disparities were substantial: mean total income in the objective-only group was nearly double that of the other two groups. Those with both condition types were over three times more likely to receive Supplemental Security Income (SSI) compared to those with objective-only conditions (23.0% vs 7.7%). However, average benefit amounts remained relatively consistent across groups. Nearly all individuals across groups had some form of health insurance, but the types of coverage differed markedly. The 'both types' group relied primarily on public insurance (70.2%), while private coverage was most common in the objective-only group (59.7%).

The main regression results, shown in Table 2, analyze the relationship between disability type and the probability of receiving Supplemental Security Income (SSI) and welfare benefits. To aid in interpreting these findings, the table includes both regression coefficients and odds ratios (ORs). An odds ratio greater than 1 means that individuals with that condition are more likely to receive benefits compared to those without it; an OR below 1 means they are less likely. The results indicate that individuals with cognitive impairments are more than twice as likely to be recipients of SSI in comparison to those without such limitations (OR = 2.21). Difficulties in independent living exhibited a similar magnitude, with an odds ratio of 2.39, representing the highest estimated effect among all disability categories. Individuals with ambulatory limitations (e.g., difficulty walking) also demonstrated a strong positive association (OR = 1.82), while impairments in vision and hearing were associated with smaller yet statistically significant

increases in SSI receipt (OR = 1.17 and 1.24, respectively). Notably, despite being severe impairments, self-care difficulties (e.g., needing assistance with dressing or bathing) are associated with a lower likelihood of receiving SSI (OR = 0.82). This indicates that people with self-care difficulties were actually less likely to receive SSI despite having significant functional challenges.

When analyzing welfare receipt, a similar but slightly weaker pattern appears. Cognitive difficulties again show the strongest positive link, with an odds ratio of 1.71. Difficulties with independent living (OR 1.39) and ambulatory limitations (OR 1.33) are also linked to increased welfare participation. Vision and hearing challenges correspond to smaller increases (OR 1.26 and 1.10, respectively), while self-care difficulties are negatively related to welfare receipt (OR 0.91). These results highlight how the same disability categories that influence SSI participation also affect access to welfare benefits, though with more minor impacts, indicating overlapping but separate administrative pathways for both programs.

To further illustrate these inequities, I examined the broader economic circumstances of individuals across disability types.

Figure 1 shows differences in economic outcomes—such as average and median income, and the percentage of people living below the poverty line—across different disability categories. People with both objective (measurable) and subjective (perceived) disabilities consistently have the worst economic results, with lower incomes and higher poverty rates. Individuals with only subjective disabilities (e.g., cognitive or independent living impairments) face less extreme, but still significant economic hardship. By contrast, those with objective-only conditions (e.g., vision or hearing impairments) have higher average and median incomes and a lower share living below the poverty line. This suggests that limitations in benefit access are accompanied by broader financial disadvantages among individuals with more complex disability profiles. These patterns indicate that while individuals with subjective or combined disabilities are most economically disadvantaged, they are not always the most likely to receive assistance, underscoring potential gaps in program design and recognition. Additionally, these economic disparities support the findings in Table 2: the types of disabilities most linked to receiving SSI are also those most connected to socioeconomic instability. This highlights how benefits serve as a partial, but uneven, safety net.

I also modeled the predicted probability of SSI receipt by disability category to visualize the magnitude of these differences more intuitively. Figure 2 shows apparent differences in the predicted probability of SSI receipt across disability groupings. Individuals with subjective-only disabilities - such as cognitive, self-care, or independent living difficulties—have the highest and most stable predicted probabilities, averaging around 65–70%. Those with objective-only disabilities, including vision, hearing, or ambulatory impairments, display a broader range of predicted probabilities, with a median around 35% but spanning from near zero to higher likelihoods. Individuals with both subjective and objective disabilities have predicted probabilities concentrated near zero, with minimal variability despite having multiple types of functional limitations. These results suggest that disability type meaningfully shapes SSI access, with subjective impairments more strongly aligning with program eligibility criteria. At the same time, those with combined limitations do not see higher predicted probabilities.

Taken together, these figures deepen the understanding of the regression findings. They show that the relationship between disability type and benefit receipt cannot be viewed in isolation; it reflects a broader hierarchy of recognized need. Disability types that are easier to understand or verify—such as cognitive or independent living difficulties—are more likely to lead to benefit eligibility, while others remain marginalized. With implications for fairness in benefit access, these results suggest that policy definitions of disability may unintentionally uphold socioeconomic disadvantages by systematically favoring certain functional limitations over others.

TABLES AND FIGURES

Table 1: Sample Characteristics

	Both Types of Disability	**Objective Disability**	**Subjective Disability**
N	417515	473140	457749
N (Weighted)	13417	16285	15499
Mean Age	48.9	49.2	37.1
Gender			
Percent Female	52.5%	48.8%	48.4%
Percent Married	34.2%	48.6%	24.9%
Education			
Percent Less Than High School	64.6%	54.2%	60.2%
Percent High School Grad	22.6%	24.7%	22.4%
Percent Some College	8.8%	13.6%	12.4%
Percent College Plus	4.1%	7.5%	5.0%

Work Status			
Percent Employed	22.0%	58.4%	44.3%
Percent Unemployed	3.7%	3.9%	6.6%
Percent Not In Lf	74.3%	37.7%	49.1%
Income ($)			
Median Total Income	11,500	26,000	11,246
Mean Total Income	22,364	43,095	25,733
Median Wage Income	24,990	40,609	21,238
Percent Below Poverty	34.1%	18.7%	27.7%
Percent Receives SSI	23.0%	7.7%	14.9%
Percent Receives Welfare	5.8%	2.7%	4.6%
Percent Receives SS	27.4%	13.3%	12.2%
Percent Any Disability Assist	26.6%	9.8%	18.1%
Mean SSI Amount ($)	10,047	10,554	9,460
Mean Welfare Amount	2,848	3,202	3,318
Mean SS Amount ($)	12,778	13,353	11,696
Health Insurance			
Percent Any Health Insurance	91.8%	88.6%	88.9%
Percent Public Insurance	70.2%	38.0%	51.3%

Percent Private Insurance	35.2%	59.7%	47.0%

Notes: Estimates are weighted using ACS person weights. Both Types = individuals with both objective and subjective disabilities. Objective Only = vision, hearing, or ambulatory difficulties only. Subjective Only = cognitive, self-care, or independent living difficulties only. SSI = Supplemental Security Income. SS = Social Security.

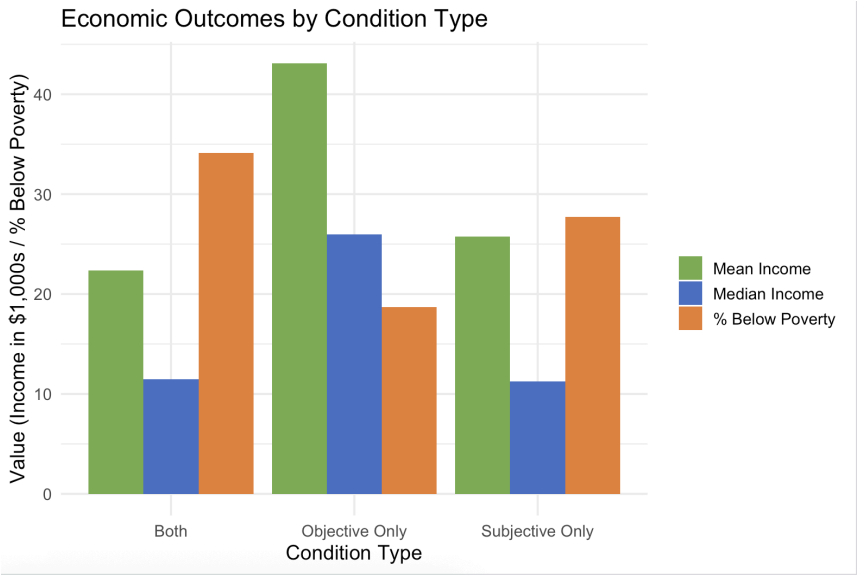
Table 2. Combined SSI Welfare

Disability Type	SSI Coefficient	SSI OR	Welfare Coefficient	Welfare OR
Vision	0.16***	1.17	0.23***	1.26
Hearing	0.21**	1.24	0.09*	1.10
Ambulatory	0.60**	1.82	0.29***	1.33
Cognitive	0.79**	2.21	0.54***	1.71
Self-care	**-0.20****	**0.82**	**-0.10*****	**0.91**
Independent Living	0.87**	2.39	0.33***	1.39

Note: Estimates are weighted using ACS person weights. Objective disabilities include vision, hearing, or ambulatory difficulties, while subjective disabilities include cognitive, self-care, or independent living limitations. SSI = Supplemental Security Income; OR = Odds Ratio.

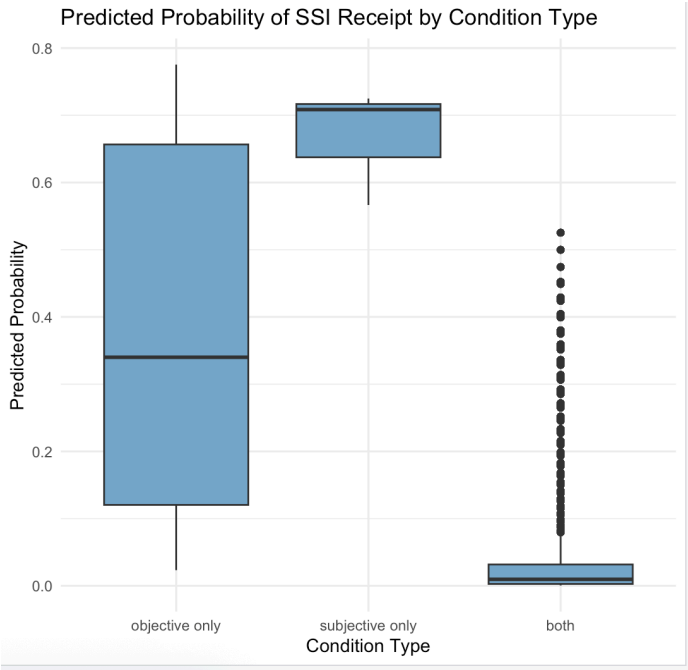
* $p < 0.05$; ** $p < 0.01$; *** $p < 0.001$.

Figure 1. Economic Outcomes by Condition Type



Notes: Mean and median incomes are shown in thousands of dollars. Percent below poverty represents the share of each group living under the federal poverty threshold. Objective disabilities include vision, hearing, or ambulatory difficulties, while subjective disabilities include cognitive, self-care, or independent living limitations.

Figure 2. Predicted Probability of SSI Receipt by Condition Type



Notes: Predicted probabilities are derived from the full SSI regression model. Objective disabilities include vision, hearing, or ambulatory limitations; subjective disabilities include cognitive, self-care, or independent living limitations; "both" indicates individuals with overlapping objective and subjective disabilities. The median predicted probability is highest for individuals with subjective disabilities, while those with objective disabilities show greater variation. Individuals with both types of disabilities have the lowest median predicted probability, with a concentrated distribution near zero

DISCUSSION

This study provides evidence that the type of disability meaningfully structures access to income-based support programs like SSI and welfare. While the regression models show that individuals with cognitive or independent living difficulties have the highest odds of benefit receipt, this pattern does not necessarily

reflect greater impairment or need. In fact, descriptive and economic data suggest that individuals with both objective and subjective disabilities—those likely facing the greatest barriers to employment and daily functioning—experience the lowest predicted probability of receiving SSI. This disconnect between functional limitation and program access points to underlying structural biases embedded in eligibility criteria.

These findings reinforce that eligibility is not determined solely by impairment severity or work limitations. Rather, disability types that align with existing documentation norms, clinical language, or administrative ease are more likely to be recognized and approved. For example, cognitive or independent living difficulties, though serious, are often captured by standard evaluation tools or already embedded in eligibility rubrics. In contrast, individuals with overlapping conditions, or those whose impairments fall outside easily classifiable boundaries, may be overlooked—even when their employment outcomes and income indicators signal severe need.

This may help explain the apparent divergence from prior literature. While past research has emphasized that subjective or non-visible disabilities face significant disadvantages during the approval process, this study analyzes population-level data on receipt of benefits among those who ultimately qualify—not who applies or is denied. The higher odds observed among individuals with subjective disabilities may therefore reflect a distinct subset of claimants (such as those with psychiatric or developmental impairments) whose conditions, while subjective in nature, are nonetheless recognized under functional eligibility standards used by SSI. In this way, the findings do not contradict the broader literature, but instead highlight a more complex adjudicatory landscape in which certain subjective impairments are better captured than others.

This has important implications for how disability is conceptualized in policy. If access to assistance is driven more by diagnostic fit than by lived impairment, programs may inadvertently exclude some of the most vulnerable individuals, especially those whose conditions do not fit neatly within eligibility checklists. As shown in our findings, economic disadvantage is greatest among those with both objective and subjective disabilities, yet they remain least likely to access benefits designed to support them.

The observed patterns also suggest a need to revisit the assumption that disability programs naturally prioritize those most affected. In practice, the current structure may reinforce inequities by privileging visibility, simplicity, or administrative recognition—factors that do not necessarily correlate with real-world hardship. This is particularly concerning given that the goal of SSI and similar programs is to provide a safety net for those whose impairments prevent sustained employment.

To address these disparities, several policy avenues deserve consideration:

1. Broaden eligibility frameworks to better reflect diverse, intersecting forms of impairment. This includes expanding definitions and allowing multi-dimensional assessments that capture combined or fluctuating conditions.

2. Reduce documentation burdens that disproportionately affect individuals with less formally recognized or more complex disabilities. Streamlined application processes or alternative verification pathways may improve access for overlooked groups.

3. Center lived experience and functional limitation as a core criterion in eligibility determinations. Aligning program access more closely with actual impairment and socioeconomic disadvantage can help ensure that support reaches those who need it most.

Future research should examine how these dynamics play out in other disability-related programs, such as SSDI, Medicaid waivers, or vocational rehabilitation services. Understanding whether similar biases persist across systems will be essential for designing more inclusive and equitable policy frameworks.

CONCLUSION

This paper demonstrates that access to disability-related income support is deeply shaped by how impairments are classified, documented, and interpreted within administrative systems. Individuals with cognitive or independent living difficulties are most likely to receive benefits, while those with combined objective and subjective impairments—despite facing the most severe economic hardship—are often under-recognized. The findings challenge the assumption that benefit receipt directly reflects need or impairment severity. Instead, they reveal a system that rewards conformity to eligibility norms over real-world disadvantage.

Addressing these structural inequities will require more inclusive eligibility frameworks, reduced documentation barriers, and a renewed focus on functional limitation rather than diagnostic fit. By reimagining how disability is defined and verified in public policy, it may be possible to create programs that are not only more effective, but also more just.

REFERENCES

References
Davenport, T. E., Stevens, S. R., & Perera, R. A. (2014). Access to care for chronic pain in medically underserved populations: A review of structural barriers and health disparities. Pain Management Nursing, 15(4), 759–766.

Disability Benefits Group. (n.d.). SSDI benefits for chronic pain: Understanding eligibility. Retrieved from https://ssdibenefitsgroup.com/ssdi-benefits-chronic-pain-elgibility/

England, J., Smith, C., & Zhou, L. (2020). Geographic disparities in disability benefit approvals: Specialist access and rural health inequities. Journal of Disability Policy Studies, 31(2), 201–217.

Hoffman, K. M., Trawalter, S., Axt, J. R., & Oliver, M. N. (2022). Racial bias in pain assessment and treatment recommendations and its implications for disability adjudication. Proceedings of the National Academy of Sciences, 119(12), e2102356119.

Jenkins, S., & Rigg, J. A. (2004). Disability and disadvantage: Selection, onset, and duration effects. Journal of Social Policy, 33(3), 479–501.

Liebert, H. (2021). Does external medical review reduce disability insurance inflow? arXiv preprint. Retrieved from https://arxiv.org/abs/2101.03117

Monnat, S. M., & Brown, R. L. (2020). Racial and ethnic disparities in SSDI entry and health outcomes. National Bureau of Economic Research Working Paper. Retrieved from https://www.nber.org/brd/20241/racial-and-ethnic-disparities-ssdi-entry-and-health

Rottenberg, J., Devendorf, A. R., Kashdan, T. B., & Disabato, D. J. (2018). The curious neglect of high-functioning after psychopathology: The case of depression. Perspectives on Psychological Science, 13(5), 549–566.

Social Security Administration. (2014). Pain-related impairments and disability determination. Social Security Bulletin, 50(1), 13–23. Retrieved from https://www.ssa.gov/policy/docs/ssb/v50n1/v50n1p13.pdf

Social Security Administration. (2023). Disability evaluation under Social Security (Blue Book). Retrieved from https://www.ssa.gov/disability/professionals/bluebook/AdultListings.htm

Timmermans, S., & Buchbinder, M. (2013). Patients-in-waiting: Living between sickness and health in the genomics era. Journal of Health and Social Behavior, 54(4), 501–517.

https://www.ssa.gov/policy/docs/ssb/v50n1/v50n1p13.pdf

Social Security Administration. (2023). Disability evaluation under Social Security (Blue Book). Retrieved from https://www.ssa.gov/disability/professionals/bluebook/AdultListings.htm

Timmermans, S., & Buchbinder, M. (2013). Patients-in-waiting: Living between sickness and health in the genomics era. Journal of Health and Social Behavior, 54(4), 501–517.