

A Prescription for a Healthier Democracy: The Role of Health Care in Civic Participation

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Picture a woman waiting for her regular exam at the doctor's office. The doctor walks in and begins to ask familiar questions: "How's your family? Any recent illnesses? How's that new medicine working for you? Are you registered to vote? Did you have any questions about the voter education and registration materials in the waiting room?"

She soon receives a "civic health house call," in which a local doctor calls to inform her about an upcoming community forum on health, hosted at a local clinic, and to remind her of the importance of voting. On Election Day, she and her husband (they both used to be among the millions of infrequent voters in America) cast their votes at her local health center, a registered polling place. She sees her doctor, once himself an infrequent voter, standing in line, ready to vote.

This was the picture envisioned in 2008 when the National Physicians Alliance convened ten health care organizations in coalition under the banner of the nonpartisan Rx: Vote Campaign. The goal was to register voters in clinics and community health centers nationwide. Some participating groups already had existing programs, while

other health professional groups were newcomers to voter registration. Collectively, we registered more than twenty-six thousand voters and demonstrated that health care providers can be a resource for advancing greater civic participation. In this article, we describe the rationale behind the Rx: Vote Campaign, explore the broader implications of this effort, and outline opportunities for greater collaboration among civic engagement advocates, health care providers, and researchers.

Civic Engagement and Health Are Interrelated

"Health...is essential to...[the] ability to participate fully in a democratic society," according to the U.S. Department of Health and Human Services (2008, p. 73). In addition, the U.S. Department of Health and Human Services asserts that health is a resource for full democratic participation and that "the resources needed for health should be distributed fairly." Consider the related proposition that greater civic participation itself can improve an individual's health; as a means of increasing the fairness of resource distribution and social determinants of health, civic participation can help improve the health of a community. Conversely, our

nation's health disparities echo disparities in civic participation. Is it possible that the two are mutually reinforcing components of a vicious unhealthy cycle?

Civic Disparities

According to the U.S. Census Bureau's Current Population Survey, more than 59 million eligible Americans did not register to vote in 2008. An additional 15,167,000 Americans who did register to vote in 2008 did not actually vote. Studies such as the California Voter Participation Survey demonstrate that nonvoters are disproportionately less educated, single, young, minorities, and low-income compared to frequent voters. In the last three national elections, for example, Americans earning less than \$15,000 annually voted, on average, 54 percent as often as Americans with an annual income above \$75,000. Uninsured eligible voters also tend to vote significantly less often than Americans with health insurance. These disparities (and low voter turnout in general) are even more pronounced in off-year elections for state legislators and local officials. Not surprisingly, low turnout and voting disparities across the socioeconomic gradient contribute to inequity in the design of social policy. FairVote (n.d.)

reported that legislators in the 107th and 108th Congresses were, on average, three times more responsive to high-income constituents than middle-income constituents and were the least responsive to the needs of low-income constituents.

Although electoral participation is critical to the health of democratic governance, voting disparities reflect just one of the gaps in the civic engagement of Americans. Sidney Verba, Kay Lehman Schlozman, and Henry Brady (1995) found, for example, that people with low income and educational attainment are three times less likely to communicate with government officials than are higher-income Americans. Low-income families are up to six times less politically active than higher-income families. Political efficacy appears to vary by income, reports Meira Levinson (2007), and citizens with higher income have more faith than low-wage earners in their ability to influence government. Political efficacy also varies by race, with whites enjoying greater political efficacy than African Americans and Latinos.

Health Disparities

The same groups that are historically underrepresented in civic life also bear an unequal burden of disease. Life expectancy is shorter for minorities and for individuals with lower income and lower educational level. Shorter life expectancy, in turn, reflects disparities in vir-

tually every aspect of health, from access to preventive services and primary care to the quality of care received for diabetes, HIV, other diseases, and cardiovascular surgery. Public health and health service researchers have generated a vast body of knowledge that helps to characterize these health disparities, their causes, and their profound societal impact. In their report, commissioned by the Joint Center for Political and Economic Studies, Thomas LaVeist and coauthors recently (2009) estimated that the combined costs of health inequality and premature death in the United States between 2003 and 2006 were \$1.24 trillion. Policymakers, in turn, are now giving welcome (though still insufficient) attention to health disparities. In June 2009, the U.S. Department of Health and Human Services issued a report titled “Health Disparities: A Case for Closing the Gap.” America’s health disparities, in essence, mirror the civic disparities that plague the nation.

The emergence of a new framework that examines the social determinants of health has led to widespread awareness in the public health community that disparities are the result of unhealthy living and working conditions, unhealthy behaviors, and limited access to quality health care, including routine primary care and prevention. Less well understood, however, is the extent to which lack of power and political efficacy are,

in and of themselves, determinants of poor health outcomes and health disparities. Some researchers, including Richard Hofrichter and colleagues at the National Association of County and City Health Officials, have recognized this link. In *Health and Social Justice*, Hofrichter describes how sustained disinvestment in poor communities as well as gradual weakening of social and safety net services and regulatory structures have contributed to health disparities. To address the disparity, Hofrichter calls on the public health community to “shift resources and power toward disadvantaged social populations” (2003, p. 35). Implicit in this analysis is the proposition that lack of political voice or power among disadvantaged populations contributes to health disparity.

This view has not yet spread among health care practitioners. As Robert Lawrence at the Johns Hopkins School of Public Health notes, some contend that the health care community’s analysis of health disparities “has itself become a victim of the biomedical model, thus obscuring the underlying hegemonic influences of wealth and power” (2005, p. 399).

Since lack of “political voice” reflected in civic participation disparities appears to contribute to a disproportionate burden of illness in society, it is possible that health disparities, in turn, drive a widening gap in civic participation.

The U.S. Census Bureau found that in 2008, for instance, illness or disability prevented one in five low-income eligible voters from registering to vote, compared to one in twenty higher-income eligible voters. All combined, nearly 2.3 million registered voters did not vote in 2008 owing to illness or disability. Because low-income Americans tend to suffer a disproportionate burden of illness, a reasonable hypothesis is that health inequity itself hinders electoral participation among marginalized populations and is a barrier to democratic governance. As Larry Marx noted in *American Prospect*, “Data shows that increasing inequality of wealth, education, and access to health care reduces democratic participation and in turn leads us to feel that we have no power to influence the decisions affecting our quality of life” (2008; emphasis added).

Several structural barriers, including scheduling elections during the workweek, hinder participation for many eligible voters, particularly those from underrepresented communities. Studies cited in the report of the California Voter Participation Study suggest that one in four of these eligible voters fail to vote or register to vote because of a busy or conflicting schedule. Low voter motivation also appears to play a key role; the U.S. Census Bureau found that two million registered voters did not vote in 2008 for lack of interest. Voter

motivation appears to be related to lack of accessible information and perceived self-efficacy. According to Susan Clark (n.d.), who led the community-driven design process that produced California’s Easy Voter Guide, this lack of efficacy leads to “performance anxiety” among many would-be voters.

Health Care as a Civic Institution

Health care is one of the largest of America’s social enterprises and serves as a critical point of entry into society for millions, particularly for our most marginalized and sickest neighbors. Yet the health care system has never been an integral part of the civic engagement movement. Although there are several reasons for this distance, S. Brint and C. S. Levy (1999) suggested that one significant factor may be the historic trend in twentieth-century medicine toward specialization, emphasis on professional achievement, and internal affairs rather than a biosocial and collaborative approach to health. Tom Wolff’s description in the *National Civic Review* of the experience of the Healthy Communities movement reflects this tension between civic engagement and health care advocates:

[The term] healthy is often associated with health care and the disease treatment industry, which narrows associations to the term significantly. For community groups working from a civic engagement, or a community

organizing, approach, the term had more drawbacks than advantages. For those working from within the health care system (hospitals and the like), the term was often deemed license to take over leadership [2003, p. 103].

A poor civic engagement rate among health care workers is a symptom of health care’s civic isolation. One study of voting habits by University of Pennsylvania researchers David Grande, David Asch, and Katrina Armstrong (2007) found that physicians, on average, voted 9 percent less often than the general public and 22 percent less often than lawyers. Perhaps in response to this level of civic disengagement and the public’s eroding trust in the medical profession, several medical organizations, notably the American Medical Association and the American Board of Internal Medicine, recently began describing civic engagement as an important aspect of medical professionalism. Still, there are few models on incorporating civic participation within the health professions at all stages of training and practice. To date, most civic engagement for physicians-in-training overemphasizes professional *advocacy for patients* rather than *civic engagement with patients*.

Civic Engagement as a Health Intervention

For health care providers and advocates, the proposition that civic

participation itself may contribute to improved health is new and intriguing. Most of the research that suggests a causative link between civic participation and health illustrates a common interest in the concept of efficacy, whether at the personal or the community level. At the patient level, medical research published by M. Brekke (2001), J. A. Turner (2005), D. K. King (2010), and L. M. Alvy (2010) and their coauthors indicates that self-efficacy—generally defined as a patient’s perceived sense of being able to influence his or her own life, is linked to better health outcomes in patients with rheumatoid arthritis, diabetes, HIV, and other chronic diseases. At the community level, Nina Wallerstein (2006) and other researchers have chronicled community empowerment strategies that are associated with improvement in health. In Detroit, for example, civic factors, among them level of community participation and perceived neighborhood control, were associated with improved self-reported health and depressive symptoms among residents of one community. In Indonesia, greater participation in one community was linked to a higher childhood immunization rate compared to less participatory areas. In Norway, civic participation was associated with reduced cardiovascular risk factors. More research is required to explore the rich, relatively uncharted territory of the relationships between civic engagement and health outcomes. Engage-

ment of the public, civic practitioners, and health care providers could help to identify and develop key research questions. Increased political efficacy of communities and individuals, greater equity of resource distribution, development and application of social capital, and increased participation in healthy activities may all be possible means by which well-developed civic engagement efforts lead to improved health outcomes.

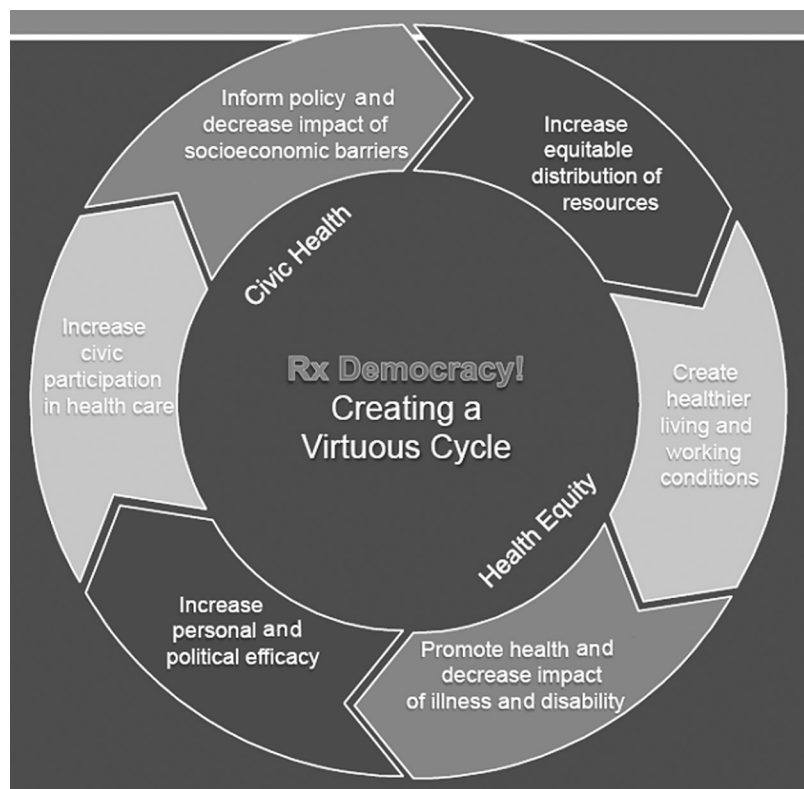
Opportunities

Recall the picture at the beginning of this article, of the woman at her doctor’s office registering to vote. Fast-forward to a few years later. Her daughter has started medical school, where she is developing

skills to promote civic agency and self-efficacy as means of improving patient health. Soon thereafter, alongside thousands of health professionals and advocates for health equity and civic participation, she joins a transformed health care system that helps to usher millions of traditionally underrepresented and infrequent voters into democratic governance. She reads articles in medical, public health, and political science journals that are contributing to a new and influential dialogue about civics and health.

This is the future envisioned by Rx: Democracy, a coalition built on the inaugural Rx: Vote Campaign to transform the health care system and the civic participation

Figure 1. Creating a Virtuous Cycle



movement by uniting them in common pursuit of improving civic and physical health. Although this is relatively uncharted territory for many in health care, a historic number of providers have expressed strong interest in turning the vicious cycle of health inequity and civic disparity into a virtuous cycle by joining with and learning from the civic engagement community (see Figure 1).

Rx: Democracy doesn't only aim to inspire doctors and clinics to offer voter registration services. To examine and amplify the benefits of civic participation, a growing number of health care providers are advancing the idea that the health care system can and should be a resource for civic participation. Through nonpartisan advocacy, increased research, demonstration projects, and education campaigns, the health care community can help define the benefits of civic participation to the medical profession and help patients become active participants in civic life.

Robert Putnam once described voting abstention as "a sign of deeper trouble in the body politic than as a malady itself" (2000, p. 35). It is time we combine the unique strengths of the health care system and the civic participation movement to transform our approach to the most pressing challenges to our health and our democracy.

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