


Incorporating Health into Studies of Political Behavior: Evidence for Turnout and Partisanship

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Abstract

We argue that research on political behavior, including political participation, public opinion, policy responsiveness, and political inequality will be strengthened by studying the role of health. We then provide evidence that self-rated health status (SRHS) is associated with voter turnout and partisanship. Using the National Longitudinal Study of Adolescent Health (Add Health) and General Social Survey (GSS), we find that people who report excellent health are more likely to vote and more likely to identify with the Republican Party. Moreover, the effects of health on voter turnout and partisanship appear to have both developmental and contemporaneous components. Taken together, our findings suggest that *health inequalities* may have significant *political consequences*.

Keywords

health, political participation, partisanship, health inequalities

Health is a vital component of the human experience that affects nearly every aspect of our lives and the lives of those around us. While scholars recognize that “health and illness shape who we are politically” (Carpenter 2012, 303), health is often viewed by political scientists as “outputs” of policy, for instance, the financing and delivery of health care, instead of a dimension of social inequality that potentially has broad political consequences. Compared with the unhealthy, if healthy people are more likely to turn out and have systematically different policy preferences or predispositions, as we suggest, then electoral results and the policies that are enacted may have a “health bias.” This suggests a feedback cycle linking population health to politics: increasing health disparities may produce increasing inequalities in policy representation, which in turn produces policies that may be detrimental to the unhealthy, which in turn creates even greater health disparities, and so on.

While the political implications of population health disparities are potentially vast, systematic comparative research on the impact of health on political behavior is in its infancy (but, see Mattila et al. 2013). Theorizing about how health is related to political behavior is a formidable task as it requires integrating literatures from political science, sociology, psychology, health economics, the history of medicine, and public health to generate new theories that link health conditions and risk behaviors to political outcomes. Empirically testing hypotheses also

requires innovative research designs as existing surveys (e.g., the National Election Survey or the Behavioral Risk Factor Surveillance Survey) often do not have extensive measures on health outcomes *and* political activity or policy preferences.

Nonetheless, we argue that our understanding about health and political behavior will be strengthened by thinking about health in more comprehensive ways. Previous research focuses almost exclusively on physical ailments and disability. Schur and colleagues, for instance, find that individuals with disabilities are less likely to register and vote (Schur and Kruse 2000; ; Schur et al. 2002), tend to identify with the Democratic Party, and favor a greater government role in health care (Schur and Adya 2013). Physical disability discourages voting among habitual voters much like unemployment prior to an election (Rosenstone 1982). Hence, focusing on physical disability tells us little about how health influences the development of civic minded, politically active adults or how it contributes to a cycle of political inequality that persists across generations.

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We argue that measures of self-rated health (SRHS) are more useful to understanding political inequality than physical disability. Using the National Longitudinal Study of Adolescent Health (Add Health) and the General Social Survey (GSS), we find that people who report excellent health are more likely to vote and more likely to identify with the Republican Party. More specifically, our models estimate that adolescents who report being in excellent health have a probability of turning out five years later that is 7 percentage points higher than adolescents who report being in poor health. These same adolescents are also 4 percentage points more likely to identify with the Republican Party in young adulthood. We also find that health influences turnout and party identification among adults with suggestive evidence that the effect of health on turnout increases with age. Taken together, our results suggest that health disparities may have significant political consequences.

We stress, however, that the relationships we uncover in this article are intended to shed light on puzzles of causation for future research, instead of telling a convincing causal story. We provide additional ideas for further research in the conclusion.

Using Self-Rated Health Status to Measure Health

Generalized health is an enduring self-concept of well-being (Boardman 2006), which is measured using a self-rated health status (SRHS) question asking respondents “In general, how is your health?” with five (or four) allowable responses of excellent, very good, good, fair, and poor. Empirically, SRHS is highly correlated with medically determined health conditions, such as coronary heart disease, cancer, and physical functioning (Bjorner, Fayers, and Idler 2005) as well as health service use (Angel and Gronfein 1988). There is also evidence that self-reported poor health is a *better* predictor of subsequent mortality than objectively determined health status (Jylhä 2009). Thus, many claim that “an individual’s health status cannot be assessed without” SRHS and that this single item captures “an irreplaceable dimension of health status” (Idler and Benyamini 1997, 34).

We believe that SRHS is more relevant to a range of political processes and is better suited to explore the developmental effects of health on political behavior than specific health conditions capturing physical disability. Unlike many physical and mental limitations that develop in old age, SRHS originates in early childhood (Palloni 2005) and is transmitted across generations (National Research Council 2000) lending itself to studying the cycle of political inequality that persists across generations due to

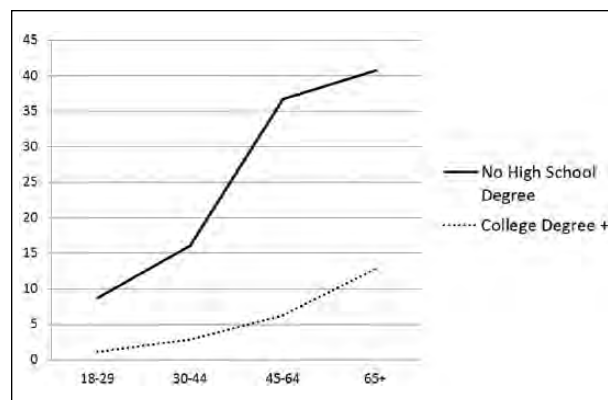


Figure 1. Percentage with poor or fair self-rated health, by education and age, NHIS 2011.

NHIS = National Health Interview Survey.

genetic, environmental, and societal factors. As important, SRHS is highly correlated with macrosocial forces, such as socioeconomic status (SES), poverty, race, family structure, and neighborhood characteristics (Palloni 2005) that likely matter for political behavior and public opinion. Much of the public health literature has worked to understand and explain the link between health and SES, also known as the “health gradient” (e.g., Lantz et al. 1998). Figure 1 shows an example of the health gradient by plotting the percentage of individuals with poor or fair SRHS across age and educational attainment using the 2011 National Health Interview Survey.¹

As shown in Figure 1, health disparities across educational attainment exist in young adulthood and widen across the life course so that at age sixty-five plus those without a high school degree are about three times as likely to report being in poor or fair health compared with those with a college degree or higher (see also Palloni 2005).²

The fact that SRHS originates in childhood, is transmitted across generations, and is socially patterned suggests that adolescent SRHS is an important preadult factor that affects the *development* of behavior, such as voter turnout (Plutzer 2002), and political predispositions, such as party identification (Jennings and Niemi 1991), that persist across the life span. As we show below, SRHS is also useful to explore changes in political behavior as people age as it is related to health trajectories across the life span (Ferraro 2006). SRHS, thus, informs conventional life course research that considers the distinctive relationship between age, political behavior, and public opinion (e.g., Milbrath 1965).

Using SRHS to measure health has a number of practical benefits as well. Objective measures of health, such as the presence of a disease, or register-based reports, such as days spent in the hospital, are often not readily available

for respondents who are also asked about political outcomes. Related, data limitations and power issues prevent scholars from obtaining enough respondents with specific health conditions in their surveys; for example, large sample sizes are needed to explore the effects of say, asthma, which inflicts roughly 8 percent of the population (Centers for Disease Control) on political behavior. Objective indicators of health also tend to differentiate individuals at the extremes of the health distribution and provide conclusions about how “bad health” affects outcomes. SRHS has more variance and offers inferences about how being in “good health” is related to political behavior. Finally, while objective measures are heralded for their reliability, there is evidence that even objective, self-reported indicators of health are subject to response error that may result in attenuation biases (Baker, Stabile, and Deri 2003).

At the same time that SRHS has both theoretical and empirical benefits, using SRHS to measure health has two specific drawbacks. First, there is evidence that the correlation between SRHS and objective measures of health varies by SES (Dowd and Zajacova 2010) and age (Groot 2000) suggesting that what it means to be in poor health varies across groups. In other words, the subjectivity inherent in the response categories to the SRHS question makes comparisons across individuals difficult. Unlike objective indicators of health, such as weight or height, SRHS has no single, commonly used metric. Hence, if one group of respondents reports higher levels of SRHS than another, it is impossible to know if the true level of health is actually higher or if one group interpreted the question differently (see, for example, Hopkins and King 2010). The measurement error that results from the lack of comparability across individuals likely leads to an underestimation of the effect of health on political behavior.

The second disadvantage to using SRHS is that responses about health may not be independent of the outcomes we wish to use them to explain. Poor health may be one of the few “legitimate” reasons for eligible citizens to decide not to vote; individuals not voting may try to rationalize their behavior by mentioning health limitations. In the case of partisanship, party identification may be predictive of self-reported health. The endogeneity of SRHS is likely to lead to an overestimation of the effect of health on political behavior. We mitigate this problem by using responses to the SRHS question in adolescence to predict turnout and partisanship *five years later*. Finally, there is evidence that the biases in estimates that use SRHS tend to cancel out as the biases that result from measurement error and endogeneity are in opposite directions (Bound 1989). As we show below, our results suggest that SRHS has a meaningful effect on political behavior, even with these disadvantages. We note ways to improve the measurement of SRHS for future work in the discussion.

Conceptually Linking SRHS to Turnout

Political scientists have long viewed voting as a habit that develops over the life course (Milbrath 1965; Miller and Shanks 1996; Plutzer 2002), thus acknowledging the pervasive relationship between age and voter turnout. The typical pattern is a curvilinear one: turnout increases steeply until young adulthood and gradually increases from then on until voters reach their sixties, whereby turnout decreases (Milbrath 1965). This life cycle pattern suggests that the influence of health on turnout likely has both developmental and contemporaneous factors.

Developmental Components

Factors that originate in adolescence often affect turnout by enabling citizens to overcome the high costs of first-time voting, which in turn influences the development of voting as a habit (Plutzer 2002). As Plutzer (2002) explains, young citizens must decide whether to vote in their first eligible election; this decision is determined in large part from parental, demographic, and personal factors that occur in adolescence. Those who vote likely become habitual voters quickly after their first election, while those who do not vote are likely to remain nonvoters in subsequent elections. Once nonvoters make the transition to habitual voters, factors that determined their initial starting values are less important.

Given that SRHS is highly correlated with parental health, SRHS may be an important preadult force that affects trajectories of participation that persist across the life span. At the same time, however, SRHS may simply be part of the individual political disadvantage that parents transmit through education and income (Verba, Schlozman, and Brady 1995) given its relationship with SES. For instance, health may be related to politically relevant resources simply because of SES. In our analyses below, we find that while SES remains an important determinant of voting, poor SRHS is associated with low turnout among youths and this effect is statistically significant after controlling for SES. This suggests that while wealth and health are highly correlated, they are independent preadult factors that contribute to the cycle of political inequality that persists across generations.

Contemporaneous Components

While turnout in one’s first few elections is heavily influenced by preadult factors, turnout in adulthood and beyond is driven by factors that affect the politically relevant resources needed for participation. As citizens age, health may directly affect these resources. It takes time to manage

failing health that is inevitable with aging, time that may alternatively be used to learn about political affairs. Similarly, being ill constitutes the kind of major life event that may discourage political participation by directing attention to personal matters and away from political ones (Stoker and Jennings 1995).³ The financial burdens of poor health, such as medical expenses to cover doctor visits, medication, and treatments, as well as the temporary or permanent loss of employment that typically accompanies poor health (e.g., Havemen et al. 1994), decreases the probability of campaign contributions and, therefore, the chances of being contacted by campaign organizations. Finally, health conditions that develop in old age, such as dementia (Irastorza, Corujo, and Bañuelos 2011), impair cognitive abilities and executive functioning that likely affects the civic skills required for participation.

Thus, our expectations are that SRHS is an important preadult factor that impacts youth voter turnout, but that also differentiates habitual voters across the life cycle and, particularly, in old age. Empirically, we expect for adolescents that report being in excellent health to be more likely to turnout in young adulthood compared with adolescents with poor reported health. We also expect for adults with excellent rated health to be more likely to turn out compared with those in poor health, but that the effect of health on turnout increases with age.

Data and Method

We use two datasets to explore the role of SRHS on turnout across the life span including the National Longitudinal Study of Adolescent Health (Add Health) and the General Social Survey (GSS).

The National Longitudinal Study of Adolescent Health (ADD Health)

The National Longitudinal Study of Adolescent Health (Add Health) is a longitudinal study of a nationally representative sample of seventh- to twelfth-grade students surveyed in 1994–1995 (W1) with follow-up surveys conducted in 1996 (W2), 2001/2002 (W3), and 2007/2008 (W4). Add Health asks numerous questions to respondents and parents regarding a number of topics including health-related behaviors, attitudes, relationships, civic activities, and political participation. We use data from W1 and W3 as the voter turnout measure is only available for W3. For descriptive statistics on all variables, see Table A1 in the online appendix (<http://prq.sagepub.com/supplemental/>).

Measures

The dependent variable is voter turnout in the 2000 presidential election asked in W3. Forty-three percent of the

sample reported voting in the 2000 election. We measure health using a SRHS question with five allowable responses of excellent (32% W3, 28% W1), very good (41% W3, 40% W1), good (22% W3, 25% W1), fair (4% W3, 6% W1), and poor (<1% in W3 and W1). We code SRHS so that higher values represent better health. As health may have both developmental and contemporaneous effects, we measure SRHS in W1 and W3. SRHS in W1 is our measure of adolescent health and captures the developmental effect of health, while the SRHS in W3 measures the contemporaneous effect health.⁴

We control for other variables that affect youth voter turnout including respondent gender (1 = *female*), race (black, Hispanic, and other; white is omitted), income at W3, employment at W3, age at W3, education at W3 (no high school degree is omitted), and religious attendance (Plutzer 2002). We also include a dummy variable to indicate whether the respondent had missing family data. Finally, to account for the role that the home environment has on later political participation (Plutzer 2002), we include maternal educational attainment (no high school degree is omitted)⁵ and family income at W1.⁶

The General Social Survey

To analyze the relationship between health and turnout among the general population, we use the GSS. The GSS conducted twenty-four nationally representative surveys between 1972 and 2010 that included both the turnout and health measures.⁷ Descriptive information on all variables is included in Table A1 in the online appendix.

Measures

The dependent variable is a measure of voter turnout in the *most recent* presidential election. In our sample, 63 percent reported voting in the most recent election.⁸ Health is measured using SRHS with answers including excellent (32%), good (46%), fair (18%), or poor (5%). We code health linearly with higher values indicating better health.⁹ There is a slight correlation between self-rated health and age ($r = -.26$), with 13 percent of those in poor health being sixty-five years of age or older.

We include other covariates in the analyses that are important for voter turnout. We include indicator variables of the highest degree earned, with no high school degree as the omitted category and the general expectation that highly educated people are more likely to participate (Verba, Schlozman, and Brady 1995). Race is included as indicator variables (white, black, and other) with the white category omitted. An indicator variable is included for gender (1 = *female*) as well as marital status (1 = *married*) as married persons are more likely to turn out (Stoker and Jennings 1995). We include age

Table 1. Logistic Regression Predicting Turnout in Presidential Elections with SRHS, Using the GSS and Add Health.

Add health (N = 12,540)			GSS (N = 19,807)		
		Δ probability min to max			Δ probability min to max
SRHS (W1)	0.07 * (.04)	7%	SRHS	0.17 *** (.03)	12%
SRHS (W3)	0.10 *** (.03)	9%			
Age (W3)	0.08 *** (.02)	20%	Age (centered at 46)	0.04 *** (.002)	54%
High school grad (W3)	0.49 *** (.09)	12%	High school degree	0.96 *** (.07)	21%
			Some college	1.35 *** (.18)	22%
College grad (W3)	1.20 *** (.09)	28%	College degree or higher	1.91 *** (.09)	32%
Black	0.49 * (.15)	12%	Black	-0.28 * (.09)	-6%
Other	-0.72 *** (.13)	-16%	Other	-0.104 *** (.13)	-25%
Female	-0.05 (.05)		Female	0.03 (.05)	
Hispanic	-0.36 * (.13)	-9%			
Employment (W3)	0.03 (.05)				
Income (W3)	0.00002 (.000002)				
Family income (W1)	0.004 *** (.001)	58%	Strong partisan	0.92 *** (.08)	18%
Mom high school grad	0.150 * (.08)	4%	Newspaper readership	0.19 *** (.02)	17%
Mom college grad	0.41 *** (.09)	10%	Married	0.44 * (.05)	10%
			Religious attendance	0.10 *** (.01)	17%
Religious attendance (W3)	0.14 *** (.02)	20%	Year	-0.03 *** (.01)	-14%
			Year squared	0.001 *** (.0010)	13%
Missing family information	-0.13 * (.06)	-3%			
Constant	-04.27 *** (.47)		Constant	-01.75 *** (.13)	

Standard errors in parentheses. Age is mean centered. Weights are used to account for the complex survey design. Robust standard errors are reported for analyses using Add Health. SRHS = self-rated health status; GSS = General Social Survey.

* $p < .1$. ** $p < .05$. *** $p < .01$ with a two-tailed test.

centered at the mean (forty-six years of age) to ease statistical interpretation. We also include partisan strength (1 = *strong partisan*, 0 *otherwise*), religious attendance (0 = *never*, 1 = *less than once a year*, 2 = *once a year*, 3 = *several times a year*, 4 = *once a month*, 5 = *2 to 3 times a month*, 6 = *nearly every week*, 7 = *every week*, and 8 = *more than once a week*), and newspaper readership (0 = *never*, 1 = *less than once a week*, 2 = *once a week*, 3 = *few times a week*, 4 = *everyday*); all of these things are positively related to voter turnout (Verba, Schlozman, and Brady 1995). Finally, to account for temporal trends in voter turnout, we include year and year squared.

Analytical Approach

We estimate turnout using logistic regression as the dependent variable is binary. For Add Health, robust standard errors, clustered by state, are included to correct for non-independence across observations within states and estimates are weighted to account for the complex survey design. For the GSS, we used weights to account for

household size and the oversampling of African Americans (Marsden 2012). In models not shown, results for both datasets are nearly identical when we code SRHS categorically instead of linearly. For the GSS, results are robust to the inclusion of a fuller set of controls (see Table A2) as well as when full scales are used to measure education and strength of partisanship instead of binary indicators. Results are also nearly identical when including questions that ask respondents about civic engagement, although these are only asked in select years. We report the estimated changes in the predicted probabilities when the variable changes from its minimum to maximum value, keeping all other variables constant at the mean.

The Effect of SRHS on Turnout

As shown in Table 1 using Add Health, both adolescent and contemporaneous SRHS are positively associated with youth voter turnout. Keeping all other variables constant, the model estimates that an adolescent who is in excellent health has a probability of turning out five years later that is 7 percentage points higher than an adolescent

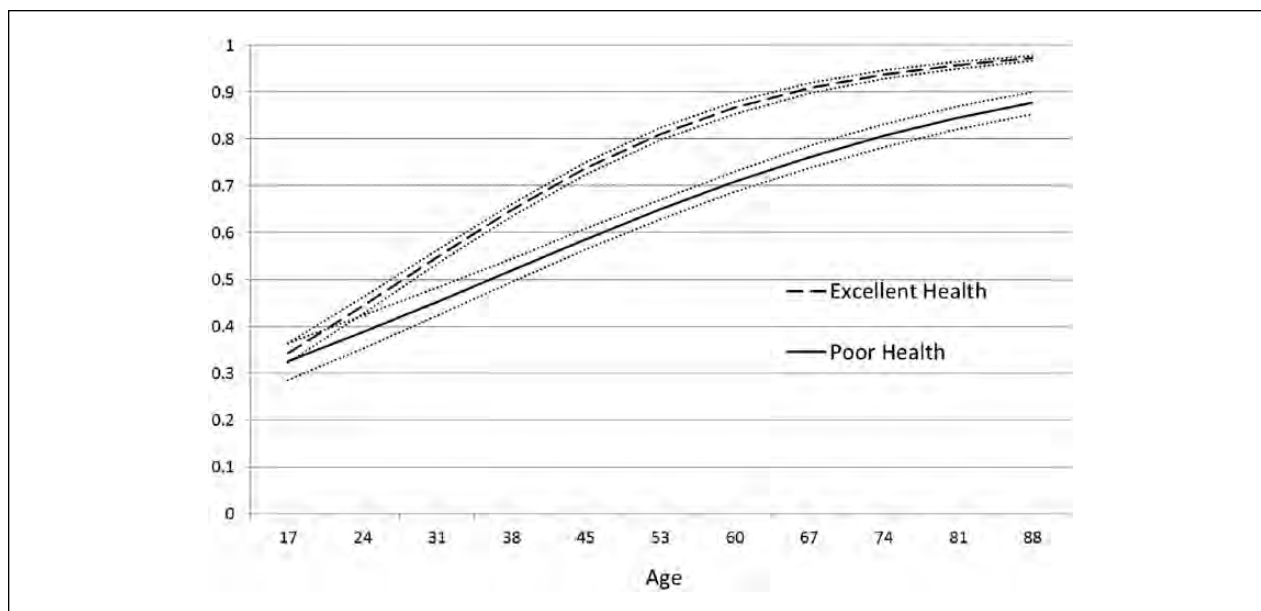


Figure 2. Predicted probabilities of voting across age for people of poor and excellent health, from analyses using the GSS in Table 1.

GSS = General Social Survey.

who is in poor health. The magnitude of the effect of adolescent health on youth voter turnout is more than the effect of maternal high school degree, which is about 4 percentage points. Table 1 also shows that youths in excellent health at the time of the 2000 election have a probability of turning out that is about 9 points higher than young adults who report being in poor health. The contemporaneous effect of health is equal in magnitude to the effect of having a mother with a college degree versus a mother who dropped out of high school. In short, our results suggest that SRHS has both developmental and contemporary components that are associated with voting and that rival other important factors.

Table 1 also presents the results of regressing SRHS on voter turnout in the most recent election using the cumulative GSS. As shown in Table 1, better SRHS is associated with an increase in the probability of voting in the most recent presidential election. Specifically, the model predicts that increasing health from poor to excellent increases the probability of voting by 12 percentage points. While education and age have stronger impacts on turnout, the effect of SRHS is similar to the effects of race and marital status and only slightly less than partisan strength, religious attendance, and newspaper readership.

Because SRHS is useful to understand how health affects turnout across the life cycle, we estimated an additional model (not shown) that includes an interaction variable between SRHS and age. While the coefficient

on the interaction term is positive and statistically significant ($p = .01^{***}$), the main effects are also significant, suggesting that health influences turnout regardless of age, but that the effect increases as age increases. We plot the predicted probabilities of voting across age levels for those of poor health compared with those in excellent health in Figure 2. Figure 2 shows that the turnout gap between those of poor and excellent health widens as age increases and then slowly narrows in old age. We must stress, however, that the GSS does not survey institutionalized individuals and healthy individuals are likely over-represented, especially in the oldest cohorts.

The results in Table 1 suggest that poor SRHS in adolescence is associated with lower turnout in young adulthood and beyond and that health has both developmental and contemporaneous components. Moreover, the relationship between health and turnout may be different depending on age. While identifying the correlates of political participation is an important endeavor in its own right, the implications of such research are amplified if nonparticipants have different political preferences than the politically active as differential participation rates coupled with differential preferences increases the risk of nonresponsiveness. In the next section, we show that not only is SRHS related to voter turnout, but it is also related to partisanship suggesting that *health inequalities* in participation may have significant *political consequences*.

Conceptually Linking SRHS to Partisanship

How might SRHS influence partisanship?¹⁰ While classic research on the origins of partisanship suggests that family socialization plays a large role (Campbell et al. 1960), partisanship also shifts in response to political issues, events, and candidates (Franklin 1984). Similar to voter turnout, it is likely that the influence of health on partisanship has both developmental and contemporaneous factors.

Developmental Components

Studies of political socialization show that partisanship begins to form in childhood and early adolescence (Jennings and Niemi 1974) with parents being particularly influential. For instance, Lewis-Beck et al. (2008) find that in families where both parents share a party affiliation, nearly three-fourths of offspring adopt the same party. Conversely, only about one-tenth of offspring rebelled politically against their parents and identified with the opposing party (Lewis-Beck et al. 2008).

Like partisanship, parental health is highly correlated with offspring health (National Research Council 2000), yet a large portion of the intergenerational transmission of health, like political activity, is linked to SES. For instance, Case, Lubotsky, and Paxson (2002) find that children from lower income households with chronic health conditions have worse health than do children from higher income households. They also find that poor health has cumulative impacts on SES that persist across the life span.

Consequently, there are a variety of theoretical pathways linking adolescent SRHS to partisanship years later. One pathway involves the simultaneous transmission of health and party affiliation from parent to child, either due to parental nurturing or genetics or some combination of the two. If parents of poor rated health are likely to identify with a certain party, offspring may adopt a similar party and likely have similar health conditions and outcomes in adulthood. Genetics may also play an indirect role by influencing personality traits, which tend to form early (McCrae and Costa 2008), exhibit stability in adulthood (Caspi 2000), and are related to health (Rhodes and Smith 2006) and partisanship (Mondak 2010). For instance, Mondak (2010) finds that people who are high on the agreeableness trait are also likely to identify with the Democratic Party. High levels of agreeableness are associated with less risky behaviors in youth (Markey et al. 2006). Adults who scored high on this dimension are less likely to smoke (Malouff, Thorsteinsson, and Schutte 2006) and have lower rates of alcoholism, depression, and arrest (Laursen, Paulkkinen, and Adams 2002). Thus,

personality traits may simultaneously influence SRHS and partisanship years later. Finally, it may be that adolescent health is related to different experiences that ultimately influence opinions regarding the determinants of health, tapping into broader political debates regarding individual versus social responsibility that likely affect partisan attachments. For instance, Robert and Booske (2011) find that healthy people are less likely to believe that social factors, such as affordable health care, play a role in determining health; they are also less likely to think that social policy, such as reducing poverty and improving education, are effective at improving public health. All of this research suggests that adolescents who report being in excellent health are more likely to identify with the Republican Party in young adulthood compared with those who report being in poor health.

Contemporaneous Effects

Besides having developmental components, the impact of health on partisanship also has contemporaneous effects as individuals react to elite rhetoric, the behavior of party leaders, and the political agenda (Brooks and Manza 1997). Advances in medicine and technology coupled with an aging global population and new understandings of disease and the body have pushed the relevance of health into discussions of politics (Carpenter 2012). And, while on and off the political agenda since at least the Progressive Era, the failure of Clinton's Health Security Plan and the passage of Obama's Affordable Care Act brought health care reform—and health—back into the political spotlight. Given that Democrats have traditionally supported an expansive role of government to improve the health of the nation, the expectation is that people who are most in need of those improvements (e.g., those with poor SRHS) will be least likely to support the Republican Party. Moreover, we expect for the contemporaneous effect of health on partisanship to be stronger in recent years as health care reform has gained national prominence in political debates.

The Effect of SRHS on Partisanship

We estimate the effect of health on party identification using both the Add Health and GSS data. For Add Health, students are asked in W3, "With which party do you identify?" to which 14 percent identified with the Republican Party. For the analyses using the GSS, respondents are asked, "Generally speaking, do you usually think of yourself as a Republican, Democrat, Independent, or what?" Responses are recoded into a binary variable with a positive response indicating identification with the Republican Party. In our sample, 26 percent of adults identified with the Republican Party. Similar to the analyses above, we

Table 2. Logistic Regression Predicting Republican Party Identification with SRHS, Using the GSS and Add Health.

Add health (N = 12,540)			GSS (N = 38,286)		
		Δ probability min to max			Δ probability min to max
SRHS (W1)	0.11** (.05)	4%	SRHS	0.18*** (.02)	9%
SRHS (W3)	0.09*** (.04)	2%			
Age (W3)	0.07*** (.02)	6%	Age (centered at 46)	0.07*** (.001)	9%
High school grad (W3)	0.45*** (.12)	4%	High school degree	0.27*** (.05)	5%
			Some college	0.42*** (.08)	8%
College grad (W3)	0.86*** (.13)	6%	College degree or higher	0.45*** (.06)	9%
Black	-2.33*** (.26)	-11%	Black	-0.189** (.09)	-23%
Other	-1.66*** (.22)	-7%	Other	-0.91*** (.11)	-13%
Female	-0.33*** (.06)	-3%	Female	-0.16*** (-.03)	-3%
Hispanic	-0.92*** (.24)	-5%			
Employment (W3)	-0.04 (.09)				
Income (W3)	0.0000001 (.00003)				
Family income (W1)	0.001 (.001)		Married	0.10** (.04)	2%
Mom high school grad	0.001 (.22)		Religious attendance	0.10*** (.01)	15%
Mom college grad	0.19 (.21)		Year	0.07*** (.01)	27%
			Year squared	-0.002*** (.0004)	-19%
Religious attendance (W3)	0.30*** (.02)	18%	Constant	-2.24*** (.08)	
Missing family information	-0.09** (.09)	-1%			
Constant	-5.19*** (.54)				

Standard errors in parentheses. Age is mean centered. Weights are used to account for the complex survey design. Robust standard errors are reported for analyses using Add Health. SRHS = self-rated health status; GSS = General Social Survey.

* $p < .1$. ** $p < .05$. *** $p < .01$ with a two-tailed test.

measure the linear effect of health in both surveys using SRHS; the difference between the two is that we measure developmental SRHS (at W1) and contemporaneous SRHS (at W3) in the Add Health data, whereas in the GSS, we only have contemporaneous measures. In models not shown, results are nearly identical when we code SRHS categorically instead of linearly.

We control for the “usual suspects” that have been shown to influence party identification including education, race, gender, age, and religious attendance (Lewis-Beck et al. 2008) measured identically to the previous analyses. We also include marital status in the GSS analyses and year and year squared to account for temporal trends in partisanship. In the Add Health analyses, we include various indicators of the home environment, including maternal education at W1 and family income at W1. As before, logistic regression models with survey weights are used for both analyses; in addition, robust standard errors clustered by state are included to correct for non-independence across observations within states in Add Health. We also report the estimated changes in the predicted probabilities when the variable changes from its minimum to maximum

value, keeping all other variables constant at the mean. Results are shown in Table 2.

As shown in Table 2, better self-rated health is associated with an increase in the likelihood of identifying with the Republican Party in young adulthood and beyond. As shown in Table 2, SRHS has both developmental and contemporaneous effects on youth partisanship. Specifically, the model predicts that adolescents who report being in excellent health are 4 percentage points more likely to identify with the Republican Party years later compared with those who report being in poor health. The model also predicts that young adults who are in excellent health at the time of the survey are 2 percentage points more likely to identify with the Republican Party. Race remains an important factor in partisan attachments; black youths are 11 percentage points less likely to identify with the Republican Party compared with whites.

Similar results are obtained using the GSS. The model shown in Table 2 predicts that the probability of identifying with the Republican Party is 9 percentage points higher for people in excellent health compared to respondents who report being in poor health, keeping all other variables constant. To be fair, other variables matter

more. For instance, the strongest predictor of Republican identification is race (blacks have probabilities that are 23 points lower than whites). However, health continues to have an effect on party identification and rivals other important covariates, such as having a college degree or being older. In models not shown, we find that the effect of health on partisanship declines as age increases as the interaction between age and SRHS is negative and statistically significant ($B = -.003^*$). This is exactly what we would expect if the salience of health to partisan cleavages has increased over time (Carpenter 2012).

In additional analyses (see Table A3 in the online appendix), we find empirical support for the inverse relationship between SRHS and partisanship. Using the GSS, for instance, citizens with poor SRHS are 5 percentage points more likely to identify with the Democratic Party compared to those with excellent self-rated health. The relationship between adolescent health and partisanship among young adults is more complex. Inferences drawn from analyses that exclude adolescents who do not identify with either major party are sensitive to alternative model specifications. However, in additional analyses, we find that better health is associated with having a partisan identity, regardless of whether that identification is with the Democratic or Republican Party. Clearly, more research is needed to explore the ways in which better health contributes to the development of a partisan identity as well as if and how it shifts that identity toward the Republican Party during those early formative years.

In sum, there is empirical support that health status is associated with party identification both among youths and adults. Moreover, the results suggest that the effect of health on partisanship has both developmental and contemporaneous components, holds up in the presence of traditional controls, rivals other more studied covariates, such as education and gender, and has increased over time as the relevance of health to partisan cleavages has increased.

Discussion

Even though our results suggest that health is a new dimension of political inequality, we must emphasize the associational nature of our data as well as the limitations of using SRHS to measure health. While cross-sectional data, such as the GSS, are useful for certain analytic purposes (e.g., identifying generational differences) they do little to identify causal relationships among variables that may persist across the life span. The supplemental analyses using Add Health provide additional leverage as adolescent health is measured years *before* voter turnout and partisanship; however, we still do not know, for instance, how *changes* in health impact *changes* in political behavior or, more fundamentally, whether health is causally

related to turnout or partisanship in the first place. We argue that to better understand the relationship between health and political participation, scholars need to move beyond cross-sectional analyses and employ other research designs, such as longitudinal analyses (Plutzer 2002), quasi-experimental designs by linking voter records to death certificates (Hobbs, Christakis, and Fowler 2014), or regression discontinuity analyses (Dinas 2014).

In addition, while we have argued that measuring health using SRHS is superior, to some degree, to objective measures of physical disability, we acknowledge that SRHS also suffers from measurement error and endogeneity biases. Survey researchers can help ameliorate biases from measurement error with the use of anchoring vignettes (Hopkins and King 2010). Anchoring vignettes address the intergroup incomparability that results from different uses of the response scale by asking respondents to use the same response categories to describe hypothetical people or situations. For instance, respondents are asked to rate the health of an individual who is usually energetic, but occasionally feels fatigued, has some trouble bending, lifting and climbing stairs, occasional pain, and who has spent a few days in bed due to illness in the past year. As the same response categories are used, the vignette provides a common reference point that scholars can then use to rescale SRHS through a variety of methodological techniques. For more detailed information, see Hopkins and King (2010). The endogeneity biases that are common in cross-sectional survey research can be improved by using other research designs that better capture the causal mechanisms linking health to political behavior, as suggested above.

Conclusion

In May 2013, while crediting the recent success of immigration reform in Congress to the Hispanic vote that went heavily against Republicans in 2012, Gail Collins quipped,

If somebody came up with a dramatic poll showing that all the people with diabetes, asthma, and chronic back problems had voted against Mitt Romney, there would no longer be a problem getting funding for health care reform.

Our results suggest exactly that; we find that people with excellent SRHS are not only more likely to participate in politics, but that they also have different partisan attachments. In short, health appears to be highly relevant to political behavior and the broader political system. This result may surprise some political scientists who have focused on the sociological divisions of political power based on class and other demographic factors. Yet,

public health scholars have long recognized the fundamental links between health, class, and demographic characteristics, such as gender, race, and ethnicity. The empirical evidence presented in this paper suggests that political scientists should also consider how health is related to individual political behavior as well as how health disparities may translate into relevant political divisions that affect electoral outcomes and eventually public policy.

With the limitations in mind, our results suggest that the *health inequalities* in political voice may have significant *political consequences*. If healthy people are more likely to turn out and have systematically different policy preferences than the unhealthy, then electoral results and the policies that are enacted may have a “health bias.” The health policies offered and enacted by the government may favor the healthy and not be suitable for those in poor health, much like disparities in political voice across income levels influence the enactment of public policies from which the poor are most likely to benefit (Hill and Leighley 1992). One avenue for future research is to explore the policy implications of these political inequalities, perhaps by comparing policies in states where the participation gap between those in excellent and poor health is relatively small to states with large inequalities in participation across health.

Additional empirical analyses about the relationship between health outcomes, risk behaviors, political participation, and public opinion would help further determine the relevance of health to political behavior. More broadly, we have little consensus about which dimensions of health matter most or how. Health is a multidimensional concept, yet the majority of research looks at isolated concepts of health leading to disparate findings and little progress on the mechanisms that link health to turnout. This is a large shortcoming as the pathway linking health to political behavior most likely depends on the indicator of health.

Scholars interested in exploring the impact of health on political behavior should also consider other forms of participation. The majority of literature focuses on voter turnout, which is arguably one of the easiest forms of political participation. How does health affect other political activities like working on campaigns or in the community, contacting government officials, and contributing money? We imagine that chronic illness likely affects social networks that play a large role in fostering political activity and political discussions, as health is negatively related to labor force participation (McDonough and Amick 2001).

We also know little about how health influences policy preferences. One possibility is that changes in health may cause shifts in policy preferences. The evidence that health is causally related to public opinion is suggestive, but

promising. Henderson and Hillygus (2011), for instance, find that strong Republicans with health-related self-interests are about as likely to oppose universal health care as Democrats. Health-related self-interests are also associated with increased support for the Affordable Care Act (ACA) among strong Republicans and decreased support among strong Democrats, causing partisans to converge in their preferences (Pacheco 2014). We advise scholars to continue exploring how health affects policy preferences on health-related matters as well as other issues.

Integrating health into our studies of political behavior may also inform other long-standing debates of political processes at the individual level. Education is arguably the most important and consistently documented resource that encourages political participation, both among youths (Plutzer 2002) and adults (Verba, Schlozman, and Brady 1995). After decades of research, however, political scientists question whether education has a direct, causal impact on participation or whether preadult forces, such as cognitive ability or personality traits, account for the positive relationship between education and political participation in adulthood (e.g., Kam and Palmer 2008). Interestingly, many of the same preadult factors that may account for the spurious relationship between educational attainment and political participation correlate highly with childhood health (Cacioppo et al. 1996; Michael 2004). Besides illuminating the causal link between education and voter turnout, health may also be a potential mechanism by which genetic factors influence political behavior as health is inherited (National Research Council 2000) and related to biomarkers such as cortisol (the biomarker of the stress response, for example, Hajat et al. 2010), and personality factors, such as conscientiousness (Rhodes and Smith 2006), that affect participation and preferences (Mondak 2010). Finally, as we suggest, looking at health may be particularly important to understanding political participation among the elderly.

There is still much to learn about the impact that health has on political participation and public opinion with implications to our understandings of policy responsiveness and political inequality. Indeed, our primary goal is to theoretically and empirically show that health is associated with political behavior and public opinion in hopes that other scholars will follow suit. The relationships between adolescent or adult health and voter turnout or partisanship are not overwhelming, but they do exist and are highly correlated with arguably the most studied covariate, educational attainment, which makes health all the more relevant to political science research.

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Authors' Note

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Notes

1. The National Health Interview Survey (NHIS) is collected by the National Center for Health Statistics, which is part of the Centers for Disease Control and Prevention and has tracked health topics annually since 1957. The NHIS is a large-scale household interview survey of a statistically representative sample of the U.S. civilian noninstitutionalized population. For more information go to the website located at http://www.cdc.gov/nchs/nhis/about_nhis.htm.
2. Estimates in Figure 1 are weighted to account for the complex survey design.
3. While beyond the scope of this paper, having a family member recently diagnosed with a chronic medical condition may also affect political participation of otherwise healthy respondents.
4. There is little evidence that adolescent health is related to sample attrition. In addition, our results are nearly identical when we do not include adolescents who are immigrants (doing so reduces our sample by about 10 percent).
5. The parental survey targeted the mother or female mother figure. Only in cases where none were available did a father/father figure complete the parental survey.
6. In results available upon request, we also included a measure of parent civic engagement at W1, which asks whether the parent is a member of a civic or social organization. The inclusion of this variable drops the number of cases by two thousand and causes the coefficient on the self-rated health status (SRHS) at W1 to fail to reach statistical significance. When values on the parental civic engagement variable are mean-imputed, the coefficient on SRHS at W1 is statistically significant ($B = .067^*$ with a two-tailed test).
7. Specifically, data is available for the following years: 1972, 1973, 1974, 1976, 1977, 1980, 1982, 1984, 1985, 1987, 1988, 1990, 1991, 1993, 1994, 1996, 1998, 2000, 2002, 2004, 2006, 2008, and 2010.
8. There is an over-reporting of voting since many people incorrectly report voting, either due to social desirability or memory failure (e.g., Burden 2000). There is a possibility that as over-reporting is correlated with high SES (Ansolabehere and Hersh 2012) and good health is correlated with high SES that there is bias in our estimates. We overcome this bias by providing additional analyses using longitudinal data and measures of adolescent health. Nonetheless, we acknowledge that our conclusions should be taken with caution.
9. Analyses are nearly identical when health is measured as a categorical variable.
10. We acknowledge that health may affect political attitudes beyond partisanship including ideology, opinions about the saliency of issues, feelings toward political candidates, and views toward specific policies including health care reform, abortion, the death penalty, welfare, and others. It is beyond the scope of the paper to look at these different types of attitudes, although we encourage others to do so.

References

- Angel, Ronald, and William Gronfein. 1988. "The Use of Subjective Information in Statistical Models." *American Sociological Review* 53:464–73.
- Ansolabehere, Stephen, and Eitan Hersh. "Validation: What big data reveal about survey misreporting and the real electorate." *Political Analysis* (2012): mps023.
- Baker, Michael, Mark Stabile, and Catherine Deri. 2003. "What Do Self-Reported, Objective, Measures of Health Measure?" *The Journal of Human Resources* 4:1067–93.
- Bjorner, Jakob B., P. M. Fayes, and E. L. Idler. 2005. "Self-Rated Health." In *Assessing Quality of Life*, edited by Peter Fayes and Ron Hays. Oxford: Oxford University Press, pp. 309–323.
- Boardman, Jason D. 2006. "Self-Rated Health among U.S. Adolescents." *Journal of Adolescent Health* 38:401–408.
- Bound, John. 1989. "Self-Reported vs. Objective Measures of Health in Retirement Models." Working Paper No. 2997, National Bureau of Economic Research. Available at: <http://www.nber.org/papers/w2997>
- Brooks, Clem, and Jeff Manza. 1997. "Social Cleavages and Political Alignments: US Presidential Elections, 1960–1992." *American Sociological Review* 62:937–46.
- Burden, Barry C. 2000. "Voter Turnout and the National Election Studies." *Political Analysis* 8:389–398.
- Cacioppo, John T., Richard E. Petty, Jeffrey A. Feinstein, and W. Blair G. Jarvis. 1996. "Dispositional Differences in Cognitive Motivation: The Life and Times of Individuals Varying in Need for Cognition." *Psychological Bulletin* 119:197–253.

- Campbell, Angus, Philip E. Converse, Warren E. Miller, and Donald E. Stokes. 1960. *The American Voter*. Chicago: University of Chicago Press.
- Carpenter, Daniel. 2012. "Is Health Politics Different?" *Annual Review of Political Science* 15:287–311.
- Case, Anne, Darren Lubotsky, and Christina Paxson. 2002. "Economic Status and Health in Childhood: The Origins of the Gradient." *American Economic Review* 92:1308–34.
- Caspi, Avshalom. 2000. "The child is father of the man: Personality continuities from childhood to adulthood." *Journal of Personality and Social Psychology*. Vol. 78(1): 158–17.
- Dinas, Elias. 2014. "Does Choice Bring Loyalty? Electoral Participation and the Development of Party Identification." *American Journal of Political Science* 58 (2): 449–65.
- Dowd, Jennifer B., and Anna Zajacova. 2010. "Does Self-Rated Health Mean the Same Thing across Socioeconomic Groups? Evidence from Biomarker Data." *Annals of Epidemiology* 20 (10): 743–49.
- Ferraro, Kenneth F. 2006. "Health and Aging." *Handbook of Aging and the Social Sciences* 6:238–56.
- Franklin, Charles E. 1984. "Issue Preferences, Socialization, and the Evolution of Party Identification." *American Journal of Political Science* 28:459–78.
- Groot, Wim. 2000. "Adaptation and Scale of Reference Bias in Self-Assessments of Quality of Life." *Journal of Health Economics* 19 (3): 403–20.
- Hajat, Anjum, Ana Diez-Roux, Tracy G. Franklin, Teresa Seeman, Sandi Shrager, Nalini Ranjit, Cecilia Castro, Karol Watson, Brisa Sanchez, and Clemens Kirschbaum. 2010. "Socioeconomic and Race/Ethnic Differences in Daily Salivary Cortisol Profiles: The Multi-ethnic Study of Atherosclerosis." *Psychoneuroendocrinology* 35:932–43.
- Haveman, Robert, Barbara Wolfe, Brent Kreider, and Mark Stone. 1994. "Market work, wages, and men's health" *Journal of Health Economics* Vol. 13 (2): 163–182.
- Henderson, Michale, and D. Sunshine Hillygus. 2011. "The Dynamics of Health care opinion, 2008–2010; partisanship, self-interest, and racial resentment." *Journal of Health Politics, Policy, and Law* 36.6: 945–960.
- Hill, Kim Quaile, and Jan E. Leighley. 1992. "The Policy Consequences of Class Bias in State Electorates." *American Journal of Political Science* Vol. 26 (2): 351–365.
- Hobbs, William R., Nicholas A. Christakis, and James H. Fowler. 2014. "Widowhood Effects in Voter Participation." *American Journal of Political Science* 58 (1): 1–16.
- Hopkins, Daniel, and Gary King. 2010. "Improving Anchoring Vignettes: Designing Surveys to Correct Interpersonal Incomparability." *Public Opinion Quarterly* Vol. 74 (2), 201–222.
- Idler, Ellen L., and Yael Benyamini. 1997. "Self-Rated Health and Mortality: A Review of Twenty-Seven Community Studies." *Journal of Health and Social Behavior* 38:21–37.
- Irastorza, Luis Javier, Pablo Corujo, and Pilar Bañuelos. 2011. "Capacity to Vote in Persons with Dementia and the Elderly." *International Journal of Alzheimer's Disease*. Available at: <http://www.hindawi.com/journals/ijad/2011/941041/>
- Jennings, M. Kent, and Richard G. Niemi. 1974. *The Political Character of Adolescence: The Influence of Families and Schools*. Princeton: Princeton University Press.
- Jennings, M. Kent, and Richard G. Niemi. 1991. "Issues and Inheritance in the Formation of Party Identification." *American Journal of Political Science* 35 (4): 970–88.
- Jylhä, Marja. 2009. "What Is Self-Rated Health and Why Does It Predict Mortality? Towards a Unified Conceptual Model." *Social Science & Medicine* 69:307–16.
- Kam, Cindy D., and Carl L. Palmer. 2008. "Reconsidering the Effects of Education on Political Participation." *The Journal of Politics* 70:612–31.
- Lantz, Paula M., James S. House, James M. Lepkowski, David R. Williams, Richard P. Mero, and Jieming Chen. 1998. "Socioeconomic Factors Health Behaviors and Mortality: Results from a Nationally Representative Prospective Study of US Adults." *Journal of American Medical Association* 279:1703–1708.
- Laursen, Brett, Lea Paulkkinen, and Ryan Adams. 2002. "The Antecedents and Correlates of Agreeableness in Adulthood." *Developmental Psychology* 38:591–603.
- Lewis-Beck, Michael S., William G. Jacoby, Helmut Norpoth, and Herbert F. Weisberg. 2008. *The American Voter Revisited*. Ann Arbor: University of Michigan Press.
- Malouff, John M., Einar B. Thorsteinsson, and Nicola S. Schutte. 2006. "The Five-Factor Model of Personality and Smoking: A Meta-analysis." *Journal of Drug Education* 36:47–58.
- Markey, Charlotte N., Patrick M. Markey, Andrea J. Erikson, and Barbara J. Tinsley. 2006. "Children's Behavioral Patterns, the Five-Factor Model of Personality, and Risk Behaviors." *Personality and Individual Differences* 41:1503–13.
- Marsden, Peter. 2012. *Social Trends in American Life: Findings from the General Social Survey since 1972*. Princeton: Princeton University Press.
- Mattila, Mikko, Peter Soderlund, Hanna Wass, and Lauri Rapeli. 2013. "Healthy Voting: The Effect of Self-Reported Health on Turnout in 30 Countries." *Electoral Studies* 32 (4): 886–91.
- McCrae, Robert R., and Paul T. Costa Jr. 2008. "The Five-Factor Theory of Personality." In *Handbook of Personality: Theory and Research*, edited by Oliver P. John, Richard W. Robins, and Lawrence A. Pervin, 155–81. New York: Guilford Press.
- McDonough, Peggy, and Benjamin C. Amick. 2001. "The Social Context of Health Selection: A Longitudinal Study of Health and Employment." *Social Science & Medicine* 53:135–45.
- Michael, Robert T. 2004. "Family Influences on Children's Verbal Ability." In *Family Investments in Children's Potential: Resources and Parenting Behaviors That Promote Success*, edited by Ariel Kalil and Thomas DeLeire, 49–83. New Jersey: Lawrence Erlbaum.
- Milbrath, Lester. 1965. *Political Participation: How and Why Do People Get Involved in Politics?* Rand McNally. Chicago, IL.
- Miller, Warren E., and J. Merrill Shanks. 1996. *The New American Voter*. Cambridge, MA: Harvard University Press.

- Mondak, Jeffery J. 2010. *Personality and the Foundations of Political Behavior*. Cambridge: Cambridge University Press.
- National Research Council. 2000. *From Neurons to Neighborhoods: The Science of Early Childhood Development*. Washington, DC: National Academy Press.
- Pacheco, Julianna. 2014. "A Conditional Theory of Self-Interest and Symbolic Politics." Working paper. Available at: <http://juliannapacheco.weebly.com/working-papers.html>.
- Palloni, Alberto. 2005. "Reproducing Inequalities: Luck, Wallets, and the Enduring Effects of Childhood Health." *Demography* 43:587–615.
- Plutzer, Eric. 2002. "Becoming a Habitual Voter: Inertia, Resources, and Growth in Young Adulthood." *The American Political Science Review* 96:41–56.
- Rhodes, R. E., and N. E. I. Smith. 2006. "Personality Correlates of Physical Activity: A Review and Meta-analysis." *British Journal of Sports Medicine* 40:958–65.
- Robert, Stephanie A., and B. C. Booske. 2011. "US Opinions on Health Determinants and Social Policy as Health Policy." *American Journal of Public Health* 101:1655–63.
- Rosenstone, Steven J. 1982. "Economic Adversity and Voter Turnout." *American Journal of Political Science* 26 (1): 25–46.
- Schur, Lisa, and Douglas Kruse. 2000. "What Determines Voter Turnout? Lessons from Citizens with Disabilities." *Social Science Quarterly*, Vol. 81 (2): 571–587.
- Schur, Lisa, and Meera Adya. 2013. "Sidelined or Mainstreamed? Political Participation and Attitudes of People with Disabilities in the United States." *Social Science Quarterly* 94 (3): 811–39.
- Schur, Lisa, Todd Shields, Douglas Kruse, and Kay Schriener. 2002. "Enabling Democracy: Disability and Voter Turnout." *Political Research Quarterly* Vol. 55 (1): 167–190.
- Stoker, Laura, and M. Kent Jennings. 1995. "Life-Cycle Transitions and Political Participation: The Case of Marriage." *American Political Science Review* 89 (2): 421–33.
- Verba, Sidney, Kay L. Schlozman, and Henry E. Brady. 1995. *Voice and Equality: Civic Voluntarism in American Politics*. Cambridge, MA: Harvard University Press.