Received: 10 October 2023 | Revised: 23 August 2024 | Accepted: 11 September 2024

DOI: 10.1111/ssqu.13451

ORIGINAL ARTICLE

Voter attitudes and politicians with health conditions and disabilities

Gabriele Magni[1] | **Andrew Reynolds**[2]

[1]Department of Political Science and International Relations, Loyola Marymount University, Los Angeles, California, USA

[2]Princeton University, Princeton, New Jersey, USA

Correspondence
Gabriele Magni, Loyola Marymount University.
Email: gabriele.magni@lmu.edu.

Abstract

Background: Millions of Americans live with chronic health conditions and disabilities. While disability and disabling conditions are common in the United States, the number of politicians and candidates with disclosed disabilities or chronic health conditions remains extremely low.

Objectives: This study examines what drives the lack of descriptive representation of individuals with disabilities or chronic health conditions. In particular, it examines whether disability bias, or more specifically ableism, drives voter bias against politicians with health challenges and disabilities.

Methods: The analysis relies on two original surveys with samples of American respondents that match Census quotas on key indicators. The first survey was administered to more than 1800 U.S. respondents in 2018. The second survey was administered to 6345 U.S. respondents in 2020. The approach combines observational and experimental data, as well as quantitative and qualitative analysis.

Results: The findings reveal that voters are significantly less likely to support candidates with disclosed disabilities or health conditions. Mental illness and HIV face the strongest discrimination, while physical challenges due to birth conditions like wheelchair usage and dwarfism are the least penalized. A combination of prejudice, negative character assessment, and electability concerns drive voter bias.

Conclusion: Understanding the barriers to the election of politicians with disabilities and chronic health conditions is crucial to improve the representation of marginalized communities, as descriptive representation improves public policy outcomes for marginalized communities.

The Center for Disease Control estimates that over one in four adult Americans—equivalent to 71 million people in 2022—have a disability.[1] One million Americans are legally blind, a million are legally deaf, and three million use a wheelchair or a mobility device.[2] Each year, around 800,000 Americans have a heart attack, and 1.8 million are diagnosed with cancer. A total of 1.1 million live with HIV. Over 99 million adults are overweight, and 70 million are obese.[3] Almost 50 million people live with anxiety and depression, while 11 million have bipolar disorder.[4] There are an estimated 30,000 little people living in America. While disability and disabling conditions are common in the United States, politicians and candidates with disclosed disabilities are not, suggesting that disability bias, or more specifically ableism, may be widespread among American voters. This study explores this under-investigated phenomenon using two national surveys.

People with disabilities and chronic health conditions have distinctive political preferences. They generally support greater public spending, healthcare spending, and income redistribution (Bernardi 2020; Gastil 2000; Reher 2020; Schur and Adya 2013). They have also been historically less engaged in politics (Burden et al. 2017; Gagné, Schoon, and Sacker 2019; Ojeda and Pacheco 2019; Reher 2020; Schur and Kruse, 2000). For instance, citizens with depressive symptoms and heart diseases are less likely to vote and are less interested in politics (Gollust and Rahn 2015; Landwehr and Ojeda 2020). This limited political engagement partially accounts for why the policy preferences of individuals with health conditions are not as well represented as the preferences of healthy citizens (Pacheco and Ojeda 2019).

Another factor that negatively affects preference representation is the scarcity of elected officials with chronic health conditions and disabilities. Descriptive representation can be a powerful treatment to the marginalization of minority groups (Scotch and Friedman 2014). In the United Kingdom, for instance, candidates with disabilities share the preference of citizens with disabilities for greater healthcare and public spending (Reher 2021a). But very few representatives with visible disabilities or chronic health conditions are present in the U.S. Congress. Part of the reason is that politicians with invisible disabilities (e.g., psychiatric disabilities) or chronic conditions (e.g., HIV) often have incentives to keep their stigmatizing conditions hidden from the public. Additionally, politicians with disabilities face barriers in political recruitment and campaigns that contribute to underrepresentation, including lack of resources, lack of accessibility, and ableism (Evans and Reher 2020; Waltz and Schippers 2020). In this article, we examine a complementary explanation: voter negative bias toward politicians with disabilities and health challenges.

To do so, we conducted two original large surveys in the United States. In 2020, we surveyed a sample of over 6000 American voters, investigating their likelihood of supporting candidates with various health conditions and disabilities. We find that voters penalize many health conditions but to widely varying degrees. Conditions that may be perceived as impairments to performing the job of elected officials, such as mental illness, are strongly penalized, as are those like HIV that retain acute social stigma. In contrast, conditions that do not affect cognitive capacity and cannot be attributed to individual behavior are the least penalized, as in the case of individuals who use a wheelchair because of birth condition or are little people.

We also find variation among voters in their degree of bias. African-American and LGBTQ+ voters, who are themselves members of historically discriminated against minority groups and have been more exposed to several health conditions, show greater empathy toward candidates with health challenges. LGBTQ+ voters, for instance, are less likely to penalize candidates with HIV or mental illnesses, two conditions that have disproportionately affected the LGBTQ+ community. Women and religious individuals are also more positively predisposed than the norm, while conservative voters have stronger negative bias.

[1] The Americans with Disabilities Act defines disability as "a physical or mental impairment that substantially limits one or more major life activities, a record of such an impairment, or being regarded as having such an impairment." Centers for Disease Control and Prevention. Disability and Health Data System (DHDS) [Internet]. http://dhds.cdc.gov.

[2] National Institutes of Health: https://www.nih.gov/news-events/news-releases/visual-impairment-blindness-cases-us-expected-double-2050

[3] CDC: https://www.cdc.gov/obesity/data/adult.html

[4] National Alliance on Mental Illness: https://www.nami.org/learn-more/mental-health-by-the-numbers

We supplement this analysis with a separate survey that we administered to more than 1800 U.S. likely voters in 2018. This study examines the drivers of voter discrimination with two complementary approaches. First, we rely on a conjoint experiment embedded in the survey, in which respondents voted for their preferred candidate among hypothetical alternatives within their own party. Second, we qualitatively analyze responses to an open-ended question that asked respondents to explain which candidates' characteristics (including health) influenced their vote choice. These analyses reveal that a combination of prejudice, negative assessment of candidates' character, and electability concerns drive voter bias.

Understanding the barriers to the election of candidates with disabilities is important to improve the condition of marginalized communities. Disability rights organizations have advocated the inclusion of people with disabilities in the decision-making process, as conveyed by the slogan "Nothing about us without us" (Charlton 1998). Over time, the disability advocacy community has become increasingly mobilized and visible, especially since the Americans with Disabilities Act was passed in 1990 (see Barton 2013; Mann 2018; Trevisan 2017). But the underrepresentation among elected officials of representatives from marginalized groups perpetuates the prejudice that they are not equipped to participate in political decisions. Descriptive representation matters because elected representatives often better promote the interests of their own group (Mansbridge 1999). Increasing the numbers of people with health challenges in office is crucial to improve public policy outcomes for these communities.

VOTER ATTITUDES TOWARD POLITICIANS WITH CHRONIC HEALTH CONDITIONS AND DISABILITIES

In order to be elected, individuals with disabilities and health challenges need to overcome multiple hurdles of marginalization and discrimination (Schur and Kruse 2000). Lower resources, such as income and education, and lower political efficacy may complicate the decision to run (Reher 2020). Access to funding, organization, and the electorate may be reduced by conditions that limit mobility and ability to communicate with voters (Evans and Reher 2020). Political parties are also often risk averse about nominating candidates who they perceive as being less likely to win.

This study focuses on a complementary explanation: voter negative attitudes toward politicians with chronic health conditions and disabilities. We expect such conditions to influence vote choice because these traits are especially salient, often more than gender and race (Rohmer and Louvet 2009). We argue that voters are overall more likely to display negative evaluations of such candidates, even though we expect a subset of voters to express positive evaluations, as we discuss below. We also argue that three main factors drive voter negative bias against candidates with health conditions: prejudice, doubts about the candidates' ability to fulfill the role of elected official, and electability concerns.

First, prejudice promote discrimination against these candidates. Individuals with disabilities are often seen as dependent and incompetent (Louvet, Rohmer, and Dubois 2009; Nario-Redmond 2010). Citizens often exhibit discrimination against individuals with disability and chronic health conditions. Stigmatized groups are less warm or likable (Rohmer and Louvet 2018; Weiner, Perry, and Magnusson 1988) and stimulate greater social distance (Feldman and Crandall 2007). Many illnesses elicit such attitudes, including mental illness, physical and sensory disabilities, HIV/AIDS, cancer, and obesity (Evans and Reher 2020; Feldman and Crandall 2007). This often leads to a negative moral evaluation of candidates with health conditions (Loewen and Rheault 2019).

Second, voters may doubt the ability of candidates with disabilities and health conditions to perform the job of an elected official. Since people with health challenges and disabilities are at times viewed as incapable (Evans and Reher 2020; Friedman and Scotch 2017; Rohmer and Louvet 2018), they may be considered unfit. Some illnesses may also weaken a candidate's ability to meet the job demands because they require medical treatment leading to absenteeism (Loewen and Rheault 2019).

Third, we anticipate that voters will have concerns about the ability of politicians with health conditions to win elections. Some voters will exhibit strategic discrimination (Bateson 2020). If they think that the electorate will reject disabled candidates, even voters who are not personally opposed become less likely

to support them. Candidates from traditionally marginalized groups face heightened electability scrutiny, as in the case of women, ethnic minorities, and LGBTQ+ people (Magni and Reynolds 2021b).

A hierarchy of penalties?

While most illnesses and disabilities generate some stigma and discrimination, a "hierarchy of impairments" likely exists (Friedman and Scotch 2017). In the top tier, we expect politicians with HIV, depression, and bipolar disorder. HIV/AIDS generates acute prejudice because it has often been framed as the result of stigmatized sexual activity or illegal drug use. These attitudes also build upon stigma affecting already marginalized communities who have been disproportionately affected by HIV/AIDS, such as gay men, sex workers, and drug users (Land and Linsk 2013). Recent work shows that politicians with HIV face strong discrimination in the electorate (Magni and Reynolds 2021a). Individuals living with mental illness also face strong prejudice (Rüsch, Angermeyer, and Corrigan 2005). In politics, voters penalize candidates with depression more strongly than candidates with cancer (Loewen and Rheault 2019).

Stigma is also severe (even though perhaps to a smaller degree) for other conditions considered the result of individual behavior. Illnesses seen as the result of one's voluntary behavior lead to blame attribution (Weiner, Osborne, and Rudolph 2011), which in turn prompts negative character assessment. For instance, overweight individuals are often deemed personally responsible (Oliver and Lee 2005). Blame attribution then feeds negative perceptions of overweight individuals as weak, compulsive, and poor decisionmakers. Consequently, voters rate obese candidates more negatively than average-weight candidates (Miller and Lundgren 2010; Roehling et al. 2014). Cancer and heart attacks are also sometimes seen as the result of individual behavior and lifestyle, whether true or not.

Finally, in the lowest penalty tier, we expect candidates with conditions that are less likely to be attributed to their personal behavior. This is the case, for example, of politicians who use a wheelchair because of a birth condition or who are little people. These two conditions are also less likely to raise concerns about absenteeism and cognitive ability.

We also expect that candidates with chronic health conditions will elicit positive attitudes among a subgroup of voters. This may happen because people with disabilities and debilitating illness are sometimes presented as superhumans who have overcome monumental struggles with tireless tenacity (Nario-Redmond 2010).[5] As a result, some voters may support politicians with health challenges because they see them as having strong discipline, determination, and a hard-working disposition. The personal challenges in the lives of such candidates may also increase their perceived empathy and sensitivity in the eyes of the electorate.[6] Voters in the United Kingdom consider candidates with disability as more compassionate, honest, and hard-working (Reher 2021b).

WHICH VOTERS PENALIZE POLITICIANS WITH HEALTH CONDITIONS AND DISABILITY?

We hypothesize that some minority voters and liberal voters will penalize candidates with chronic health conditions less severely than other voters. First, voters from marginalized groups often exhibit greater empathy. This is because "historically disadvantaged groups […] might find it easier to imagine themselves in the position of a person being unfairly treated, *even when that person comes from a different group*" (Sirin,

[5] One example in popular culture is Marvel's Daredevil. Blinded by a radioactive substance, he has become a superhero whose other senses are heightened, giving him 'radar sense'. See: https://www.aruma.com.au/about-us/blog/run-forest-run-disability-stereotypes-in-the-media/.

[6] Anecdotal evidence suggests that politicians who have faced pain as a result of their own or their own family members' illness or death are seen as relatable and attuned to ordinary people's suffering. For instance, Joe Biden is often celebrated for his empathy, as a result of his stuttering and the tragic loss of his wife and daughter and of his son Beau. See *The Atlantic*: https://www.theatlantic.com/ideas/archive/2020/11/joe-bidens-superpower/616957/.

Valentino, and Villalobos 2017, p. 429, italics in original). Individuals who have experienced discrimination are more supportive of members of *other* groups facing discrimination. In particular, empathy more likely emerges within historically oppressed minority groups for whom a narrative of group oppression is salient (Eklund, Andersson-Stråberg, and Hansen 2009). These two conditions are central for African-Americans and LGBTQ+ individuals, who have faced discrimination and mobilized as groups in the Civil Rights Movement and LGBTQ+ movement.

Second, we expect communities more familiar with health challenges to express greater empathy and support for candidates facing those challenges. This is because personal experience and direct social contact with illnesses reduce stigmatization and discrimination (Thornicroft et al. 2008). African-Americans and LGBTQ+ people, in particular, have greater familiarity with several chronic health conditions that have disproportionately affected their communities. African Americans are more likely than the general population to be overweight, have diabetes, experience heart attacks, die from cancer, use a wheelchair, be blind, and be living with HIV.[7] Gay men have been associated with HIV/AIDS since the beginning of the epidemic, to the extent that the disease was labeled "gay cancer" in the early 1980s. Still 40 years after the onset of the epidemic, gay and bisexual men account for almost 70 percent of the 40,000 new HIV infections that occur every year in the United States. The trans community is also disproportionately under threat: 27 percent of trans women overall and 50 percent of black trans women in the United States live with HIV.[8] LGBTQ+ people are also more likely to face mental health challenges as a result of the discrimination, harassment, and violence that they face (Huebner, Rebchook, and Kegeles 2004). LGB adults are more than twice as likely as heterosexual adults to experience a mental health condition, while transgender individuals are four times as likely as cisgender people.[9]

Additionally, we expect ideological beliefs to influence voter attitudes. Conservatives often prefer "powerful" candidates and strong leadership (Laustsen 2017) and are more likely to blame individuals for their condition (Skitka and Tetlock 1992). Conservative voters therefore should be less inclined than liberal ones to support candidates with health challenges.

Theoretical expectations: A summary

We have developed three sets of expectations. First, we expect voters to penalize candidates with disabilities and chronic health conditions because of prejudice, doubts about their ability to fulfill the role of elected official, and electability concerns. Second, we anticipate a hierarchy of penalties. We expect the strongest penalties for mental health conditions and HIV, which often generate strong stigma. Following are conditions sometimes seen as the result of individual behavior, such as obesity, which can lead to blame attribution. We expect lower penalties for conditions less likely to be attributed to personal behavior, such as using a wheelchair because of birth conditions. Third, we expect penalty variation across groups of voters, with smaller penalties from minority and liberal voters. In particular, Black and LGBTQ+ individuals are expected to display less bias because of greater empathy stemming from personal or community experiences.

DATA AND METHODS

To examine how voters react to political candidates with disabilities and health challenges, we conducted two surveys with samples that mirror census quotas for age, gender, income, and education. The two surveys were administered online by the companies Dynata (formerly Survey Sampling International) and

[7] US Department of Health and Human Services, Office of Minority Health: https://minorityhealth.hhs.gov/omh/browse.aspx?lvl=3&lvlid=61; National Federation of the Blind: https://www.nfb.org/resources/blindness-statistics

[8] HIV Government Statistics: https://www.hiv.gov/hiv-basics/overview/data-and-trends/statistics.

[9] National Alliance on Mental Illness: https://www.nami.org/Your-Journey/Identity-and-Cultural-Dimensions/LGBTQI

Cint. As we explain below, the surveys included both observational and experimental items and provide quantitative and qualitative evidence.[10]

Observational analysis

We administered one of the two surveys to 6340 likely U.S. voters in 2020. The survey included a battery of items asking respondents how likely they would be to support candidates with chronic health conditions or disabilities: "Compared to a healthy candidate, how likely are you to vote for a presidential candidate who… is overweight with diabetes? | has had a heart attack? | has cancer? | is HIV positive? | is being treated for depression? | has bipolar disorder? | uses a wheelchair? | is blind or visually impaired? | is deaf? | is a 'little person' or dwarf?"

The survey then presented a series of questions measuring respondents' socio-demographic characteristics, party preference, and political ideology. This data set provides the opportunity to conduct descriptive analysis on the penalty faced by candidates with various health challenges and to examine which voters penalize (or support) these candidates.

Experimental analysis

We administered a separate survey to 1829 U.S. citizens in 2018. This survey allows us to analyze the reasons for voter bias with two complementary approaches: an embedded conjoint experiment and an open-ended question in which respondents could freely report their attitudes toward candidates' health and other characteristics. The open-ended question asked: "Think about the characteristics of the candidates that we showed you: gender, religion, age, health, sexual orientation, education, race/ethnicity, and political experience. Can you briefly tell us what information, in general, has led you to decide which candidates you would be more likely to vote for?" This question offers insight into the relative importance of health conditions on vote choice and the reasons why candidates' health may play a role in the decision.

The conjoint experiment presented respondents with five pairs of hypothetical candidates for whom we kept party constant, similarly to a primary election. For each candidate, we randomized eight sociodemographic characteristics across survey participants: health, gender, race/ethnicity, age, religion, sexual orientation, education, and political experience. Within the health attribute, in addition to candidates with no chronic health condition, we presented respondents with candidates who are overweight with diabetes (one of the most widespread health conditions), candidates using a wheelchair as a result of birth condition, and candidates with HIV, distinguishing between candidates who acquired HIV at birth or later in life. This differentiation with regard to HIV helps shed light on the effects of blame attribution and character assessment as drivers of voter bias.[11]

After each pair of candidates, we asked respondents who they would be more likely to vote for. We also asked two additional questions: "Which of these two candidates would you prefer to have as a neighbor?" and "Which of these two candidates has better chances to win the election?" These questions allow us to examine the impact of outright prejudice and electability concerns on vote choice. In particular, the statistical analysis allows us to quantify the causal effect of each candidate's trait (e.g. being overweight, living with HIV, using a wheelchair) on voter prejudice and electability concerns.

[10] The Supporting Information Appendix reports information on sample characteristics and survey instruments for both surveys.

[11] See the Supporting Information Appendix for a complete description of the conjoint design. The appendix also reports an example of the conjoint task displayed to respondents (Supporting Information Figure 1).

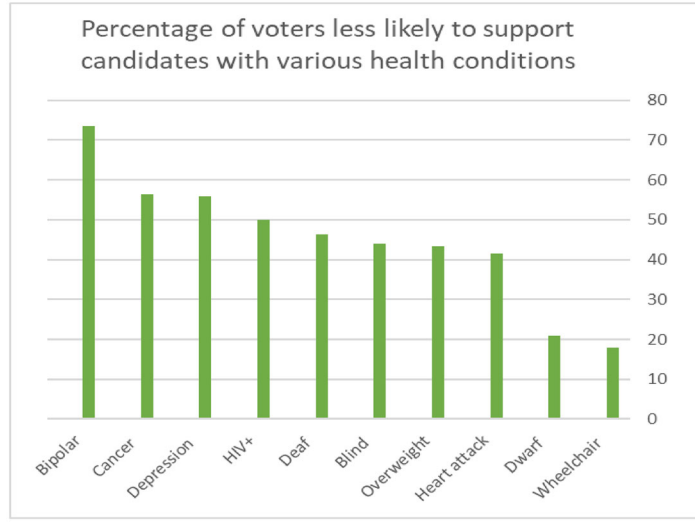

FIGURE 1 Voter penalty for candidates with health challenges and disabilities. The figure depicts the electoral penalties faced by candidates with health conditions and disabilities.

RESULTS

Observational analysis: We first present descriptive results from our 2020 survey conducted with more than 6000 likely U.S. voters. Figure 1 reports the percentages of respondents and subgroups of respondents who are "much less likely" and "less likely" to support candidates with health conditions and disabilities compared to "healthy" candidates.

All health conditions face severe negative bias, but penalties vary substantially across conditions. Mental illnesses and HIV are the most penalized. More than 70 percent of voters are less likely to vote for a politician with bipolar disorder, 55 percent for someone with depression, and 50 percent for a candidate with HIV. Cancer, which can be strongly debilitating, at times be life threatening, and potentially elicit blame attribution, is also harshly penalized, with 56 percent of voters less likely to support a candidate who has cancer. Other conditions that are perceived to impair the ability of performing the duties of elected officials also face substantial penalties, but to declining degrees. Between 40 percent and 45 percent of voters are less likely to vote for a politician who is overweight, blind, deaf, or had a heart attack. Candidates who use a wheelchair because of birth condition or are little people—conditions that normally do not affect cognitive capacity and are less likely to spark blame attribution—are discriminated against by about 20 percent of voters.

Which voters penalize candidates with health conditions?

Table 1 reports results from ordered logistic regressions exploring which respondents penalize candidates with health challenges. We ran ordered logistic regressions because the dependent variable is measured on a five-point scale, ranging from "much less likely to vote for" to "much more likely to vote for" candidates with health conditions. Negative coefficients in Table 1 indicate that respondents' attributes listed in the first column are associated with lower support for politicians with the health condition or disability reported at the top of columns 2–11. For instance, the negative "Age" coefficient in the "Overweight column" indicates that, as voters' age increases, attitudes toward overweight politicians become more negative—in other words, older voters are less likely to support overweight politicians than younger voters.

African Americans penalize candidates who are overweight or have cancer less than what white voters do but exhibit greater penalties for candidates struggling with mental health. Interestingly, African

TABLE 1 Vote for candidates with chronic health conditions and disability.

Health Conditions and Disabilities	Overweight	Heart attack	Cancer	HIV+	Depression	Bipolar	Wheelchair	Blind	Deaf	Dwarf
Age	−0.01***	−0.01***	−0.01***	−0.01***	−0.03***	−0.02***	−0.003	−0.01***	−0.01***	−0.01**
	(0.002)	(0.002)	(0.002)	(0.002)	(0.002)	(0.002)	(0.002)	(0.002)	(0.002)	(0.002)
Education	−0.07***	−0.07***	−0.05**	0.03	0.02	0.0002	0.03	0.07***	0.05**	−0.02
	(0.02)	(0.02)	(0.02)	(0.02)	(0.02)	(0.02)	(0.02)	(0.02)	(0.02)	(0.02)
Income	−0.04**	−0.003	0.002	0.003	−0.05**	−0.10***	−0.02	−0.04*	−0.02	−0.03
	(0.02)	(0.02)	(0.02)	(0.02)	(0.02)	(0.02)	(0.02)	(0.02)	(0.02)	(0.02)
LGBT (self)	−0.10	−0.20*	−0.13	0.46***	0.40***	0.27**	0.26*	0.15	0.14	0.13
	(0.10)	(0.10)	(0.10)	(0.11)	(0.10)	(0.09)	(0.12)	(0.10)	(0.10)	(0.12)
Religiosity	0.04	0.05*	0.04*	−0.05*	0.08***	0.08***	0.02	0.05*	0.04	0.09***
	(0.02)	(0.02)	(0.02)	(0.02)	(0.02)	(0.02)	(0.03)	(0.02)	(0.02)	(0.03)
Military (self)	−0.10	0.02	−0.06	−0.27***	−0.06	0.004	−0.03	−0.03	−0.10	−0.02
	(0.08)	(0.08)	(0.08)	(0.08)	(0.08)	(0.08)	(0.10)	(0.08)	(0.08)	(0.10)
Conservative	0.02	−0.10***	−0.07**	−0.24***	−0.17***	−0.15***	−0.06*	−0.11***	−0.09***	−0.10***
	(0.02)	(0.02)	(0.02)	(0.02)	(0.02)	(0.02)	(0.03)	(0.02)	(0.02)	(0.03)
Party: Republic	0.09	−0.16	−0.05	−0.29***	−0.18*	−0.10	−0.13	−0.12	−0.14	−0.28**
	(0.08)	(0.09)	(0.08)	(0.08)	(0.08)	(0.08)	(0.10)	(0.08)	(0.08)	(0.10)
Party: Independ	0.13	−0.06	0.06	−0.04	−0.08	0.02	−0.01	0.04	−0.02	−0.08
	(0.07)	(0.07)	(0.07)	(0.07)	(0.07)	(0.07)	(0.08)	(0.07)	(0.07)	(0.08)
Gender: Male	0.003	0.07	0.17**	−0.13*	−0.26***	−0.12*	−0.29***	−0.22***	−0.18**	−0.22**
	(0.06)	(0.06)	(0.06)	(0.06)	(0.06)	(0.06)	(0.07)	(0.06)	(0.06)	(0.07)
Gender: Other	0.18	0.18	0.44	0.02	0.13	0.71*	0.33	0.51	0.68	−0.62
	(0.38)	(0.37)	(0.34)	(0.39)	(0.36)	(0.35)	(0.46)	(0.38)	(0.39)	(0.41)
Race: Black	0.44***	0.14	0.33**	−0.02	−0.55***	−0.26*	0.04	−0.26*	−0.20	0.12
	(0.12)	(0.12)	(0.11)	(0.11)	(0.11)	(0.11)	(0.14)	(0.11)	(0.11)	(0.13)

(Continues)

TABLE 1 (Continued)

Health Conditions and Disabilities	Overweight	Heart attack	Cancer	HIV+	Depression	Bipolar	Wheelchair	Blind	Deaf	Dwarf
Race: Latinx	−0.01	−0.18	0.06	0.04	−0.19	−0.10	0.005	−0.15	−0.08	−0.02
	(0.11)	(0.11)	(0.11)	(0.11)	(0.11)	(0.11)	(0.13)	(0.11)	(0.11)	(0.13)
Race: Asian	−0.16	−0.47***	−0.14	−0.45***	−0.43***	−0.18	−0.47**	−0.50***	−0.40***	0.03
	(0.12)	(0.12)	(0.12)	(0.12)	(0.12)	(0.12)	(0.14)	(0.12)	(0.12)	(0.15)
Race: Native	0.17	0.22	0.22	0.32	0.29	0.43	−0.24	−0.10	−0.19	0.02
	(0.23)	(0.24)	(0.22)	(0.23)	(0.22)	(0.22)	(0.27)	(0.23)	(0.22)	(0.27)
Race: Other	−0.11	0.12	0.28	0.07	−0.03	−0.24	0.15	−0.18	0.02	0.21
	(0.18)	(0.19)	(0.19)	(0.19)	(0.19)	(0.18)	(0.23)	(0.19)	(0.19)	(0.23)
Observations	5472	5472	5472	5471	5469	5470	5472	5472	5472	5472

Note: The table reports the results of ordered logistics regression calculated in R using the polr command from the MASS package. To print the stars associated with the p-value, we used the stargazer command from the stargazer package. Data come from our original 2020 survey administered online by Dynata.
*$p < 0.05$; **$p < 0.01$; ***$p < 0.001$.

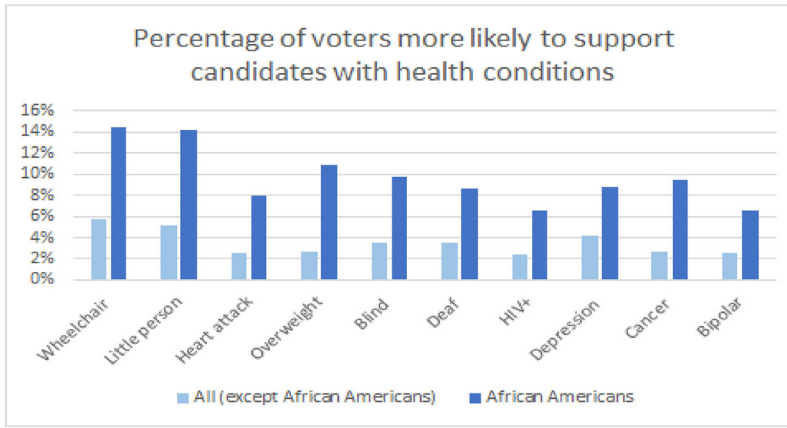

FIGURE 2 Support for candidates with health challenges among African-American voters. The figure shows that African-American voters are more likely to support candidates with health conditions and disabilities than non-African-American voters.

Americans are also consistently *more* likely to vote for candidates with all health conditions (see Figure 2). While the data at hand do not allow us to fully test the reasons why, this may be the effect of familiarity with diseases and of "group empathy." In contrast, Asian Americans are less likely than white voters to support politicians with health conditions (Table 1). Even though a minority group, Asian Americans often lack a salient narrative of group oppression, a condition important for group empathy to emerge (Eklund, Andersson-Stråberg, and Hansen 2009).

Table 1 shows that LGBTQ+ individuals penalize candidates with mental health conditions and HIV less than straight voters. As discussed, the LGBTQ+ community has experienced (and continues to experience) HIV/AIDS and mental illnesses at disproportionate levels. HIV/AIDS also contributed to group mobilization within the LGBTQ+ community in response to government discrimination. This has likely promoted familiarity and empathy for individuals facing HIV and mental health challenges, which translates in greater support for candidates with HIV, depression, and bipolar disorder.

The fact that racial minorities (and in particular Black voters) and LGBTQ+ people show less bias toward politicians with a variety of health conditions suggests that a perceived linked fate may be at play, as we observe a linked effect across otherwise distinctive groups. In other words, a feeling of historical exclusion may link together marginalized communities that have faced discrimination, with individuals from these communities more likely to support candidates from various traditionally marginalized groups.

Conservative voters penalize candidates with health conditions more than liberals, with the only exception of candidates who are overweight. In contrast, religious individuals show less negative attitudes, with the only exception of candidates with HIV, who they penalize more strongly. This is not surprising, given the strong negative rhetoric promoted over the years by the religious right against people with HIV/AIDS. Regarding sociodemographic characteristics, women and younger voters are generally more supportive than men and older voters. Education has mixed effects, reinforcing the penalty for health conditions sometimes perceived as behavioral outcomes (i.e., being overweight, heart attacks, and cancer), but reducing the penalty for candidates with physical disabilities like blindness and deafness.

Experimental analysis: Drivers of voter negative bias

We explore the reasons for voter bias with a second survey conducted with more than 1800 U.S. respondents. The conjoint experiment embedded in the survey focused on candidates who are overweight with

TABLE 2 Driver of voter negative bias (conjoint analysis).

Drivers of Voter Negative Bias	Prejudice (%)	Electability (%)	Electability (controlling for prejudice) (%)
HIV+	−7***	−9.1***	−5.8***
HIV+ since birth	−5.1***	−5.8***	−3.5***
Overweight with diabetes	−3.5***	−5.8***	−4.2***
Wheelchair since birth	−0.6	−2.8**	−2.5**

Note: The table reports the results of our conjoint experiment. We ran OLS regressions with cluster-robust standard errors because each respondent evaluated several pairs of candidates. The dependent variable is the choice indicator, and the independent variables are the set of dummies for the attribute levels. Since attribute levels are independently randomized from one another, OLS produces unbiased and consistent estimates of the average marginal component effects, or AMCEs (Horiuchi, Smith, and Yamamoto 2018, p. 199; Hainmueller et al. 2014).
*$p < 0.05$; **$p < 0.01$; ***$p < 0.001$.

diabetes, use a wheelchair because of birth condition, and candidates with HIV, acquired either at birth or later in life (to explore potential blame attribution).

Respondents penalize candidates who have HIV or are overweight more severely than candidates who have been HIV-positive since birth or use a wheelchair because of birth condition. In the vote simulations, marginal means reveal that respondents chose "healthy" candidates 54.8 percent of the time, compared to 42.8 percent for candidates with HIV, 45.4 percent for overweight candidates, 47.3 percent for those living with HIV since birth, and 50.2 percent for those using a wheelchair. Additionally, average marginal causal effects (AMCEs) show that compared to "healthy" candidates, candidates with HIV face on average a penalty of 11.9 percentage points, those who are overweight of 9.1, candidates living with HIV since birth of 8.1, and those using a wheelchair since birth of 4.5 points. Consistently with Weiner's attribution theory of responsibility (Weiner et al. 1988), these findings reveal that voters penalize more severely candidates who can potentially be considered responsible for their situation, as opposed to candidates who cannot be blamed for a condition acquired at birth.[12]

We further investigate the drivers of voters' bias by asking respondents: "Which of these two candidates… (i) …would you prefer to have as a neighbor? (ii) …has better chances to win the election?" The results reveal that prejudice and electability concerns contribute to voter bias. Table 2 reports AMCEs with percentage point penalties where the baseline is a "healthy" candidate for prejudice, electability concerns, and electability concerns controlling for prejudice. Candidates with HIV experience the greatest prejudice, while electability concerns are the only statistically significant factor explaining voter bias against candidates using a wheelchair because of birth condition. The third column in Table 2 reveals that part of electability concerns mask prejudice, but electability remains an important factor influencing vote choice even when we control for prejudice.[13]

Answers to an open-ended question offer further insights into voter attitudes toward candidates with health conditions. When asked to explain their vote choice in their own words, many respondents indicated that candidates' health conditions played a role. A content analysis of the answers confirms that prejudice plays a driving role and stigma manifests in negative moral evaluations, inasmuch as candidates with chronic health conditions are seen by some as failing to take care of themselves. For some respondents, chronic health conditions are an indicator of a weak or negative character, which is described as undesirable in elected officials. For instance, one respondent said: "Health is a big issue for me…those that are obese I look down at. If you can't even take care of your own basic health needs and make wise choices, I cannot trust you to make political judgments on my behalf." Another explained: "One [candidate] I was most concerned by was overweight and diabetic; 35 years old. Without parsing the cause of

[12] Supporting Information Appendix Figures 2 and 3 report the conjoint results based on average marginal causal effects and marginal means, respectively.

[13] Supporting Information Appendix Table 2 reports the full model specifications and results.

his obesity, the combo, combined with his age indicated to me an irresponsible personal behavior. This mirrors, quite likely, his approach to public life, and I can't back that." Confirming the importance of attribution of responsibility, a respondent said: "I would prefer a candidate who actively took care of their health but wouldn't hold it against anyone who was born or disabled [sic]." Another respondent expressed prejudice: "some had aids [sic] that's not a good disease."

Other voters perceive chronic health conditions as a debilitating impairment to the ability of politicians to fulfill their job. For instance, one respondent noted: "I would prefer someone who is physically healthy so they would be up to the demands of the job." Others said: "I felt that the candidates that were HIV positive, I wouldn't vote for them because how long will the person be in office and how much will their health affect the job they do." "In most cases it was their health. I was worried they would be out sick more than most so wouldn't elect them." Two respondents said they preferred "[a candidate who] is also healthy and able to work under pressure" or "someone not burdened by sickness." Even more explicitly, others expressed support for candidates "if they are not under a death condition" and worried that "HIV positive people might not live as long as their contemporaries."

On the other hand, a very small number of respondents indicated they would be more inclined to support candidates with health conditions and disabilities than other candidates. This stemmed from positive stereotypes associated with people with disabilities, who are sometimes perceived as heroic and inspiring. For example, one respondent stated: "Though there were many HIV-positive [candidates], most were in middle or senior years, which I took as a sign of a disciplined personality." Other respondents argued that candidates with health conditions are more likely to have empathy and sensibility for other people's struggles because of their own struggles. For example, one respondent explained: "if they have a health issue, they are more likely to be sympathetic to ill citizens and be more understanding." Another one similarly remarked: "I believed that his life experience with HIV would make him more attuned to the issues of people at-risk and in-need."

CONCLUSION

The presence of high-profile elected officials living with health conditions has been highly consequential, as they have advanced battles against diseases and disabilities. Franklin D. Roosevelt funded the research which led to a vaccine for polio. Through multiple battles with cancer, Senator Arlen Specter highlighted the need for research into non-Hodgkin's lymphoma. After 16 years in Congress, Patrick Kennedy acknowledged his own struggles with depression, addiction, and bipolar disorder as he began a crusade to highlight the challenges of living with mental illness. However, the number of politicians with known health challenges has historically been low. Individuals with disabilities and chronic health conditions continue to be underrepresented among elected officials.

This study shows that voter negative bias is one of the reasons explaining the scarcity of these politicians. Our two surveys, respectively conducted with more than 6000 and more than 1800 U.S. likely voters, reveal that voters strongly discriminate against candidates with health challenges. Voters penalize all conditions, but the penalty is strongest for HIV/AIDS and mental illnesses, which face severe stigma and prejudice. Perhaps unsurprisingly, candidates with bipolar disorders are substantially more penalized than politicians with any other condition. A second tier of penalties includes various conditions that can be strongly debilitating or elicit attribution of responsibility such as cancer, heart attacks, being overweight, and physical disabilities. Conditions for which individuals cannot be blamed because they were acquired at birth and challenges that are less likely to lead to absenteeism, such as using a wheelchair or being little people, face more limited penalties. These tiers of penalty mostly fulfilled our expectations, even though cancer was more penalized than what previous work has found (Loewen and Rheault 2019).

There is also evidence suggesting the power of empathy in lessening voter bias against politicians with health challenges. African Americans—who are more likely to live with many of the conditions considered and to have personal contact with friends, relatives, and colleagues who have such conditions—show greater likelihood of support. This suggests that contact breeds empathy, which in turn lessens prejudice.

The contact theory of empathy is reinforced by the (more positive) way LGBTQ+ voters respond to candidates with HIV and mental illnesses. Familiarity and contact therefore play an important role when it comes to health and disability.

Several factors drive voter bias. Prejudice, negative character assessment, and electability concerns all play a role in creating challenges to the election of politicians with health conditions. Electability concerns are perhaps a greater factor than what was previously acknowledged. Part of the explanation may be that most Americans are not accustomed to individuals with health challenges in leadership roles and assume that society is not ready to elect candidates with such conditions. This leads to strategic discrimination (Bateson 2020): voters worry that such candidates will be rejected by the electorate and, as a result, become less supportive. This self-fulfilling prophecy is pernicious. If citizens are less likely to vote for candidates because they are seen as unelectable, marginalized groups never have a seat at the table. The relative importance of electability concerns vis-a-vis prejudice, however, also leaves the door open to the hope that, as more candidates with health challenges will run for office and win races, concerns about their electoral viability will decrease in voters' minds, and some of the barriers to descriptive representation will weaken.

This study also has some limitations. For instance, the analysis focuses on hypothetical candidates. This decision helps us isolate the impact of a candidate's disability from other candidate's traits that may affect vote choice. But it also prevents us from analyzing how real-world candidates can offset potential disability bias with their personal stories and campaign actions. Future studies should also investigate how a candidate's disability interacts with other candidates' traits, including party ID, race and ethnicity, gender, and class. This could shed light on the intersectional challenges faced by candidates who are minoritized on more than one dimension. Additionally, future work could develop a more granular analysis, exploring how voters react to a candidate's disability in different elections (e.g., primaries vs. general) and in elections for offices at different levels (e.g., local, state, and federal).

Better understanding the barriers to the election of politicians with disabilities and health conditions is crucial to improve the condition of this marginalized community. The lack of descriptive representation hinders the promotion of the rights and interests of marginalized groups. This is because legislators from marginalized groups share the lived experiences of the groups they come from and often better promote the interests of their own group (Boas and Smith 2019; Mansbridge 1999; Reher 2021a). Indeed, disability organizations have advocated for the inclusion of people with disability in the decision-making process with the slogan "Nothing About Us Without Us" (Charlton 1998). Electing more politicians with disabilities and health challenges will constitute an important step toward greater political inclusion, as would be the decision of more politicians currently in office to disclose their disabilities.

CONFLICT OF INTEREST STATEMENT

The authors declare no conflicts of interest.

DATA AVAILABILITY STATEMENT

All data and code used for analysis will be made publicly available on the Harvard Dataverse.

ORCID

Gabriele Magni https://orcid.org/0000-0003-0324-8303

REFERENCES

Barton, L. (ed). 2013. *Disability Politics and the Struggle for Change*. London: Routledge.

Bateson, R. 2020. "Strategic Discrimination." *Perspectives on Politics* 18(4): 1068–87.

Bernardi, L. 2020. "Depression and Political Predispositions: Almost Blue?" *Party Politics* 27(6): 1132–43.

Boas, T. C., and A. E. Smith. 2019. "Looks Like Me, Thinks Like Me: Descriptive Representation and Opinion Congruence in Brazil." *Latin American Research Review* 54(2): 310–28.

Burden, B. C., P. Herd, J. M. Fletcher, D. P. Moynihan, and B. M. Jones. 2017. "How Different Forms of Health Matter to Political Participation." *The Journal of Politics* 79(1): 166–78.

Charlton, J. 1998. *Nothing about Us without Us: Disability Oppression and Empowerment*. Berkeley and Los Angeles: University of California Press.

Eklund, J., T. Andersson-Stråberg, and E. M. Hansen. 2009. "I've Also Experienced Loss and Fear." *Scandinavian Journal of Psychology* 50(1): 65–69.

Evans, E., and S. Reher. 2020. "Disability and Political Representation: Analyzing Barriers to Elected Office in the UK." *International Political Science Review* 43(5), 697–712.

Feldman, D. B., and C. S. Crandall. 2007. "Dimensions of Mental Illness Stigma." *Journal of Social and Clinical Psychology* 26(2): 137–54.

Friedman, S., and R. K. Scotch. 2017. "Politicians with Disabilities: Challenges and Choices." In *Oxford Research Encyclopedia of Politics*. 1–21. Oxford, U.K.: Oxford University Press.

Gagné, T., I. Schoon, and A. Sacker. 2019. "Health and Voting over the Course of Adulthood." *SSM Population Health* 10: 100531.

Gastil, J., 2000. "The Political Beliefs and Orientations of People with Disabilities." *Social Science Quarterly* 81: 588–603.

Gollust, S., and W. Rahn. 2015. "The Bodies Politic: Chronic Health Conditions and Voter Turnout in the 2008 Election." *Journal of Health Politics, Policy and Law* 40(6): 1115–55.

Hainmueller, J., D. J. Hopkins, and T. Yamamoto. 2014. "Causal inference in Conjoint Analysis: Understanding Multidimensional Choices via Stated Preference Experiments." *Political analysis* 22(1): 1–30.

Horiuchi, Y., D. Smith, and T. Yamamoto. 2018. "Identifying Voter Preferences for Politicians' Personal Attributes: A Conjoint Experiment in Japan." *Political Science Research and Methods* 8(1): 75–91.

Huebner, D. M., G. M. Rebchook, and S. M. Kegeles. 2004. "Experiences of Harassment, Discrimination, and Physical Violence among Young Gay and Bisexual Men." *American Journal of Public Health* 94(7): 1200–1203.

Land, H., and N. Linsk. 2013. "HIV Stigma and Discrimination: Enduring Issues." *Journal of HIV/AIDS & Social Services* 12(1): 3–8.

Landwehr, C., and C. Ojeda. 2020. "Democracy and Depression: A Cross-National Study of Depressive Symptoms and Nonparticipation." *American Political Science Review* 115(1): 323–30.

Laustsen, L., 2017. "Choosing the Right Candidate: Observational and Experimental Evidence that Conservatives and Liberals Prefer Powerful and Warm Candidate Personalities, Respectively." *Political Behavior* 39(4): 883–908.

Loewen, P. J., and L. Rheault. 2019. "Voters Punish Politicians with Depression." *British Journal of Political Science* 51(1): 427–36.

Louvet, E., O. Rohmer, and N. Dubois. 2009. "Social Judgment of People with a Disability in the Workplace." *Swiss Journal of Psychology* 68(3): 153–59.

Magni, G., and A. Reynolds. 2021a. "The Persistence of Prejudice: Voters Strongly Penalize Candidates with HIV." *Political Behavior* 44: 1843–62.

Magni, G., and A. Reynolds. 2021b. "Voter Preferences and the Political Underrepresentation of Minority Groups: Lesbian, Gay, and Transgender Candidates in Advanced Democracies." *The Journal of Politics* 83: 1199–215.

Mann, B. 2018. "Survival, Disability Rights, and Solidarity." *Disabilities Studies Quarterly* 38(1).

Mansbridge, J., 1999. "Should Blacks Represent Blacks and Women Represent Women?" *The Journal of Politics* 61(3): 628–57.

Miller, B. J., and J. D. Lundgren. 2010. "An Experimental Study of the Role of Weight Bias in Candidate Evaluation." *Obesity* 18(4): 712–18.

Nario-Redmond, M. R. 2010. "Cultural Stereotypes of Disabled and Non-Disabled Men and Women." *British Journal of Social Psychology* 49(3): 471–88.

Ojeda, C., and J. Pacheco. 2019. "Health and Voting in Young Adulthood." *British Journal of Political Science* 49(3): 1163–86.

Oliver, J. E., and T. Lee. 2005. "Public Opinion and the Politics of Obesity in America." *Journal of Health Politics, Policy and Law* 30(5): 923–54.

Pacheco, J., and C. Ojeda. 2019. "A Healthy Democracy? Evidence of Unequal Representation across Health Status." *Political Behavior* 42: 1245–67.

Reher, S. 2020. "Mind This Gap, Too: Political Orientations of People with Disabilities in Europe." *Political Behavior* 42: 791–818.

Reher, S. 2021a. "Do Disabled Candidates Represent Disabled Citizens?" *British Journal of Political Science* 52: 520–34.

Reher, S. 2021b. "How Do Voters Perceive Disabled Candidates?" *Frontiers in Political Science* 2: 634432.

Roehling, P. V., M. V. Roehling, A. Brennan, A. R. Drew, A. J. Johnston, R. G. Guerra, I. R. Keen, C. P. Lightbourn, and A. H. Sears. 2014. "Weight Bias in US Candidate Selection and Election." *Equality, Diversity and Inclusion: An International Journal* 33: 334–46.

Rohmer, O., and E. Louvet. 2009. "Describing Persons with Disability." *Rehabilitation Psychology* 54(1): 76–82.

Rohmer, O., and E. Louvet. 2018. "Implicit Stereotyping against People with Disability." *Group Processes & Intergroup Relations* 21(1): 127–40.

Rüsch, N., M. C. Angermeyer, and P. W. Corrigan. 2005. "Mental Illness Stigma: Concepts, Consequences, and Initiatives to Reduce Stigma." *European Psychiatry* 20(8): 529–39.

Schur, L., and M. 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, L. A., and D. L. Kruse. 2000. "What Determines Voter Turnout?" *Social Science Quarterly* 81: 571–87.

Scotch, R. K., and S. Friedman. 2014. "Changing Times: Self-Disclosure and the Representational Styles of Legislators with Physical Disabilities." *Disability Studies Quarterly* 34(4).

Sirin, C. V., N. A. Valentino, and J. D. Villalobos. 2017. "The Social Causes and Political Consequences of Group Empathy." *Political Psychology* 38(3): 427–48.

Skitka, L. J., and P. E. Tetlock. 1992. "Allocating Scarce Resources: A Contingency Model of Distributive Justice." *Journal of Experimental Social Psychology* 28(6): 491–522.

Thornicroft, G., E. Brohan, A. Kassam, and E. Lewis-Holmes. 2008. "Reducing Stigma and Discrimination." *International Journal of Mental Health Systems* 2(1): 3.
Trevisan, F. 2017. *Disability Rights Advocacy Online: Voice, Empowerment and Global Connectivity*. New York: Routledge.
Waltz, M., and A. Schippers. 2020. "Politically Disabled: Barriers and Facilitating Factors Affecting People with Disabilities in Political Life within the European Union." *Disability & Society* 36: 517–40.
Weiner, B., D. Osborne, and U. Rudolph. 2011. "An Attributional Analysis of Reactions to Poverty." *Personality and Social Psychology Review* 15(2): 199–213.
Weiner, B., R. P. Perry, and J. Magnusson. 1988. "An Attributional Analysis of Reactions to Stigmas." *Journal of Personality and Social Psychology* 55(5): 738–48.

SUPPORTING INFORMATION

Additional supporting information can be found online in the Supporting Information section at the end of this article.

How to cite this article: Magni, Gabriele, and Andrew Reynolds. 2024. "Voter Attitudes and Politicians with Health Conditions and Disabilities." *Social Science Quarterly* 1–15. https://doi.org/10.1111/ssqu.13451