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# Politics and population health: Testing the impact of electoral democracy

Andrew C. Patterson<sup>a,\*</sup>, Gerry Veenstra<sup>b</sup>

<sup>a</sup> *Prentice Institute for Global Population and Economy, University of Lethbridge, 4401 University Dr W, Lethbridge, AB T1K3M4, Canada*

<sup>b</sup> *Department of Sociology, University of British Columbia, 6303 NW Marine Dr, Vancouver, BC V6T1Z1, Canada*



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## ABSTRACT

This study addresses questions of whether and why electoral democracies have better health than other nations. After devising a replicable approach to missing data, we compare political, economic, and health-related data for 168 nations collected annually from 1960 through 2010. Regression models estimate that electoral democracies have 11 years of longer life expectancy on average and 62.5% lower rates of infant mortality. The association with life expectancy reduces markedly after controlling for GDP, while a combination of factors may explain the democratic advantage in infant health. Results suggest that income inequality associates independently with both health outcomes but does not mediate their associations with democracy.

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## 1. Introduction

A growing body of evidence indicates that democratic governance may be an especially powerful kind of preventive medicine. Studies report that democratic nations have longer life expectancy (Besley and Kudamatsu, 2006; Lin et al., 2012; Wigley and Akkoyunlu-Wigley, 2011), less infant mortality (Gerring et al., 2012; McGuire, 2013; Navia and Zweifel, 2003), and more public investment in health care (Correa and Namkoong, 1992; Liang and Mirelman, 2014) compared to autocratic nations. To date, a majority of studies affirm a positive correspondence between political democracy and population health (Muntaner et al., 2011, 2013) even after controlling for a variety of confounders, which suggests that the kind of relationship citizens have with their country's ruling elite plays a key role in determining their health and well-being.

Several factors potentially undermine this conclusion, however. Although a number of insightful explanations have been offered, few empirical studies shed light upon their relative importance and the analysis of potential mediators is uncommon in this literature. The apparent global democratic advantage in health may be overestimated because successful autocratic regimes do not always report their information to the data repositories most researchers use (Ross, 2006). Recent studies address this issue by imputing their missing data (Wigley and Akkoyunlu-Wigley, 2011; Gerring et al., 2012; García, 2014), but these rely principally upon popular measures of a country's

supposed 'level' of democracy without offering a conceptual definition of democracy itself. Competing measures of political regimes are also based on vastly different conceptualizations, which can undermine the validity of the studies that use them (Munck and Verkuilen, 2002). Studies often focus on the more sensitive measures of infant and child mortality as barometers for population health overall, but less often comment on the reliability of the democracy-health correspondence across outcomes or its implications for health throughout the life course. Taken together, despite seemingly overwhelming evidence that political democracy corresponds with stronger population health, these problems point to a shortage of clear and convincing evidence for a causal relationship between the two.

To address these issues, we start by defining democracy as a system of rule in which citizens choose their leaders by voting in elections (Przeworski, 1991) and operationalize regime type accordingly as being either electoral democracy or non-democracy. While not the only solution to questions of what political regime types comprise, we believe this choice suits research on population health for a number of reasons. In comparison with measures of the 'level' of democracy, a binary variable makes the analogy to a naturalistic experiment especially plausible, allowing an average difference between 'electoral democracies' and 'non-democracies' to be quantified and discussed. Secondly, measures that alternatively use the more encompassing conceptualization schemes for political regime type (as is the case for the dataset we use) can often be broken down into subcomponent measures that distinguish each country's electoral process from other putative elements of democracy. The

\* Corresponding author.

focus on electoral as opposed to other types of democracy allows for these other, distinctly political components to be tested as possible mediators. Criteria that focus on elections play a critical role in almost every conceptualization for political regimes (a 'necessary cause' for democracy to exist), but allowing these other factors to be examined separately can facilitate a better understanding of the implications of political regime types for health.

Next, we offer a set of hypotheses for what mechanisms in particular link political democracy to health and then attach a unique variable to each of these hypotheses, the mediating influence of which can be tested using standard regression techniques. The mere fact that leaders come to power through elections will arguably motivate them to promote population health. Famines, for instance, are avoidable public health disasters for which voters will likely blame elected officials and promptly vote them out of office, which is why they are argued not to occur in democracies (Sen, 1994). However, a number of other mechanisms, political or economic in nature, may also be at play.

### 1.1. Political explanations

We propose three explanations that involve the political consequences of democratic governance for health. Distinguishable from the mere presence of elections by a number of accounts (e.g., Sen, 1994; Gerring et al., 2012), the *Executive Constraint Hypothesis* argues that democracies have better population health because they have systems of checks and balances that restrain leaders from making unilateral decisions. An elected leader who wants to overhaul a country's health services, for instance, can only do so by vetting their plans through some legislative body, whereas autocratic leaders can do so by fiat which will likely compromise the wisdom and fairness of whatever they use to replace existing services. As the *Public Deliberation Hypothesis* (Sen, 1994; see Chandra and Rudra, 2015) furthermore argues, citizens of free democratic societies, being expert on the problems that they and their families face, will have both the opportunity and tendency to voice their opinions openly about policy choices that impact health. Once citizens understand how poor sanitation and unclean water supplies threaten their health, they can make their concerns known in newspapers and other public media such that a politician who hopes to succeed in a forthcoming election would be foolish to ignore those concerns. The *Institutional Strength Hypothesis* (Gerring et al., 2005, 2012) argues that, as a consequence of a (typically democratic) package of freedoms and equality under the law, standards for decorum must be generally agreed upon in democracies rather than being subject to arbitrary enforcement from above. This situation encourages the growth of institutional protocols, property protections, rule of law, and other amenities to resolve conflicts of interest. As a result all of the different kinds of privileges that can potentially harm the health of others, such as ownership of a motor vehicle, access to firearms, and the right to deliver health care services, are subject to intense scrutiny from courts and licensing boards. These policy frameworks take shape over the course of many years, though, which means that larger differences in health should emerge only when comparing long established regimes.

### 1.2. Economic explanations

Democracies may also be more effective than non-democracies in encouraging either income growth or a more equitable distribution of income, patterns which have their own respective implications for health. According to the *Economic Growth Hypothesis*, if economic prosperity is good for health on the individual level (Link and Phelan, 1995, 2010) and the national level (McKeown, 1976, 1988; McKeown and Brown, 1955), and if strength of institutional infrastructure makes democracies more reliable places to do business such that they should experience stronger growth in national wealth (Gerring et al., 2005;

Madsen et al., 2015), then economic prosperity should be another mediator. At least one recent study (Klomp and de Haan, 2009) supports this view. In contrast, the *Inequality Reduction Hypothesis* (Moon and Dixon, 1985) posits that inequality is the more important mediator. Both material deprivation (Waitzkin, 2007; Link and Phelan, 1995, 2010) and socioeconomic inequality (Wilkinson and Pickett, 2006, 2010) presumably harm health at the population level. Yet democracy is a system in which all citizens can influence policy through their ability to vote, which gives political clout to people who are poor and marginalized that they would not otherwise have in an autocracy. Arguably, political leaders will take this into account as they devise the country's economic policies, or else risk losing a significant portion of their constituency to a competitor.

To test each of the abovementioned hypotheses, we use annual comparative data from the past half century. Our regression models compare national levels of life expectancy and infant mortality according to each country's status as electoral democracy or not, examine the longitudinal impact on health after the installation of an electorally democratic regime, and test potential mediators. We then discuss some important implications of our findings.

## 2. Methods

### 2.1. Population data

Analysis is based on annual data for 168 countries as they existed from 1960 through 2010. The Polity IV dataset was used to determine which countries existed at what time. World Bank Indicators were appended to represent national vital statistics and economic prosperity. Because these were absent for countries that were disproportionately poor and autocratic, data from the United Nations National Accounts Main Aggregates Database and the 1997 historical supplement to the United Nations Demographic Yearbook were assumed for occasions where World Bank data were missing. Finally, the Standardized World Income Inequality Database (Solt, 2009) was appended to the working dataset to provide comparative information on income inequality. Data were laid out in "long" format by country-years.

### 2.2. Variables

This study examines predictors of *life expectancy* and *infant mortality rates*. Following other studies (e.g., Gerring et al., 2012; McGuire, 2013) these measures of population health were lagged by one year to curtail endogeneity. A *democracy* is regarded as any country that has "formal competition among publicly supported candidates" according to the *Executive Recruitment Concept* typology of the Polity IV dataset (Marshall et al., 2011, p. 23). Electoral democracies are thus compared to regimes that follow any of the other patterns identified in this typology. Additional variables were selected to test each of the abovementioned hypotheses (respectively). *Executive constraints* (the Polity IV variable XCONST) characterize the degree to which some system of checks and balances restricts the decision latitude of a country's ruler (s). *Competitive political participation* (the Polity IV variable PARCOMP) "refers to the extent to which alternative preferences for policy and leadership can be pursued in the political arena" (p. 26) as a consequence of the "degree to which ... political participation is free from government control" (p. 71). *Democratic regime tenure* is the length of time a regime has stayed constantly democratic since either a transition from non-democracy or the year 1900, whichever occurred most recently, and assumes a value of zero for non-democracies. Per-capita *gross domestic product (GDP)* at current U. S. exchange rates is expressed in 2010 dollars and then logged. Crude birth rates and crude death rates are used as part of the strategy for imputing missing data. Values for the Gini coefficient taken from the Standardized World

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