

9. Health and Disability Gaps in Political Engagement: A Short Review

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This review presents a short overview of the current state of research in the field of health, disability, and political engagement. I focus on the individual-level relationship between health and political behaviour or political attitudes. Most of the existing studies have analysed the effects of health or disability on electoral turnout, and almost all of these studies have found a negative association between poor health, disability, and turnout. The relationships between health and other forms of political participation are more complex; poor health and disability can actually promote certain types of participation (e.g., signing petitions or participation in social media). However, studies of political attitudes show that poor health and disability are connected to lower levels of trust and external political efficacy and that this disengagement may even lead, for example, to increased support for right-wing populist parties. In general, political actors and researchers need to be encouraged to implement new, more inclusive solutions to bridge the health and disability gaps in political engagement.

In this review, I present a short overview of the current state of research in the field of health and political engagement. The overall aim is to provide an easily accessible evaluation of

the main concepts and empirical contributions for readers interested in the rapidly expanding field. I focus on the individual-level relationship between health and political behaviour or attitudes, that is, on what we know about the effect that individuals' health status has on their engagement with democratic politics. Given the brevity of this review, it is impossible to do justice to all of the research in this rapidly growing field. However, I try to present a balanced view by highlighting the most important research results and developments in the field.

I start by briefly discussing the definitions of health and disability, because it is important to acknowledge the differences and similarities between these two concepts for two reasons. First, political science researchers often do not make a distinction between the two. Although health and disability are two separate concepts, they can sometimes overlap empirically. Second, if we acknowledge the similarities between these concepts, there is much that political scientists can learn from the disability studies field, particularly when it comes to policies that aim to bring the voice of these disadvantaged groups into political decision-making.

After this conceptual part, I will turn to a discussion of the existing state of knowledge in the field of health, disability, and political engagement, starting by reviewing what we know about the health implications for politics and then discussing the policy implications of this accumulated knowledge.

Health and Disability

The concepts of health and disability are related, but the exact nature and overlap between the concepts is rather difficult to

define because the nature of both is contested, with little consensus on their substance. One of the most frequent definitions of health is that provided by the World Health Organization (WHO), which defines health as ‘a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity’ [1]. But compared with health, defining disability is even harder. Depending on the approach, disability can be defined as an impairment (medical definition), a functional limitation that prevents participation in work life (administrative or legal definition), or barriers in society that restrict the lives of people with disabilities (social definition).

Turning once more to WHO, they define disability as an umbrella term incorporating three dimensions: (1) impairment, (2) activity limitation, and (3) participation restriction [2]. The first dimension refers to a problem with bodily functions or structure, whereas an activity limitation is a difficulty encountered by an individual when executing a task or action. From the perspective of democratic government, the third dimension is perhaps the most interesting. Participation restrictions are defined as problems affecting individuals’ involvement in life situations. This dimension is particularly important for political scientists, as participation in democratic politics is one of the most central subjects of study in the field.

The concepts of health and disability are thus distinct, but overlap in part. For instance, not all persons in poor health belong to the group of disabled persons, but those with chronic illnesses may fall into this category. For example, diabetes may cause blood-flow problems in feet, which may lead to amputation and permanent movement restrictions. Likewise, a person

with a disability may otherwise be in excellent health, but others may have health concerns beyond their disabilities. The essential point here is that both conditions may restrict or disable people's participation in democratic life.

For political scientists, it is possible that when they say they are analysing the relationship between health and politics, they often mean they are interested in how disabilities affect people's engagement with politics. Here, the term *disabilities* incorporates the standard definition discussed earlier but also includes chronic health problems. Short-term health problems are not, in and of themselves, challenging for democracies. If a person catches a common cold just before election day and does not vote because of this condition, it will not be a problem for democracy as long as these short-term conditions are dispersed relatively randomly in the population. However, chronic health conditions are different. They are long-lasting by definition, and we know that they are not randomly distributed among different socio-economic groups in the population. They affect less well-off people to a greater extent than other groups, and this group also often has other difficulties in their lives that affect their political participation. These kinds of health differences produce health gaps in democratic participation between those in good health and those in poor health, which in turn are likely to result in bias in policies, because the voices of all groups are not equally heard in the decision-making process [3].

Therefore, it appears that political scientists are in fact more interested in participation limitations in democratic politics brought about by long-term impairments than in the effects of health conditions. This would imply that they are interested in

not only the effects of health but also disability. Because there already exists a large body of literature studying societal participation in the field of disability studies, political scientists should certainly engage with this literature more in their own studies as the issues confronted by people with health problems are often similar to those limitations faced by people with disabilities.

Health and Disability Gaps in Politics

Health and disability gaps in politics refer to differences in political engagement between those in good health and those in poor health, or between those with disabilities and those without. The gaps may be related to participation or to differences in political attitudes, values, or identifications. Most studies have focused on different forms of political participation, and studies analysing the effects of health [4] or disability [5] on electoral turnout have been particularly popular. Almost all of these have found a negative association between health and turnout, with a scoping review of 40 studies showing that this negative relationship is robust, has electoral consequences, may shape policies, and may deepen existing health inequalities [6]. Theoretically, researchers have attributed this negative effect to a lower sense of political efficacy, lower levels of social and financial resources, or diminished social networks amongst people with poor health. However, more information is needed about condition-specific effects on turnout, because it seems that although the relationship is usually negative, some conditions increase the likelihood of turning out [7].

Poor health seems to affect voting choices as well. In terms of the traditional left-right dimension, people with poor health

or disabilities are more likely to identify themselves with the political left [8]. Most studies of actual party choices in elections have been conducted in countries using the first-past-the-post electoral system, with results from the UK showing that people in poor health in general [9] or people with depression [10] are more likely to favour Labour over the Conservatives, and in the United States, results show that the Republicans are similarly favoured by those in good health [11]. However, more recent studies of European multiparty systems indicate that poor health is associated with a higher likelihood of voting for right-wing populist parties [12]. Finally, there are also some results indicating that mental health issues may affect voting choices in referendums as well, as was the case with the Brexit referendum [13].

Regarding forms of political participation other than voting, the results are more varied and depend on the context, type of illness, and participation form. The pioneering study by Söderlund and Rapeli found that among Nordic citizens, poor health can actually motivate people to participate [14]. Poor health can intensify the importance of politics for individuals because welfare policies, particularly those related to healthcare services and transfers, become more important for people with health problems. Similar results were subsequently found in a wider European comparison and also in other contexts [15]. For instance, contacting politicians, signing petitions or initiatives, being politically active in social media, and boycotting certain products were found to be typical forms of participation in which people with poor health were more active than those in good health.

Interest in politics is a key indicator of citizens' attitudes towards politics. Interest is usually quite a stable trait that is developed in adolescence and is generally relatively consistent over the individual's life course. Findings relating to the correlation between health and interest are somewhat mixed. Analyses with cross-sectional data have shown that depression and disabilities are associated with lower levels of interest in politics [16], but a longitudinal study of the effects of general health on interest levels found evidence of a relatively weak connection [17].

One of the main attitudes promoting political participation is political efficacy, which is typically broken down by political scientists into two subcomponents. The first, internal political efficacy, refers to individuals' evaluation of their own competence in terms of understanding and analysing politics. The second, external efficacy, refers to beliefs that politicians and the political system in general are responsive to demands from citizens. For those with high political participation, this engagement is typically preceded by the belief that one is capable of acting politically (internal efficacy) and that it is possible to make a difference through one's actions (external efficacy). Available results on how health is related to political efficacy vary. In one study, data collected from Finland showed that poor health was associated with lower levels of external efficacy but was unrelated to internal efficacy [18]. However, a later European-wide study suggested that in addition to external efficacy, low internal political efficacy is also related to people's poor health status [19]. Disability is also linked with lower levels of both types of efficacy, although the gap in internal efficacy disappears after controlling for education and certain other socioeconomic factors [20].

Another important predictor of political participation is political trust. Data on how health is related to trust show stronger patterns than results concerning efficacy. People in poor health have lower levels of trust in policy-makers and in the functioning of the political system [21]. However, the effects of low levels of trust on actual political participation are not necessarily obvious. Research from Finland shows that poor health leads to lower levels of trust, which in turn depresses traditional forms of participation (such as voting), but that it has the opposite the effect on non-institutional participation. Health problems in combination with low levels of trust motivate people to engage in participatory forms that bypass traditional party-based institutions (e.g., demonstrating, boycotting products and political participation in social media) [22]. This poor-health-related disengagement from traditional forms of participation may also be related to the observation that when people become ill, their identification with political parties also decreases [23].

To sum up, we know quite a lot about how health or disability affects political engagement in general. Poor health or disabilities affect both the amount of participation and the way people participate. They depress traditional partybased participation (such as turnout) and are linked to disappointment with the political system (low levels of trust and external efficacy). In contrast, this disappointment also encourages certain types of political activities. Poor health often motivates people to engage in actions that are directly relevant to their needs, such as participating in demonstrations related to insufficient public health care policies, or contacting politicians to try to affect decisions that go to local level health services. Hence, it is difficult to say

whether poor health or disabilities reduce participation in general (except in self-evident cases of extreme impairments), but it certainly transforms the way people participate in politics.

Obviously, there are still several important topics not covered by the existing research. First, the literature does not inform us enough on the relative importance of health problems in comparison to the main indicators of individuals' socioeconomic status. For instance, questions such as 'How significant is the effect of poor health or disabilities on political engagement when compared to low income, unemployment or low education?' have not yet been sufficiently answered. Furthermore, we do not know if and how health problems interact with socioeconomic status or life habits, although there are some results indicating that the health effect is independent of persons' social class [24].

Second, we do not know enough of the potential context specificity of the health gaps. It is probable that the effects of health are heterogeneous; that is, they vary in different cultures and political systems, or amongst different groups of people. Few studies have looked comparatively at health or disability gaps in different welfare state regimes. The hypothesis that differences between health groups should be smaller in societies where public healthcare services (combined with extensive social support networks) are widely available makes sense. Nevertheless, available analyses only partially support this idea. Comparisons of health gaps in trust and political efficacy show that both political trust and political efficacy are higher in more encompassing European welfare states, but the differences between those in good and poor health are also largest in these strong welfare states [25]. One explanation for this observation could be the

‘Nordic paradox’, which suggests that the Nordic welfare model has been unsuccessful in reducing health inequalities between socioeconomic groups, and that these inequalities ‘spill over’ to affect the health-political engagement relationship as well [26].

Implications for Policies

What are the policy implications of these results? What can be done to reduce the health and disability gaps? An obvious solution would be to reduce health inequalities, although this is something that should be done regardless of gaps in political engagement between those who are healthy and those who are not. However, as the results from the Nordic countries show, this is not a straightforward task because policies aimed at promoting general levels of health in the population do not necessarily diminish political engagement gaps between health groups. Thus, we need to focus both on general levels of political activity (which are only partly related to health differences) and the between-group differences.

One way to help the situation is by promoting awareness of health gaps in political engagement, and especially by emphasising how the subdued voice of people with poor health may bias decision-making in favour of those in good health. This effort should entail increased cooperation with various health and disability advocacy groups and organisations. Public advocacy work would also benefit from more research on the matter. Currently, the biggest obstacle for high-quality research into health gaps is the lack of suitable data. To uncover the often complex and intermingled mechanisms between health issues, socioeconomic status, and political engagement, better data are needed. In practice,

this kind of analysis requires longitudinal panel data that track people's situation in terms of health and political engagement over several years or even decades. Unfortunately, existing panel data projects are not very suitable for these purposes. There are some excellent survey panel projects that include good measures of health, but these only consider a very limited range of indicators of political engagement (e.g., the UK Household Longitudinal Study). Political panel survey projects have also provided good data following changes in political engagement, but typically they do not include good measures of health or disability (if any at all). Suitable data would also encourage researchers to apply rigorous research designs to unravel the causal effects that health and disabilities have on political engagement. Currently, too much of the research is based on designs, methods, or data that can only reveal correlations without really being able to test the causal mechanisms connecting health to political engagement.

Building new or modifying existing social institutions to increase the voice of those with health issues could also alleviate the situation. Nowadays, for example, countries such as Finland require that all municipalities have compulsory disability councils, which should be consulted in all matters that could have consequences for the situation of people with disabilities. Often, however, the influence of these kinds of mandatory bodies is limited, and more research is needed into how these kinds of institutional setups can actually have a greater influence on political decision-making. Furthermore, as recent developments in party research have emphasised the importance of intraparty democracy and inclusiveness [27], a way to strengthen the voice of disadvantaged health groups could be to build similar 'councils'

within parties that are ultimately responsible for political decisions affecting the lives of people with health issues.

Equality in elections is considered to be one of the cornerstones of democracy, so special attention needs to be given to inclusive voting practices [28]. Hence, it is not a surprise that voting accessibility has been on the agenda in many countries. Voting has been made easier with various facilitation arrangements put in place, such as advance voting, e-voting, postal voting, or proxy voting, but the results – in terms of encouraging turnout – vary and are not always as helpful as expected. Comparative results from Europe indicate that health gaps are not smaller in countries which have these kinds of voter facilitation practices; in fact, the situation seems to be quite the reverse [29]. The reason for this may be that when new measures are not directly targeted specifically at people with poor health (such as advance voting), these measures may motivate other voter groups even more than those with health issues. It is also possible that countries have begun to implement voter facilitation instruments because of concern over existing health gaps. There is also contrary evidence relating to useful reforms, which has helped to close the turnout gap, at least to some extent. In the US context, allowing voting by mail has increased the turnout among people with disabilities [30]. Furthermore, providing more polling stations closer to where people live might help, because increasing physical distance from polling stations decreases the likelihood of voting among people in poor health [31].

Conclusion

In conclusion, although health and disability gaps do not exist in all areas of political engagement, they do so in many areas, and

it is a matter of concern that such a situation can lead to partial political disempowerment of people in poor health and people with disabilities. Overall, the results point to increased political disengagement and disappointment with politics amongst people with poor health, as well as to an increased willingness to engage in political protest behaviour and participate in politics in ways that bypass the traditional party-based system. Hence, measures attempting to bridge turnout gaps between health groups are particularly important. However, focusing on turnout alone will not ensure that the voice of these disadvantaged groups is heard in political decision-making. More efforts to raise awareness are required, along with research on this topic and a focus on building accessible public institutions, in order to achieve more inclusive democracy.

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