

# Introduction

## Health and Political Participation: Advancing the Field

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The implementation of the Affordable Care Act (ACA) between 2010 and 2016—and the ensuing polarized deliberations over its repeal in 2017 and ongoing efforts to undermine or thwart the law through 2018—have ushered the politics of health policy to the top of the public agenda. Analysts questioned whether new constituencies created by the law, such as young adults eligible to stay on their parents' plans until age 26, adults newly insured through Medicaid expansions, or those with access to health insurance from state and federal Marketplaces, would behave in politically important ways during the elections of 2014, 2016, and beyond. Would those who gained insurance vote to a greater degree? Would they support Democratic candidates if they perceived themselves to have benefited? How might well-documented concerns over declining US public health, such as the opioid epidemic and increasing rates of mental illness, shape electoral outcomes? How and under what conditions are health factors important influences on political behavior? While researchers on the margins of public health, medical sociology, social epidemiology, and political behavior in the United States and internationally have been examining some of these discrete questions for some time, there has been limited cohesive examination of how theories of health and political behavior intersect and add to the knowledge base of health politics in the United States. This special issue brings together established and emerging interdisciplinary scholars to advance the evidence base about how analyses of health can contribute toward new understanding of political behavior in the 21st century.

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Existing literature on health and political participation has been mainly confined within two areas: examining health as an influence on voter turnout, and assessing policy feedback effects of health policies—that is, the extent to which policy changes like coverage expansions have influenced politics. From the former, there is now growing evidence that those in poor health—whether defined in terms of disability (Schur et al. 2002), self-rated health (Pacheco and Fletcher 2015; Mattila et al. 2013), or diagnoses of particular illnesses (Gollust and Rahn 2015; Ojeda 2015; Ojeda and Pacheco 2017; Sund et al. 2017)—are less likely to vote than those in good health or not facing mobility limitations. The magnitude of these associations may in fact rival those typically observed for studies of turnout, like income and education (Burden et al. 2017), yet health is still too rarely considered as an important variable in mainstream studies of political outcomes. A few recent studies have also considered health in the aggregate at the ecological level as important for political outcomes. For instance, areas more affected by opioid use and mortality and/or with shorter life expectancy may have voted in larger proportions for Trump in the 2016 election (Monnat and Brown 2017; Wasfy, Stewart, and Bhambhani 2017; Goodwin et al. 2018; Bor 2017). While the literature on health and participation is strong and growing, it often does not consider the political processes that precede and construct the health status variables that comprise the key independent variables of interest, nor does the literature sufficiently consider the vast implication of the findings for the maintenance and perpetuation of inequities in health and in politics.

On the policy feedback side, it is well established that policies can influence political behavior and attitudes (Campbell 2012); this can happen when policies change or redefine new political communities of constituents, who may have newly available resources or new understanding of the meaning they assign to politics, thus affecting their likelihood of political engagement (Skocpol 1995; Mettler and Soss 2004; Campbell 2012). While many empirical health policy studies have evaluated the effects of the ACA on health and economic outcomes (e.g., access to care, health status, financial well-being) (Sommers et al. 2016), too rarely have studies addressed how health policy affects political outcomes, although this is changing (Michener 2018). Newer work exploring whether and how the implementation of the ACA shaped voter turnout (Haselswerdt 2017; Clinton and Sances 2018) begins to explore the policy feedback effects of health policy.

These two sets of literatures—health and political outcomes, and policy feedback—have been pursued largely as discrete empirical projects,

contributing toward theory but not integrating new understandings at the intersection of policy feedback and political behavior. But in health policy, the two are necessarily linked. Simply put, health policy has the potential to affect the public's health and their political engagement, and both of these will in turn influence the trajectory of political actions in response, public beliefs about the role of government, and public demand for new health policies in the future. Many important areas of inquiry not adequately addressed by extant literature are examined by the authors contributing to this special issue, including understanding the conditions under which health policy (not only the establishment of new benefits but also the retrenchment of existing benefits) creates or fails to create new constituencies; advancing our understanding of the meaning of self-rated health; and most important, tackling the implications of these questions at the intersection of health and political participation for persistent and growing health and political inequities in the United States (see, e.g., Cohen, Grogan, and Horwitt 2017).

The central policy feedback question in the United States over the last several years has been, as noted above, whether the ACA, a major welfare state expansion, would generate supportive constituencies as past welfare state expansions have done (Campbell 2003; Mettler and Soss 2004). Whatever its actual political impacts, the ACA has reshaped policy feedback studies by leading scholars to focus on the barriers that may prevent new policy from producing new politics (see, e.g., Patashnik and Zelizer 2013; Jacobs and Mettler 2018). Several articles in the present issue continue this effort to unpack the causal chains of health policy feedbacks.

In their article, Michael W. Sances and Joshua D. Clinton study a key link in this chain: the partisan breakdown of those who gained coverage under the ACA. Implicit in the idea of policy feedback is the notion that people who would not necessarily have supported a policy in the abstract are driven by personal experience with the actual policy to support it and perhaps defend it against retrenchment. This effect can be undermined, however, if members of the public who oppose the policy at the outset do not benefit from its enactment, either because the policy simply does not help them or because ideology and partisanship lead them to refrain from "taking up" the new benefits. In the case of the ACA, Sances and Clinton found no such pattern for the ACA's Medicaid expansion but did find that Democrats were more likely to gain insurance under the ACA's state-based marketplace for nongroup insurance. This suggests that policy feedback effects are likely to be more significant for the Medicaid expansion than

for the ACA's private insurance policies, because Medicaid expansion cuts across partisan lines to a greater degree.

Jacob Haselswerdt and Jamila Michener pose a health policy feedback question from a different angle: What happens to political engagement when health coverage is taken away? Focusing on the large-scale disenrollment from Tennessee's Medicaid program in 2005 and 2006, they found evidence that county-level drops in enrollment were associated with depressed gubernatorial turnout. This finding is especially relevant in light of ongoing efforts at the federal and state level to cut back on both Medicaid and other ACA coverage policies. If Haselswerdt and Michener's findings are generalizable, they suggest that those who lose coverage will be more likely to disengage from politics than to turn out and punish the politicians responsible.

While Medicaid seems capable of producing feedback effects both in theory and in reality (also see Haselswerdt 2017; Clinton and Sances 2018), the political effects of private insurance regulations, the other major plank of the ACA, are more ambiguous. In this special issue, Jacqueline Chattopadhyay uncovers a heretofore underappreciated reason that such provisions might fail to generate supportive constituencies: they may simply fail to convey meaningful resources to potential beneficiaries. Chattopadhyay suggests that, because such policies merely ensure that the individual receives an *offer* of coverage, and because they depend so much on other policies to actually function, they are unlikely to generate what policy feedback scholars call "resource effects." Taken together with Sances and Clinton's findings, this suggests we should not expect these regulations to be politically durable.

These questions of health and political behavior are especially important as they relate to vulnerable populations. This is particularly true than when we consider the political voice of Americans with disabilities, whose lives are profoundly shaped by politics and public policy. Sierra Powell and April A. Johnson provide much-needed analysis of the attitudes and political behavior of people with disabilities as reported in the American National Election Study. Their findings suggest a more complicated picture of this population's political engagement than one of simple disenfranchisement: people with disabilities are less likely to vote but more likely to participate in other ways. Furthermore, their low voter turnout may be driven through surprising mechanisms, such as a lack of attentiveness to political news, rather than expected channels like reduced personal efficacy.

In their article, Christopher Ojeda and Christine M. Slaughter focus on the political engagement of the largest population of Americans with

disabilities: those suffering from depression. Moving beyond the finding that depression reduces political participation (Ojeda 2015), Ojeda and Slaughter examined effects across race and gender subgroups and looked for factors that may mitigate the “depression-participation gap.” Their findings are a testament to the limits that depression places on political life: the gap persists across subgroups, and almost none of the possible mitigators (church attendance, income, health insurance) meaningfully reduce it. One exception that bears further study, however, is their finding that the presence of a coethnic candidate completely eliminated the depression-participation gap among black men in the 2008 presidential election.

David K. Jones explores the relationship between health and politics among one of the country’s most disadvantaged and vulnerable populations on both dimensions: the predominantly poor and African-American residents of the Mississippi Delta. His article is a sobering reminder that political engagement cannot solve public health problems when it is stifled by structural political limitations like those faced by the African Americans of the delta.

In studies of both health and politics, the validity and reliability of measurement are constant concerns, so it comes as no surprise that the study of health and political behavior has measurement issues of its own. Julianna Pacheco identifies an important shortcoming of self-reported health status, a popular measure of health across many fields. Using anchoring vignettes, Pacheco demonstrates that self-reported health measures “health optimism” as well as actual health and that such optimism is also correlated with voting, leading to a spurious correlation between “health” and voter turnout. Pacheco’s identification of such an important measurement problem and her presentation of a solution in the form of anchoring vignettes are evidence of progress in the study of health and politics.

While they cover diverse topics, the articles collected in this volume are unified in that they represent the maturation of the study of health and political behavior. They move beyond the simple question of whether health and health policy affect politics, searching for new observable implications and asking difficult questions about the sometimes tenuous and complex causal chains that link (or fail to link) these concepts. Another theme emerging from these articles is that the continued maturation of the field will require maturation in data and measurement—from the way surveyors identify and sample respondents with disabilities (Powell and Johnson) to the way questionnaires measure health status (Pacheco).

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