AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 422
(A-22)

Introduced by: Minority Affairs Section, National Medical Association

Subject: Voting as a Social Determinant of Health

Referred to: Reference Committee D

Whereas, Social determinants of health are the non-medical unavoidable patient life conditions that directly influence healthcare risks and account for 30%-55% of healthcare outcomes[1-3]; and

Whereas, Citizens from historically excluded backgrounds are more affected by barriers to voting than White citizens: in states that have strict voting ID laws, Latino turnout drops by 9.3%, Black turnout by 8.6%, and Asian turnout by 12.5% after implementation of these laws compared to previous voter turnout statistics[4]; and

Whereas, Experiencing barriers to participating in the electoral process is correlated with an increased likelihood of being uninsured. In a national study on disparities in voter access, it was demonstrated that an increase in barriers to voting access is associated with a 25% overall greater probability of being uninsured[5-9]; and

Whereas, Individuals who experience voter suppression have disproportionately worse health outcomes, and these disparities largely affect people of color. Given that Healthy People 2020 identified civic participation as a social determinant of health[6,10-13]; and

Whereas, Inequitable distribution of resources and disproportionate negative health outcomes are closely associated, such that socioeconomic variables in a community can predict low voter turnout, including but not limited to demographics, household income, age, and residential mobility[6,11]; and

Whereas, Overt and covert methods have been used for voter suppression, especially against historically marginalized populations. The National Conference of State Legislatures found that almost 70% of states require some form of state identification in order to vote which has been shown to be a barrier among African Americans, the poor, and youth. Non-White voter turnout is less restricted in states with strict voter ID laws, demonstrated by the decrease in voter turnout for primary elections specifically in non-White populations following their implementation[4,14]; and

Whereas, In the 2016 elections the majority of voters were non-Hispanic, White females aged 45-65, with a family income of $100,000 or more[15]; and

Whereas, In the election of 2020, White voter turnout was 70.9%, significantly more than the 58.4% of non-White voters who made it to the polls; demonstrating that barriers to voting in a global pandemic still disproportionately affect non-White voters more[16]; and

Whereas, Communities that have been historically and are currently excluded on the basis of race and socioeconomic status experience significantly more barriers to voter participation, which perpetuated for generations and correlate with rates of health insurance coverage among these groups. National data from multivariate analyses on voter participation and social

determinants of health demonstrate that a lack of medical insurance is significantly correlated with decreased likelihood of voting. In a study on two major US cities demonstrating this trend, it was found that individuals with any insurance had an overall voter participation of 24%, compared to 3% in those that were uninsured[17]; and

Whereas, in 2010 the Patient Protection and Affordable Care Act was implemented to increase the number of Americans with health insurance and substantially decrease healthcare associated costs. In 2012, the supreme court declared that the expansion of Medicaid, one of the goals of the Affordable Care Act, would be optional for individual states despite the provision of funding for this expansion[18]; and

Whereas, Today there are 12 remaining states that have chosen not to expand Medicaid despite overwhelming support for Medicaid expansion and the federal funding available to do so. Many of these states have utilized gerrymandering as a means to modify the evidence of public opinion and manipulate the voice of the people[19]; and

Whereas, Those without health insurance are more likely to support government healthcare programs, yet in the 2016 presidential election, voter turnout for uninsured Americans was 34%[20]; and

Whereas, almost 40% of the voting-eligible American population did not vote in 2015, with significant gaps in voter turnout existing along racial, educational, and income-level lines, largely attributable to voting restrictions and feelings of alienation from the government[7]; and

Whereas, The relationship between health and voter participation perpetuate inequities in health, social, and economic policy, further worsening health disparities. Historical examples of initiatives that increase civic participation and improve health include the women's suffrage movement which led to an increase in funding for women's health programming and a decrease in child mortality by eight to 15% . Another example exists in the removal of literacy tests in 1965, which expanded the number of Black voters, increasing government funding to areas with larger Black populations and shifting voting patterns within these communities[4,7,8,14,16, 21–24]; and

Whereas, Voting between the ages of 18-24 is associated with fewer risky health behaviors by instilling a sense of self-efficacy and increasing social connectedness. Voting is also correlated with fewer depressive symptoms in adulthood[8,9]; and

Whereas, Individuals who vote as a form of civic participation self-report a better state of health than those who do not vote as well as those who abstain from voting report a poorer state of health[19,23]; and

Whereas, Options for interventions that allow voter registration in clinical settings exist and have been successful in registering patients to vote. In a community clinic model, 89% of those who were eligible to vote were registered with clinic-based voter registration[11–13, 21]; and

Whereas, Between 2006 and 2018, physicians voted approximately 14% less than the general population[26]; and

Whereas, Additional research must examine the multidimensional impact of promotion of voter registration and civic participation on the longitudinal health outcomes of patients; therefore be it

RESOLVED, That our American Medical Association acknowledge voting is a social determinant of health and significantly contributes to the analyses of other social determinants of health as a key metric (New HOD Policy); and be it further

RESOLVED, That our AMA recognize gerrymandering as a partisan effort that functions in part to limit access to health care, including but not limited to the expansion of comprehensive medical insurance coverage, and negatively impacts health outcomes (New HOD Policy); and be it further

RESOLVED, That our AMA collaborate with appropriate stakeholders and provide resources to firmly establish a relationship between voter participation and health outcomes. (Directive to Take Action)

Fiscal Note: Modest - between $1,000 - $5,000

Received: 05/09/22

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RELEVANT AMA POLICY

Support for Safe and Equitable Access to Voting H-440.805
1. Our AMA supports measures to facilitate safe and equitable access to voting as a harm-reduction strategy to safeguard public health and mitigate unnecessary risk of infectious disease transmission by measures including but not limited to: (a) extending polling hours; (b) increasing the number of polling locations; (c) extending early voting periods; (d) mail-in ballot postage that is free or prepaid by the government; (e) adequate resourcing of the United States Postal Service and election operational procedures; (f) improved access to drop off locations for mail-in or early ballots; and (g) use of a P.O. box for voter registration.
2. Our AMA opposes requirements for voters to stipulate a reason in order to receive a ballot by mail and other constraints for eligible voters to vote-by-mail.
Citation: Res. 18, I-21

Mental Illness and the Right to Vote H-65.971
Our AMA will advocate for the repeal of laws that deny persons with mental illness the right to vote based on membership in a class based on illness.
Citation: Res. 202, A-10; Reaffirmed: BOT Rep. 04, A-20

Support of Human Rights and Freedom H-65.965
Our AMA: (1) continues to support the dignity of the individual, human rights and the sanctity of human life, (2) reaffirms its long-standing policy that there is no basis for the denial to any human being of equal rights, privileges, and responsibilities commensurate with his or her individual capabilities and ethical character because of an individual's sex, sexual orientation, gender, gender identity, or transgender status, race, religion, disability, ethnic origin, national origin, or age; (3) opposes any discrimination based on an individual's sex, sexual orientation, gender identity, race, religion, disability, ethnic origin, national origin or age and any other such reprehensible policies; (4) recognizes that hate crimes pose a significant threat to the public health and social welfare of the citizens of the United States, urges expedient passage of appropriate hate crimes prevention legislation in accordance with our AMA's policy through letters to members of Congress; and registers support for hate crimes prevention legislation, via letter, to the President of the United States.
Citation: CCB/CLRPD Rep. 3, A-14; Reaffirmed in lieu of: Res. 001, I-16; Reaffirmation: A-17

Discriminatory Policies that Create Inequities in Health Care H-65.963
Our AMA will: (1) speak against policies that are discriminatory and create even greater health disparities in medicine; and (2) be a voice for our most vulnerable populations, including sexual, gender, racial and ethnic minorities, who will suffer the most under such policies, further widening the gaps that exist in health and wellness in our nation.
Citation: Res. 001, A-18

Racism as a Public Health Threat H-65.952
1. Our AMA acknowledges that, although the primary drivers of racial health inequity are systemic and structural racism, racism and unconscious bias within medical research and health care delivery have caused and continue to cause harm to marginalized communities and society as a whole.
2. Our AMA recognizes racism, in its systemic, cultural, interpersonal, and other forms, as a serious threat to public health, to the advancement of health equity, and a barrier to appropriate medical care.
3. Our AMA will identify a set of current, best practices for healthcare institutions, physician practices, and academic medical centers to recognize, address, and mitigate the effects of racism on patients, providers, international medical graduates, and populations.

4. Our AMA encourages the development, implementation, and evaluation of undergraduate, graduate, and continuing medical education programs and curricula that engender greater understanding of: (a) the causes, influences, and effects of systemic, cultural, institutional, and interpersonal racism; and (b) how to prevent and ameliorate the health effects of racism.
5. Our AMA: (a) supports the development of policy to combat racism and its effects; and (b) encourages governmental agencies and nongovernmental organizations to increase funding for research into the epidemiology of risks and damages related to racism and how to prevent or repair them.
6. Our AMA will work to prevent and combat the influences of racism and bias in innovative health technologies.
Citation: Res. 5, I-20

Health Plan Initiatives Addressing Social Determinants of Health H-165.822
Our AMA:
1. recognizing that social determinants of health encompass more than health care, encourages new and continued partnerships among all levels of government, the private sector, philanthropic organizations, and community- and faith-based organizations to address non-medical, yet critical health needs and the underlying social determinants of health;
2. supports continued efforts by public and private health plans to address social determinants of health in health insurance benefit designs;
3. encourages public and private health plans to examine implicit bias and the role of racism and social determinants of health, including through such mechanisms as professional development and other training;
4. supports mechanisms, including the establishment of incentives, to improve the acquisition of data related to social determinants of health, while minimizing burdens on patients and physicians;
5. supports research to determine how best to integrate and finance non-medical services as part of health insurance benefit design, and the impact of covering non-medical benefits on health care and societal costs; and
6. encourages coverage pilots to test the impacts of addressing certain non-medical, yet critical health needs, for which sufficient data and evidence are not available, on health outcomes and health care costs.
Citation: CMS Rep. 7, I-20; Reaffirmed: CMS Rep. 5, I-21

Expanding Access to Screening Tools for Social Determinants of Health/Social Determinants of Health in Payment Models H-160.896
Our AMA supports payment reform policy proposals that incentivize screening for social determinants of health and referral to community support systems.
Citation: BOT Rep. 39, A-18; Reaffirmed: CMS Rep. 10, A-19

Health, In All Its Dimensions, Is a Basic Right H-65.960
Our AMA acknowledges: (1) that enjoyment of the highest attainable standard of health, in all its dimensions, including health care is a basic human right; and (2) that the provision of health care services as well as optimizing the social determinants of health is an ethical obligation of a civil society.
Citation: Res. 021, A-19