Introduction

While respondents’ health is, of course, highly correlated with key life outcomes, political scientists have, on the whole, paid little attention to the intersection of respondents’ health and political attitudes and behavior. Yet respondents’ health is very likely correlated with measures of political participation, such as registration, voting and campaigning, and with opinions about policy, particularly health policy, Medicare and social security, as well as views on the appropriate role of government in society. As the Patient Protection and Affordable Care Act continues to be implemented, and with the act certain to play a central role in the 2012 presidential campaign, close attention to the intersection of politics and health would seem warranted.

Proposed Item

To this end we propose the addition of a single item to the ANES EGSS:

“In general, would you say your own health is excellent, good, fair, or poor?”

Responses are coded from 1 (excellent) to 4 (poor).

This item has been commonly used in health and epidemiological studies since the 1950s. There is a large body of research on the validity of the item, focused particularly on whether respondents’ self-assessment of their health is a reliable indicator of objective measures of their health.

Validity of SRH Measure

The validity of measures of self-reported health (SRH) used in epidemiological and social scientific research has been repeatedly tested since its initial use in the 1950s (Jylha 2009; Fonseca et al. 2010). Early assessments of SRH measures were skeptical as to whether these were congruent with physician assessments of health for patients (Suchman et al. 1958; Haberman 1969). However, repeated later studies have found that self and physician assessments of general health (as opposed to specific ailments) are
highly correlated and that SRH can be successfully used as a valid measure of general health (Maddox and Douglass 1973). In fact, in a 2007 study of the predictive value of SRH measures, Winter et al. find that SRH is often a better predictor of general health than is a physician’s diagnosis. They conclude that “SRH itself reflects the individual’s sense of change in his or her health, specifically change in physical symptoms,” and that individuals are often aware of nuanced changes to their overall health that physicians are unaware of (Winter et al. 2007).

This is not to say the measure is not without its complications. For example, a 2002 analysis of Australian survey data found that approximately 28 percent of survey respondents changed their SRH after completing a battery of specific health-related questions (Crossley and Kennedy 2002). Another recent study concluded that SRH might be assessed differently by each age cohort (McFadden et al. 2008). And finally, scholars caution that in comparative research it is important to ascertain whether respondents’ cultural norms define health similarly because personal definitions of health affect self-assessment (Jylha 2009). However, the measure is generally seen as valid and reliable, and it is widely used in the health and health policy fields.

**Use of SRH in Epidemiologic and Social Scientific Research**

Given the general consensus that SRH is a valid measure of health, scholars have used SRH in a variety of studies in which general health is a variable of interest. A number of epidemiological and medical studies have examined the relationship between SRH and mortality (Singer et al. 1976; Mossey and Shapiro 1982; Kaplan and Camacho 1983; Pijls, Feskens, and Kromhout 1993; Wolinsky et al. 1993; and Schoenfeld et al. 1994), SRH and physical disability (Mossey et al. 1989; Idler and Kasl 1995), and SRH and hospital utilization (Wolinsky et al. 1994). Economists have also utilized SRH to measure health (Crossley and Kennedy 2002; Juerges 2007).

More recently, however, social scientists have begun employing SRH as a predictor of other social phenomena. Foraker et al. highlight the relationship between SRH and neighborhood socioeconomic status (2011), and SRH has been used as a dependent variable in studies of the effect of income on individual health (Subramanyam et al. 2009). SRH is employed as a variable of interest to ascertain the impact of public health initiatives (King et al. 2007, 2009; Imai et al. 2009; Finkelstein et al. 2011). It has
also been used to measure the health impact of armed conflict (Murray et al. 2002).

SRH has also been used more directly as a variable of interest in studies of political participation. A number of studies have found a correlation between an individual’s SRH and their level of social capital and/or social trust—both variables that have been shown to be independent predictors of political participation in their own right (Kawachi et al. 1997, 1999; Veenstra 2000; and Subramanian et al. 2002). In their 2001 study of the effect of political participation on health across socioeconomic status, Blakely et al. find that, independent of both income inequality and state median household income, socioeconomic inequality in political participation is associated with lower SRH (Blakely et al. 2001). More recently, civic participation has been found to be a significant intermediary variable in the relationship between SRH and illness-related absences from work (Lancee and ter Hoeven 2010).

**Existing Surveys Employing SRH**

As is apparent from the review of the literature above, SRH is incorporated in a wide range of survey instruments. Cross-nationally, both the World Value Survey and the European Value Survey contain measures of SRH. It is also included in the Survey of Health, Aging, and Retirement in Europe; the SF-36 Health survey; and the National Health and Nutrition Examination Survey in the United States. SRH measures also appear on major surveys addressing social scientific outcomes including the March supplement of the Current Population Survey and the 2000 Social Capital Community Benchmark Survey (SCCBS) conducted by the Saguaro Seminar.

**Preliminary Evidence of SRH as a Predictor of Political Participation**

Among US surveys only the eleven-year-old 2000 Social Capital Community Benchmark Survey\(^1\) provides an opportunity to begin exploring linkages between SRH and individual political participation. We use these data to give a preliminary illustration of the relationship between SRH and measures of participation.

The Social Capital survey contains a sample of 26,700 respondents from forty-two communities nationwide and a national sample of about 3,000 respondents. The

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1 The Social Capital Community Benchmark Survey, 2000 data used in this report were collected by Professor Robert D. Putnam of the Saguaro Seminar Civic Engagement in America, a project of the John F. Kennedy School of Government at Harvard University and numerous community foundations nation-wide, and made available through the Roper Center for Public Opinion Research.
communities, from twenty-nine states, represent a wide range of demographic characteristics. In addition to basic individual variables, this survey also contains a measure of SRH and several indicators of civic engagement and political participation.

As with the standard SRH measure, respondents were asked to rate their own health on a scale from 0 to 4 with 0=Poor and 4=Excellent. Respondents were also asked whether they were registered to vote, and whether they had voted in the previous presidential election in 1996.

<table>
<thead>
<tr>
<th>Table 1: Percent Who Voted in 1996 by SRH</th>
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<tbody>
<tr>
<td>Voted in 1996 Presidential Election</td>
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<td></td>
</tr>
<tr>
<td>No</td>
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<tr>
<td>Yes</td>
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<tr>
<td>Total</td>
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</tbody>
</table>

N=27,379 p<.001 Chi² = 295.5

The results in Table 1 suggest that a statistically significant relationship exists between respondent’s SRH and their incidence of voting in the 1996 presidential election. As health increases, so too does the likelihood of voting. Sixty-four percent of respondents reporting poor health also reported having cast a ballot for president in 1996, while 78 percent of respondents who rated their health excellent reported casting a ballot in the same election.

Of course, health has been shown to correlate with factors like socioeconomic status that also relate to political participation. The following table reports the relationship between SRH and voting controlling for respondent’s income.

<table>
<thead>
<tr>
<th>Table 2: Percent Who Voted in 1996 by SRH and Income</th>
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</thead>
<tbody>
<tr>
<td>Low Income (&lt;$30,000 annually)</td>
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<tr>
<td>Voted in 1996 Presidential Election</td>
</tr>
<tr>
<td>No</td>
</tr>
<tr>
<td>41.9</td>
</tr>
<tr>
<td>Yes</td>
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<tr>
<td>Total</td>
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</table>

p<.001 Chi² = 29.0

<table>
<thead>
<tr>
<th>Middle Income ($30,001-$50,000 annually)</th>
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<tbody>
<tr>
<td>Voted in 1996 Presidential Election</td>
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<tr>
<td>No</td>
</tr>
<tr>
<td>41.9</td>
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<tr>
<td>Yes</td>
</tr>
<tr>
<td>Total</td>
</tr>
</tbody>
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As the results in Table 2 suggest, the significant correlation between SRH and voting still exists when accounting for income for low and middle-income respondents. On balance, the propensity to vote increases as a respondent’s SRH increases for both low and middle-income respondents. The pattern is less clear for higher income respondents, though this in itself is worth further elaboration.

**Summary**

The proposed item on self-reported health assessment will allow analysis of the relationship between health and political participation, as well as opinion and attitudes in the period leading up to the 2012 presidential election, when health policy is likely to be particularly salient. While SRH measures are widely implemented in the health and health policy fields, their impact on social outcomes is only occasionally explored, and while several large-scale European and American surveys include a question on SRH, to our knowledge only the 2000 Social Capital Community Benchmark Survey includes measures of both self-reported health and political variables. The addition of an SRH item on the EGSS would address this gap.
Works Cited


