HEALTH SYSTEMS AND POLICY ANALYSIS

POLICY BRIEF 61

Health as a driver of political participation and preferences

Implications for policy-makers and political actors

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What is a Policy Brief?

A policy brief is a short publication specifically designed to provide policy makers with evidence on a policy question or priority. Policy briefs

- Bring together existing evidence and present it in an accessible format
- Use systematic methods and make these transparent so that users can have confidence in the material
- Tailor the way evidence is identified and synthesised to reflect the nature of the policy question and the evidence available
- Are underpinned by a formal and rigorous open peer review process to ensure the independence of the evidence presented.

Each brief has a one page key messages section; a two page executive summary giving a succinct overview of the findings; and a 20 page review setting out the evidence. The idea is to provide instant access to key information and additional detail for those involved in drafting, informing or advising on the policy issue.

Policy briefs provide evidence for policymakers not policy advice. They do not seek to explain or advocate a policy position but to set out clearly what is known about it. They may outline the evidence on different prospective policy options and on implementation issues, but they do not promote a particular option or act as a manual for implementation.

This policy brief is one of a new series to meet the needs of policy-makers and health system managers. The aim is to develop key messages to support evidence-informed policy-making and the editors will continue to strengthen the series by working with authors to improve the consideration given to policy options and implementation.

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List of abbreviations

AfD	Alternative for Germany
FPÖ	Austrian Freedom Party
GDP	gross domestic product
HDZ	Croatian Democratic Union
HEAL	Health and Environment Alliance
pp	percentage point
PVV	Party for Freedom (Netherlands)
UK	United Kingdom
UKIP	United Kingdom Independence Party
USA	United States of America

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Key messages

Health is central to people's lives yet an under-appreciated influence on politics.

1. **People in poor health often have negative, stigmatizing experiences with public institutions which undermine their trust in the health system, government and democracy.**
2. **People with poor health and disabilities are less likely to vote.** Limited mobility, financial constraints and social stigma all act as barriers to participating in the democratic process.
3. **Declines in the health of individuals and their communities have been linked to support for anti-democratic values and fringe political parties.**
    - Populist parties, especially on the right, give voice to voters frustrated with public institutions that have failed to meet their needs and 'left them behind'.
    - Historically, people in poor health supported mainstream left-leaning parties, but recent evidence suggests that they now gravitate towards right-wing populists.
4. **Policies that protect and promote the well-being of the public are also part of rebuilding trust** in public institutions and the democratic process.
5. **Policy-makers can better engage people in poor health in the democratic process by implementing health-promoting policies and lowering barriers to participation.**
    - People in poor health may be less likely to vote, but they do participate in politics by joining patient advocacy groups and through other non-voting activities, offering opportunities for engagement.
    - Policy-makers can ensure that more vulnerable populations are represented in politics by soliciting the opinions of people in poor health and partnering with advocacy groups.
    - Designing health policies so that the benefits are visible, meaningful and easily attributable to the government means the public is more likely to value the policies and reward the elected officials who adopt them.
6. **Health and politics exist in a self-reinforcing cycle. Rebuilding trust in democratic institutions starts by ensuring that those institutions meet the public's needs.**

Executive summary

Health is an under-appreciated influence on politics.

Health has long been an undercurrent in politics, yet its influence has been under-appreciated. It is central to our lived experience; it empowers us to socialize, work and engage in civic society. Health is also intimately tied to our social, economic and policy contexts. More Europeans than ever are living with chronic diseases and disabilities, and the COVID-19 pandemic precipitated a crisis of well-being and health system performance, forcing entire populations to confront the importance of health protections to their lives and livelihoods. In this context, health may be more relevant to politics than ever.

Poor health drives many people to disengage from voting, but this population still participates in non-voting political activities and patient advocacy groups.

Political participation requires resources like time, knowledge and money. People with poor health and disability face many barriers to participating in the democratic process, including limited mobility, financial constraints and social stigma. As a result, this population is less likely to vote and is under-represented by their elected officials. This finding has been consistently replicated across many countries, health conditions, and over time. Meanwhile, the effects of the COVID-19 pandemic on turnout have been mixed.

However, political participation is not limited to voting. People can also protest, contact elected officials, donate money, and more. Even though people with poor health vote less often, they engage in many non-voting political acts, often more so than people in better health. Moreover, health issues motivate many people to engage with patient advocacy groups and health professional societies. These groups help mobilize people in poor health to participate in politics and indirectly represent them in the democratic process.

Due to negative experiences with public institutions, people in poor health have lower trust in the health system, government, and even the democratic process.

Many people in poor health report negative experiences with the health system, social programmes and other public institutions meant to support them. These experiences include stigma and discrimination. Trust in public institutions reflects people's experiences with them. As a result, people in poor health have lower trust, confidence and satisfaction with the health system, government, politicians and other public institutions. Poor health is even tied to decreased satisfaction with the democratic process. These patterns are consistent across virtually all European countries. One exception is that people have high trust in their individual health care providers, who may represent an opportunity for rebuilding trust and re-engaging this population in the democratic process.

In recent decades, people in poor health have gravitated towards right-wing populist parties that promise to reshape a 'failing' political establishment.

The political alliances of people in poor health may be shifting. Historically, this population gravitated towards the mainstream left, which supported greater protections for health. However, the rise of populist parties, especially on the ideological right, has given voice to people who feel 'left behind' by public institutions. Their anti-establishment rhetoric appears to have appealed to people in poor health, even though many populist parties oppose public health protections. Thus, poor health at both the individual and community levels has been linked to greater support for right-wing populist parties in recent decades. Similarly, poor health has been linked to decreased support for the European Union.

Early evidence on the COVID-19 pandemic suggests mixed effects on political support. Some incumbents saw their support rise, while others saw a decline. Meanwhile, support for populist parties appears to have largely declined during the pandemic, with the public gravitating toward policies that would broaden health protections. It is unclear whether the patterns observed at the height of the COVID-19 crisis will persist into the future.

Policy-makers can re-engage people in poor health in the democratic process by implementing health-promoting policies and lowering barriers to participation.

The political salience of health gives policy-makers an opportunity to promote health alongside trust in democratic institutions. Given the close connection between health and socioeconomic conditions, policy-makers can improve population health using diverse initiatives. These can include health system reforms, strengthened social safety nets, educational expansions, economic support for working families, and more.

The public often rewards elected officials for health-promoting policies. They are more likely to do so when a policy has visible, meaningful benefits; provides universal coverage; and conveys respect to beneficiaries. Policy-makers can also directly engage people in poor health in the political process by reducing barriers to their participation, such as by making voting easier and soliciting their opinions on health policies.

Lastly, policy-makers can partner with non-governmental organizations to help ensure that this population is represented in the political process. These organizations include patient advocacy groups and health professional societies. Meanwhile, policy-makers should be mindful of how businesses can become entrenched in health policies. Private interests can wield considerable power over the success – and failure – of health reforms.

The political importance of health may continue to rise.

Several crises looming over the European continent may continue to centre health in its political debates. Climate change, migration due to conflict, and income inequality all have severe consequences for population health. The resulting health anxieties threaten to interact with economic and cultural anxieties to intensify the public's dissatisfaction with democratic institutions. Understanding the political influences of health can help policy-makers protect not only the health of populations but also democratic institutions.

POLICY BRIEF

1. Introduction: Why this brief?

Who participates in the democratic process? What produces inequities in political participation? And what drives people to turn away from democracy entirely? A functional democracy ensures equitable access for all and upholds institutions that meet the basic needs of its public. However, when people become frustrated with the performance of their public institutions, they can come to mistrust them and disengage from the democratic process – or even work towards their destruction (Almond & Verba, 1963).

At present, frustrations with public institutions and the democratic process are high in Western nations. Political parties and the public are polarized in their policy preferences and feelings about each other, reinforcing anti-democratic attitudes (Down & Wilson, 2010; Iyengar & Westwood, 2015; Kingzette et al., 2021). By speaking to the public's frustrations with the political establishment, populist parties have risen to power in several nations. In this setting, it is more challenging than ever for policy-makers to meet the needs of the public. **Figure 1** shows mistrust in government institutions and dissatisfaction with the democratic process in each European country over the past two decades.

Two common explanations for why people turn to anti-democratic values and populist parties are economic insecurity and cultural backlash (Inglehart & Norris, 2016). By one telling, declines in real wages, local manufacturing and other economic opportunities leave communities feeling 'left behind' by their governments (Oesch, 2008; Algan et al., 2017; Rodrik, 2021). The result is a move toward anti-democratic actors who promise to restore the old economic order. By another telling, the resources and rights extended to immigrants, minoritized races and ethnicities, and gender and sexual minorities leave privileged groups feeling threatened about their social standing (Hochschild, 2016; Inglehart & Norris, 2016; Smith & Hanley, 2018). Similarly, the result is an appeal to anti-democratic movements that promise to restore the old social hierarchies.

But what if health also shapes support for anti-democratic movements? Some research has suggested that, as people experience declines in their health or the health of their communities, they similarly become frustrated with their public institutions and turn to anti-democratic movements. To that end, a growing base of evidence has connected declines in the health of individuals and their communities to declines in democratic participation – and to a simultaneous rise in support for anti-democratic values and fringe political parties (Mattila et al., 2013; Pacheco & Fletcher, 2015; Bor, 2017; Koltai et al., 2019; Landwehr & Ojeda, 2020; Kavanagh, Menon & Heinze, 2021).

The connection between health and democracy is more important than ever. A rising share of populations in high-income nations are living with chronic diseases and disabilities (Hajat & Stein, 2018). The COVID-19 pandemic has compounded the issue, with entire populations forced to confront their vulnerability to illness, disability and death. As Europeans have lost faith in the democratic processes and public institutions of their countries, so too have millions lost faith in their health systems (**Figure 1**).

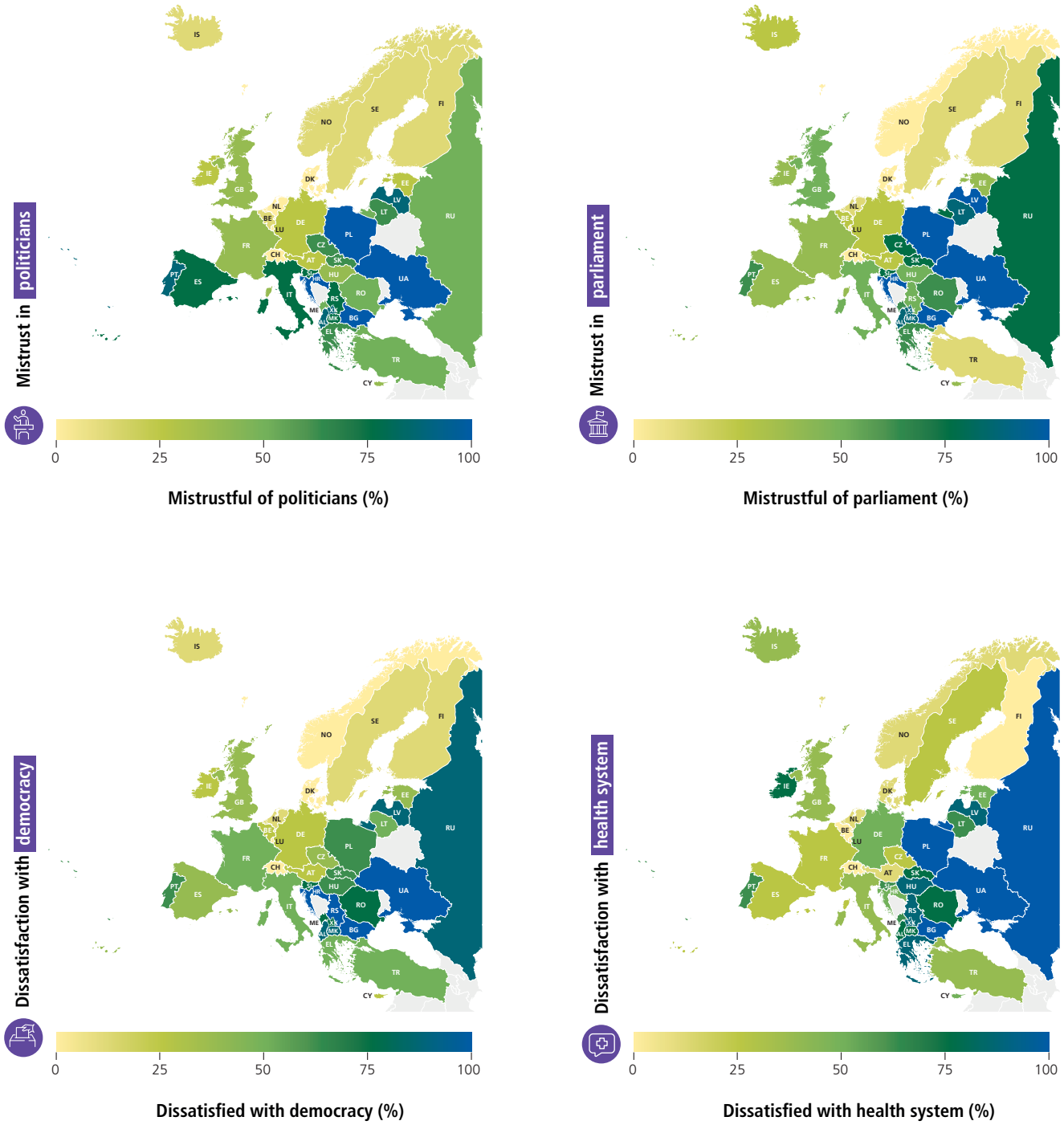
To be clear, population health is unlikely to be the primary driver of the rise in anti-democratic politics. Even so, the connection between the two highlights an important shortcoming in the performance of democratic institutions: people in poor health have systematically low trust in their health systems and governments; as a result, they are less likely to vote and more likely to support political movements working to dismantle democratic institutions. If we want our public institutions to support and represent everyone in the democratic process, then examining this population's political needs is essential.

As such, this brief argues for the importance of population health protections in ensuring that democratic institutions are equitable and accessible to all. Section 2 reviews several health crises in Europe and their relevance to politics. Sections 3–5 review the evidence for health as a determinant of politics – how individual and community-level health shapes political participation, trust, attitudes and behaviours. Section 6 reviews several policy approaches for better meeting the needs of people in poor health and involving them in the political process. It also touches on the role of private interests in health politics. Lastly, Section 7 looks forward to how health and politics may be intertwined in the future.

In this brief, we define 'health' broadly, including the chronic conditions, disabilities and health behaviours of individuals, as well as the well-being of entire populations. Research suggests that both are relevant to politics. Similarly, we take a broad view of the institutions meant to protect health, including the health system, social programmes and other public structures. Health reflects more than just a person's experiences with the health system; it also reflects their economic, social and political context (Woolf & Braveman, 2011; Braveman & Gottlieb, 2014). In this way, diverse policies ranging from medical care to public health initiatives to social and economic policy are relevant to our analysis.

By bringing attention to health in the conversation about democratic backsliding, this brief makes clear that a functional democracy requires citizens who are healthy enough to engage with it and uphold its values. As a result, policies that protect health and ability are not only essential to preserving the economic and social well-being of Europe – but they may also be essential to rebuilding trust in democracy and democratic institutions.

Figure 1: Mistrust in political actors and dissatisfaction with democratic and health institutions are widespread throughout Europe



Notes: Based on pooled, unadjusted responses to the European Social Survey from 2002 to 2022, using post-stratification weights (N=472,798). Respondents were asked to rate their trust in politicians and their country's parliament from 'no trust at all' (0) to 'complete trust' (10). Values from 0–4 were coded as mistrustful. Similarly, respondents were asked to rate their satisfaction with the way democracy works in their country and the health system of their country from 'extremely dissatisfied' (0) to 'extremely satisfied' (10). Values from 0–4 were coded as dissatisfied. Countries in grey were missing data.

2. Why focus on health and politics?

Health is central to a person's lived experience – and can impact their politics.

Good health empowers people to live their lives – to socialize with friends and family, to participate in the workforce, and to engage in civic society. Health reflects a person's values and behaviours; their demographic, social and economic conditions; workplace and government policies; and more (Woolf & Braveman, 2011; Braveman & Gottlieb, 2014). These forces are collectively called the 'structural (or social) determinants of health'.

Policy-makers and political researchers have historically focused on economic and social factors as determinants of a person's politics. Health has been largely absent from this conversation. However, a decline in health can fundamentally alter how a person interacts with the world, including their social and economic context. These experiences may consequently reshape a person's political preferences, civic engagement and voting. Their politics then feed back into the system via elected officials and their policies. The result is a self-reinforcing cycle between health, structural conditions and politics (**Figure 2**).

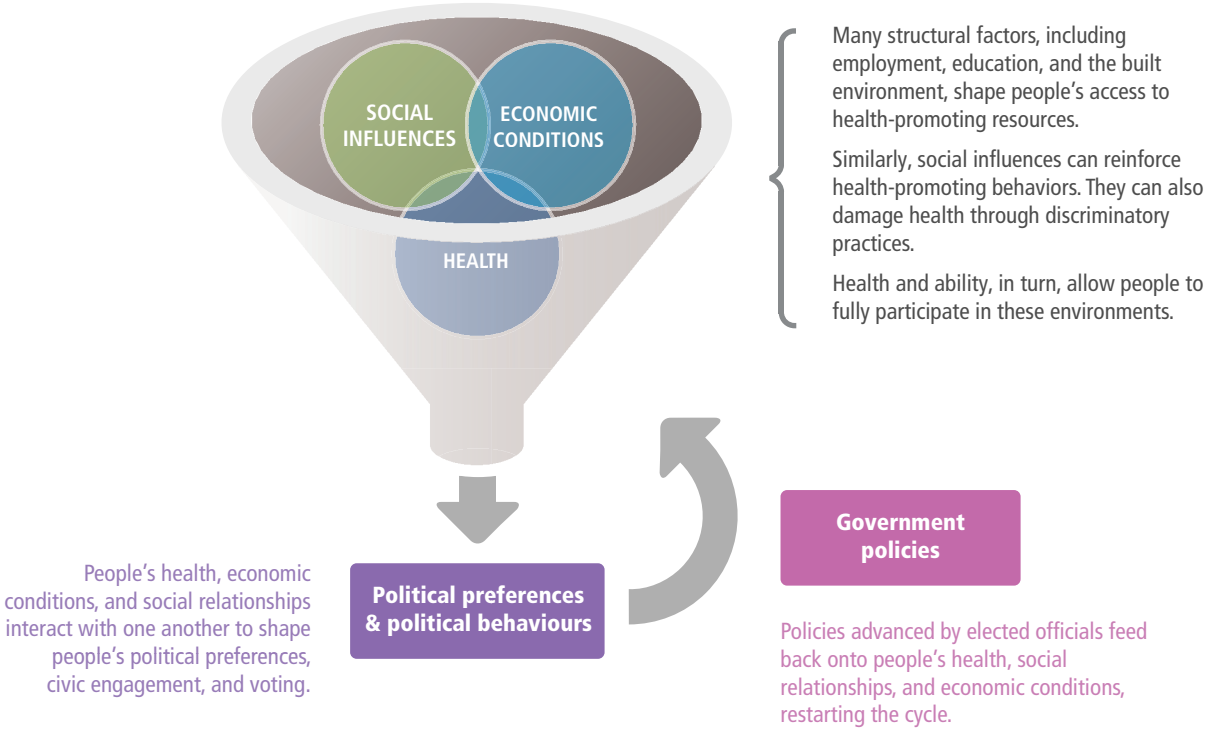
The story of health in Europe is complex. In most European countries, people are living longer than ever – yet with more chronic illness and disability than ever.

Before the pandemic, advances in public health and medicine produced decades of rising lifespans in most – but not all – European countries. In many Eastern European countries, these gains had stalled in the face of challenges to health care delivery and multi-drug-resistant infectious diseases (Mackenbach, Karanikolos & McKee, 2013).

At the same time, aging populations mean that more Europeans are living with chronic illnesses and disabilities than ever. While infectious diseases remain a central concern in many nations, chronic health problems, such as heart disease and cancer, have become the primary drivers of ill health (OECD & European Commission, 2022). In 2022, about one-third (36%) of all Europeans reported a long-standing illness or health problem (Eurostat, 2023). These rates are expected to rise over the coming decades (Hajat & Stein, 2018).

Health and ability are not equally distributed across persons and place. In Europe, there are marked inequities in illness and disability across incomes, levels of education, regions and countries (Mackenbach, Karanikolos & McKee, 2013). There is a more than 10-year gap in life expectancy among European Union member nations (World Bank, 2024).

Figure 2: Health, social structures and politics interact in a self-reinforcing cycle



The COVID-19 pandemic halted gains in life expectancy, precipitated a mental health crisis, and produced widespread disruptions to health care delivery and quality.

COVID-19 wiped away years of gains in life expectancy. Virtually all European countries saw a decrease in life expectancy across virtually all age groups and genders (Aburto et al., 2022). Between 2020 and 2021, the continent had roughly 1 million excess deaths (Rossen et al., 2022). Not all populations experienced the burdens of COVID-19 equally, with many marginalized groups facing higher rates of infection and mortality (Sze et al., 2020).

The health effects of the pandemic were not limited to mortality, as it also worsened an existing mental health crisis. In many European nations, the rates of depression, anxiety and other mental health problems – especially among young people – rose considerably after COVID-19. For example, just before the pandemic, 15% of 19–29-year-old Swedes had depression symptoms, which rose to 39% in 2020 and 2021. In Estonia, the rates were 7% and 37%. In Belgium, they were 9% and 29% (OECD & European Commission, 2022).

The pandemic also introduced dramatic disruptions to health care delivery and quality (OECD & European Commission, 2022). In-person care was limited for several months, with delays in routine services, cancer screenings, surgeries, and more. This backlog may produce lasting consequences for the health of populations across the continent.

Health touches all social, economic and foreign policies – and policy crises.

Health does not exist in isolation. It is intimately related to a person's demographic, social, economic and political conditions (Woolf & Braveman, 2011; Braveman & Gottlieb, 2014). As a result, policies designed for other purposes – and other crises – can have spillover consequences for health. Another policy brief in the European Observatory's series, 'Health for All Policies', emphasizes the importance of identifying cross-sectoral opportunities to promote health alongside other outcomes (Greer et al., 2023).

Several policy challenges on the continent represent looming health crises, including inflationary pressures that make it challenging for families to afford healthy meals or health care; rising housing costs that price families out of safe, healthy neighbourhoods; climate changes that threaten populations with heat waves and unstable food production; the ongoing war in Ukraine and its destruction of health infrastructure; forced migrations and their associated traumas; an energy crisis that threatens devastating power shortages; and more (Oliveras et al., 2021; Spiegel, Kovtoniuk & Lewtak, 2023; The Lancet, 2024).

For all these reasons, health has become a major political concern for Europeans, and even as COVID-19 recedes, it may continue to influence politics.

Even before the COVID-19 pandemic, health was on the minds of voters. Health policies have often appeared as major issues in European elections. During the Brexit campaign in the United Kingdom (UK), 'Leave' supporters campaigned on the (alleged) benefits of exiting the European Union for the country's National Health Service (Drinkwater & Robinson, 2022). Overwhelming majorities of European Union member nations demand more action from the organization on health and social policy (European Parliament, 2017).

During the pandemic, health took centre stage in politics. Shutdowns of businesses and schools became political flashpoints, misinformation about masks and vaccines fuelled political polarization, and elections became referenda of governments' pandemic responses (Altiparmakis et al., 2021; Bobba & Hubé, 2021b; Gadarian, Goodman & Pepinsky, 2022). Even as infectious waves have receded, people across the continent continue to process the losses of life and high rates of COVID-related disabilities.

The exact role of health in how the public evaluates the performance of its political actors continues to be debated (Acharya, Gerring & Reeves, 2020). Yet, even if health is not the most salient issue in a given election, it remains irrevocably linked to living standards, the health system, social programmes and other issues that are perennially influential in politics. In this way, health concerns are a steady undercurrent in many political debates.

In the next sections of this brief, we review the academic literature on how health shapes people's politics, including their voting, policy preferences and faith in democracy. Our goal is to equip policy-makers with a better understanding of an under-appreciated determinant of politics – and how to better meet the needs of their populations.

3. How does health shape democratic participation?

People in poor health face many barriers to participating in the democratic process, including limited mobility, financial constraints and social stigma.

Participating in politics requires many resources, including interest, knowledge, time and money (Brady, Verba & Schlozman, 1995). Different political acts require more or less of each of these resources. For example, volunteering on a political campaign requires time and interest, while donating to campaigns is only possible with disposable income.

However, these resources are not evenly distributed throughout the population, and people with chronic illnesses, disabilities or other health problems tend to have less of them. For example, disability often entails limitations of mobility and transportation, which can make it difficult to vote, volunteer or protest (Schur et al., 2002). People in poor health also tend to have less education and labour force participation, which reduces the monetary resources and knowledge necessary for participating in politics (Jones, 2008).

Other important barriers to participating in politics for people with health problems or disabilities are stigma, mistrust and social isolation. People with poor health can feel unwelcome in public spaces that are ill-equipped to accommodate them, reducing their motivation to participate in civic activities (Susman, 1994; Emerson et al., 2021).

Due to these forces, Europeans in poor health are less likely to feel able to participate in politics or that the government will listen to them (Shore, Rapp & Stockemer, 2019).

Because of these barriers, people with poor health and disabilities tend to vote less. The health–turnout gap has been documented across time, place and populations.

Across diverse settings, people in poor health are less likely to turn out to vote. The magnitude of the difference is large – often 10–20 percentage points (pp). This gap has been documented in Europe, the United States of America (USA) and Canada, and across many measures of health, including self-reported general health (Mattila et al., 2013; Pacheco & Fletcher, 2015; Burden et al., 2017; Couture & Breux, 2017; Pacheco & Ojeda, 2020), physical disability (Shields, Schriner & Schriner, 1998; Schur & Kruse, 2000; Schur et al., 2002), and mental illness (Ojeda, 2015; Landwehr & Ojeda, 2020) (**Box A**). The gap has not narrowed over time (Schur & Adya, 2013; Matsubayashi & Ueda, 2014). As a result, people in poor health tend to be less represented by elected officials (Pacheco & Ojeda, 2020).

One exception to the health–turnout gap appears to be politically salient health problems. For example, people with diabetes and cancer in the USA have been shown to vote more than the general population (Gollust & Rahn, 2015; McGuire, Rahn & Gollust, 2021). These exceptions may reflect the strong social identities and advocacy organizations focused on these conditions, which may help overcome barriers to voting.

The magnitude of the health–turnout gap also depends on a person's age, gender, race or ethnicity, disability or condition (with mobility issues being especially burdensome), and the resources available to help vote (Mattila et al., 2013; Ojeda & Slaughter, 2019; Schur & Kruse, 2000; Kirbiš, Mattila & Rapeli, 2024). There is also some evidence that the health–turnout gap varies in national vs local elections (Couture & Breux, 2017). These variations reflect the fact that voting requires access and motivation; it is harder for some folks than others to marshal the necessary energy and get to the polls.

Box A: How do we measure health in political studies?

In many studies across public health and political science, health is measured using a single question that asks respondents to rate their health as a whole on a 1–5 scale, ranging from 'very good' to 'very bad' (or similar endpoints). This approach can be readily adapted to mental health, disability and other domains of health and well-being.

These global self-reported measures of health map onto meaningful 'objective' outcomes. For example, they have predicted mortality in cohort studies of over 25 years across culturally and racially diverse settings (Idler & Benyamini, 1997; Miilunpalo et al., 1997; McGee et al., 1999; Strawbridge & Wallhagen, 1999; Lorem et al., 2020). They have also been shown to predict health care utilization, health behaviours, disease diagnoses and physician ratings of health status, all reasonably well (Larue et al., 1979; Miilunpalo et al., 1997; Eriksson, Undén & Elofsson, 2001; Baker, Stabile & Deri, 2004).

These measures also map onto 'subjective' experiences of health, including symptoms, people's comparisons of their health to that of their neighbours, and other health-related attitudes (Strawbridge & Wallhagen, 1999; Eriksson, Undén & Elofsson, 2001).

Also of note, clinicians rely on self-reported health (either in the form of global questions or symptom-specific questions) when making diagnoses and clinical decisions. Many aspects of health, including mental health, are difficult to measure in any other way.

These single-question measures of health are imperfect, as different demographic and cultural groups tend to interpret and rate their health differently (Beaton et al., 2000; Dowd & Todd, 2011). This can make it challenging to compare self-reported health across socioeconomic and cultural contexts. However, when used to compare health within populations, they are quick, cost-effective tools for measuring health status.

The effects of the COVID-19 pandemic on turnout have been mixed.

Several studies have examined whether the COVID-19 pandemic affected turnout in 2020, but the results are mixed. For example, in the 2020 French municipal elections, overall turnout was lower than in the previous municipal elections in 2014. It was especially depressed in areas with

higher shares of elderly voters, who were at higher risk from COVID-19 (Leromain & Vannoorenberghe, 2022). Also at the local level, more stringent lockdowns increased turnout between the two rounds of the French elections (Giommoni & Loumeau, 2022). Similarly, in Italian local elections in late 2020, turnout was lower in localities with worse elderly mortality rates (Picchio & Santolini, 2022).

By contrast, in Croatian parliamentary elections, higher local infection rates did not affect turnout (Sircar, 2021). In the USA, the association is unclear and may have varied by state (Flanders, Flanders & Goodman, 2020; Baccini, Brodeur & Weymouth, 2021). Thus, the relationship between COVID-19 and turnout appears to have been context-dependent.

Even though people with poor health vote less often, they can – and do – engage in other political processes. Often, they do so more than people in better health.

People can participate in politics in many ways besides voting, such as contacting elected officials, volunteering for campaigns, donating money and protesting. Each of these acts requires different skills and resources, some of which are more accessible to people with poor health. As a result, people in poor health often gravitate towards these activities.

In a recent study, Europeans with several health conditions scored higher on a political participation scale than people with otherwise similar characteristics (Kirbiš, Mattila & Rapeli, 2024). People with multiple conditions had even higher participation. However, for many conditions, the relationship reversed near ages 60–70, suggesting that health issues may mobilize younger people while making it harder for older people to participate.

In another study, Europeans with worse mental health were less likely to engage in a variety of non-voting political acts. The gap was larger for physically demanding acts (such as protesting or working for a political organization, a gap of 5 pp) than non-physical ones (such as contacting a politician or signing a petition, a gap of 1 pp) (Landwehr & Ojeda, 2020). However, these patterns varied across countries.

Using the same data, people in Nordic countries who reported worse general health were more likely to contact officials, protest and wear campaign badges (Söderlund & Rapeli, 2015). Using different data in Finland, people who reported worse general health were less engaged in 'institutional' forms of participation (like voting and working for parties) and more so in 'non-institutional' ones (like protesting and boycotting) (Mattila, 2020).

In a US study, people with cognitive limitations were less likely to make political contributions, but there were no differences for self-reported general health or mobility (Burden et al., 2017). In Canada, people who reported worse general health were less likely to sign petitions, yet the reverse was true for mental health (Couture & Breux, 2017).

These results show that even if people with poor health vote less often, they can – and do – engage in the political process. The inconsistencies likely reflect: (1) different political cultures and institutional supports across countries; (2) different study designs (**Box B**); and (3) different theoretical frameworks for examining how health relates to non-voting political acts and how local political or institutional factors modify that relationship.

Box B: Methods for researching the relationships between health status and political outcomes

Disentangling whether the relationship between health and politics is causal or just correlational is challenging. For one, health is rarely 'randomly assigned', which is an essential assumption in establishing whether a relationship is causal.

Second, it can be hard to know whether health or another influence, like socioeconomic conditions, is the true 'cause' of someone's politics. For example, a heart attack may lead someone to stop voting – but a lifetime of unsafe working conditions may have led to their heart disease. In this case, did health or economic conditions cause their politics?

Due to these challenges, many of the studies on health and politics rely on cross-sectional surveys that try to account for several potential confounding influences. Many researchers would not consider these designs to be rigorous enough to establish causality.

Some studies have used more rigorous designs that get closer to establishing a causal relationship. For example, panel studies have followed the same people's health and voting over time (e.g. Landwehr & Ojeda, 2020). One study compared the political participation of siblings who either did or did not become disabled, allowing the researchers to account for any confounding influences that were shared by both siblings (Burden et al., 2017).

Regardless of the exact causal pathway, the fact that people with poor health have distinct participation patterns and political preferences can still inform policy-makers' decisions. Engaging this population in the political process requires a clear understanding of their barriers to civic engagement as well as their expectations of democratic institutions.

Lastly, patient advocacy groups and health professional societies play an essential role in the political mobilization and representation of people in poorer health.

Beyond the political activities of individuals, health issues motivate people to form patient advocacy groups and health professional societies to promote political goals.

Patient advocacy groups have organized around health conditions ranging from cancer to Alzheimer's to autism spectrum disorder. Some have organized around the health risks of climate change, such as the Health and Environment Alliance (HEAL). And others have organized around specific health behaviours, including drunk driving and smoking.

Patient groups play an important role in politically engaging people in poor health. They help directly motivate this population to participate and provide resources to enable people to do so (Gollust & Rahn, 2015; McGuire, Rahn & Gollust, 2021). Their public messaging shapes political conversations around health issues (Ptacek, Dolick & Mattson, 2017). And these groups indirectly represent this population in meetings with policy-makers to advocate for research, health reforms and social programmes to support their members (Keller & Packel, 2014).

Similarly, health professionals are influential in politics. Even though individual health professionals often participate in politics at lower rates than the general public (Zhong et al., 2024), medical associations and other professional societies engage in politics on their behalf. Members of these societies frequently testify before legislatures and comment on proposed regulations, and these societies have played influential roles in the design and passage of health reforms (Oberlander, 2020). Some groups, such as Doctors for America (in the USA), even exist to encourage health professionals to run for elected office.

Lastly, many patient advocates and health professionals are so motivated by their health issues, or those of their patients and family members, that they run for elected office to enact change. For example, the European Union's Beating Cancer Plan, the Union's first budget line item dedicated to health, was facilitated in part by health professionals and patient advocates elected to the European Parliament (Iraola Iribarren & Fortuna, 2024).

In this way, health issues can positively or negatively shape the political engagement of individuals and groups. In **Section 6**, we also consider the role of private interests, such as pharmaceutical companies, hospitals and insurers, in the politicization of health.

4. How does health shape trust in public institutions?

Trust in political institutions is tightly tied to people's experiences with them.

There is a reciprocal relationship between social trust and the functioning of political institutions. Some scholars have argued that social trust is a fundamental driver of stable, prosperous institutions (Fukuyama, 1996; Putnam, 2000). Others have suggested that institutions cultivate trust through responsive actions (Miller & Listhaug, 1990; Rothstein & Stolle, 2008). Consequently, we must be alert to negative experiences with political institutions, as they may erode trust and participation in the democratic process.

This section of the brief focuses on the connections between people's health and their trust in the institutions meant to protect health. Of note there is also a sizeable literature on health, social trust and social capital – that is, relationships with other people, rather than institutions (De Luca & Lin, 2024). This literature finds that lower health is widely associated with lower social trust and social capital. All in all, a functional democratic society requires social and institutional trust – and health is relevant to both.

Many people with poor health report negative, stigmatizing experiences with the health system, social programmes and other institutions meant to support them.

The experience of accessing health care can be demeaning and stigmatizing. For many patients, these negative experiences are based on perceived judgments regarding their conditions or diseases, including mental illness (Henderson et al., 2014), substance use disorders (Probst et al., 2015) or being overweight (Puhl et al., 2021). For other patients, their experiences involve stigma and discrimination based on social identities, including gender and sexuality (Bränström & Pachankis, 2019; Falck & Bränström, 2023), race or migrant status (Pattillo et al., 2023) and religion (Samari, Alcalá & Sharif, 2018).

These negative experiences are not merely patients' perceptions: health care providers in Europe have openly admitted prejudice and discriminatory attitudes about patients based on their conditions or identities (Gilchrist et al., 2011; van Boekel et al., 2013).

Similarly, many beneficiaries of social programmes report stigmatizing and demeaning experiences in trying to access those programmes (Barnes, Michener & Rains, 2023). This stigma can be exacerbated by poor health status (Stuber & Schlesinger, 2006).

Due to negative experiences with the health system, people in poor health report lower satisfaction with it than their healthier counterparts.

A systematic review of research into the determinants of patient satisfaction with the health system found that poor health and dissatisfaction are consistently linked across a wide range of studies (Batbaatar et al., 2017). Moreover, measures of both general health and mental health have been linked to lower satisfaction with medical care.

For example, an analysis of data from 21 European Union countries found that people in poorer health were less satisfied with the health system than respondents in better health (Bleich, Özaltin & Murray, 2009). Satisfaction declined with worsening health status. Another study, using data from the Netherlands, found that patient health status was one of the strongest predictors of satisfaction with the health system (Hekkert et al., 2009).

To emphasize the magnitude of these differences, in **Figure 3**, we pool data from across Europe and compare satisfaction with the health system by reported health status. In unadjusted analyses, 71% of people who report 'very good' health were satisfied with their country's health systems – compared to just 43% of people with 'very bad' health.

The question of causation in this case is hard to disentangle as a person's health and satisfaction with the system can influence each other. However, in one study using panel data, health status at the beginning of the study predicted future satisfaction with the health system – but not the other way around (Hall, Milburn & Epstein, 1993).

Lower satisfaction with the health system translates into lower trust and confidence in it. One exception is that people have high trust in their individual providers.

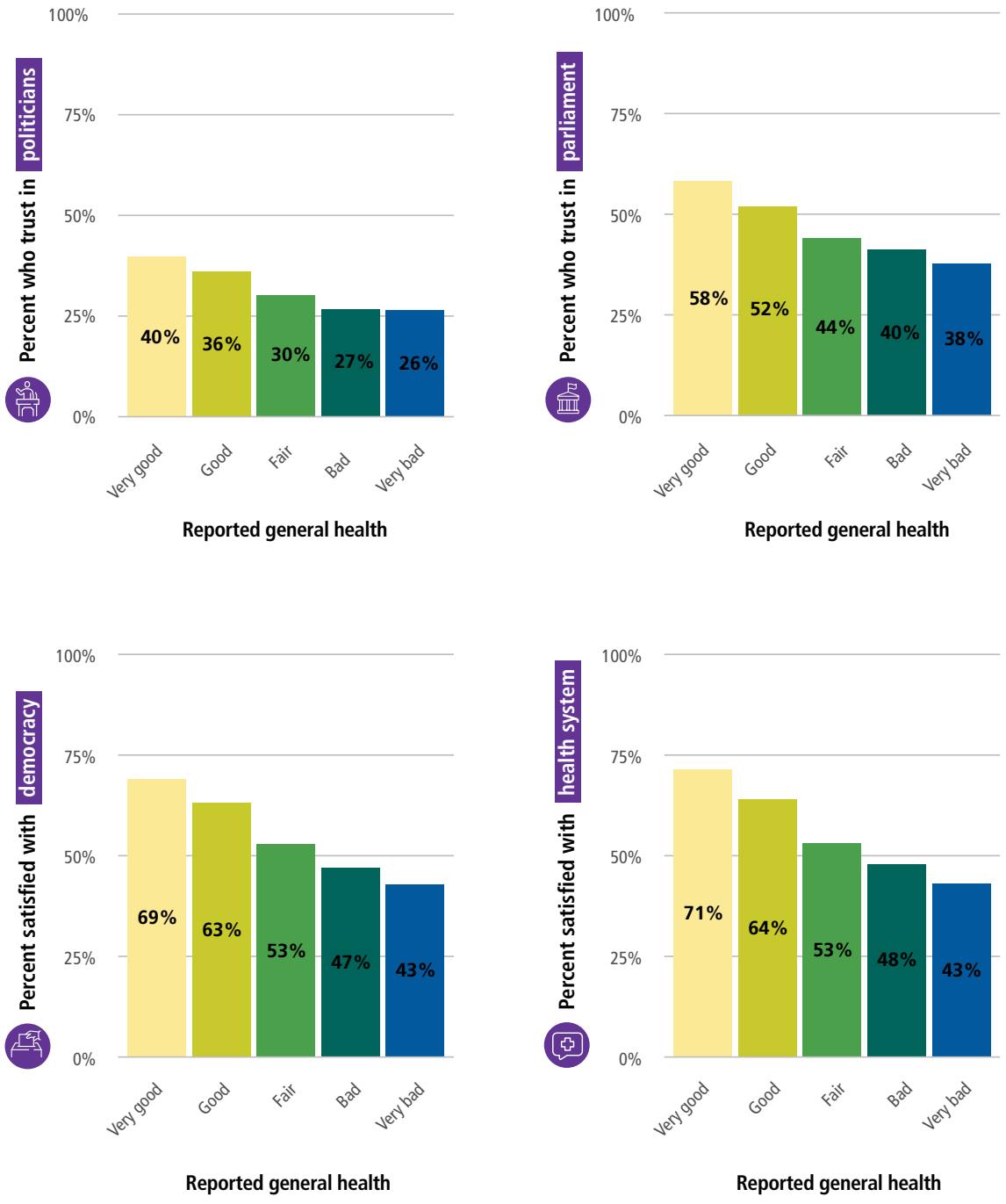
Negative experiences with the health system can have consequences for the public's trust in it. In a recent multi-national survey, including Greece, Italy and the UK, respondents who reported worse health were less confident that they could access and afford good-quality care if they became sick (Kruk et al., 2024). A similar association between self-reported health and trust in the health system has been documented in Sweden, where the relationship was partly explained by access to care (Mohseni & Lindstrom, 2007). In a convenience sample of Americans, past negative experiences with the health care system were a significant predictor of trust in the health system (Schwei et al., 2014).

Importantly, people tend to trust their individual health care providers highly, in contrast to their trust in the general 'system' (Blendon, Benson & Hero, 2014). Leaning on providers may provide an opportunity to rebuild trust, as we discuss in **Section 6**.

Attitudes about public institutions are highly related, so negative attitudes about the health system can spill over into lower trust in the political system.

People often conflate trust in various public institutions, meaning that the performance of one may impact the perception of all the others (Hooghe, 2011). As a result, when people develop mistrust in one institution identified with the government – like the health system – their mistrust can generalize to other governmental and democratic institutions.

Figure 3: Europeans who report worse health have much lower trust in political actors and lower satisfaction with democratic and health institutions



Notes: Based on pooled, unadjusted responses to the European Social Survey from 2002 to 2022, using post-stratification weights and country population weights (N=472,798). Respondents were asked to rate their trust in politicians and their country's parliament from 'no trust at all' (0) to 'complete trust' (10). Values from 5–10 were coded as trusting. Similarly, respondents rated their satisfaction with the way democracy works in their country and the health system of their country from 'extremely dissatisfied' (0) to 'extremely satisfied' (10). All values from 5–10 were coded as satisfied.

To that end, among recent users of the health system in 38 countries, poor evaluations of health system performance were associated with lower trust in government (Rockers, Kruk & Laugesen, 2012). Across 19 European nations, people reporting poor health had not only lower levels of trust in the health system but also lower levels of political trust (Mattila & Rapeli, 2018). And lower levels of political trust among people in poor health have been tied to higher rates of non-institutional political participation (such as protesting) and lower institutional participation (such as voting), at least in Finland (Mattila, 2020).

Similar health–political trust gaps have been replicated in the USA (Peterson, 1991) and Sweden (Ahnquist, Wamala & Lindstrom, 2012), and with measures of mental illness, which were tied to lower trust in the national parliament in Sweden (Lindstrom & Mohseni, 2009).

In **Figure 3**, we show the Europe-wide health gaps in trust in politicians and parliaments. Among Europeans reporting 'very good' general health, 40% trusted politicians and 58% trusted their country's parliament. By contrast, the levels of trust dropped to 26% trust in politicians and 38% trust in parliament for Europeans reporting 'very bad' health.

Political trust and well-being may even exist in a self-reinforcing cycle. In a cross-sectional study of 27 European countries, COVID-19-related financial insecurity was associated with older adults' self-reported health and emotional well-being. However, institutional trust played an important role in mediating the relationship, suggesting that higher levels of trust may have helped older adults to be resilient and adapt in the face of hardships (Lee, 2022).

Poor health may even contribute to decreased satisfaction with democracy.

Finally, reduced trust in political institutions is linked to lower satisfaction with the political system more generally. We analysed responses from 39 European countries, using the same data as many studies cited above, the European Social Survey. People reporting poor health were consistently less satisfied with democracy in their countries: 69% of Europeans in 'very good' health, compared to 43% of those in 'very bad' health (**Figure 3**). This gap was present in nearly every country in Europe (**Figure 4**).

In this way, disaffection with political institutions meant to protect the public, including people in poor health, may even contribute to mistrust in the democratic process. These results may help explain why Europeans in poor health are less likely to vote.

Notably, it is hard to know what the 'right' level of trust in public institutions and the democratic process is (**Box C**). However, when a population loses enough trust, it may no longer engage with these institutions or may work toward their destruction. As detailed in **Sections 3 and 5**, this may already be the case for Europeans in poor health.

Box C: What is the 'right' amount of trust in public institutions and the democratic process?

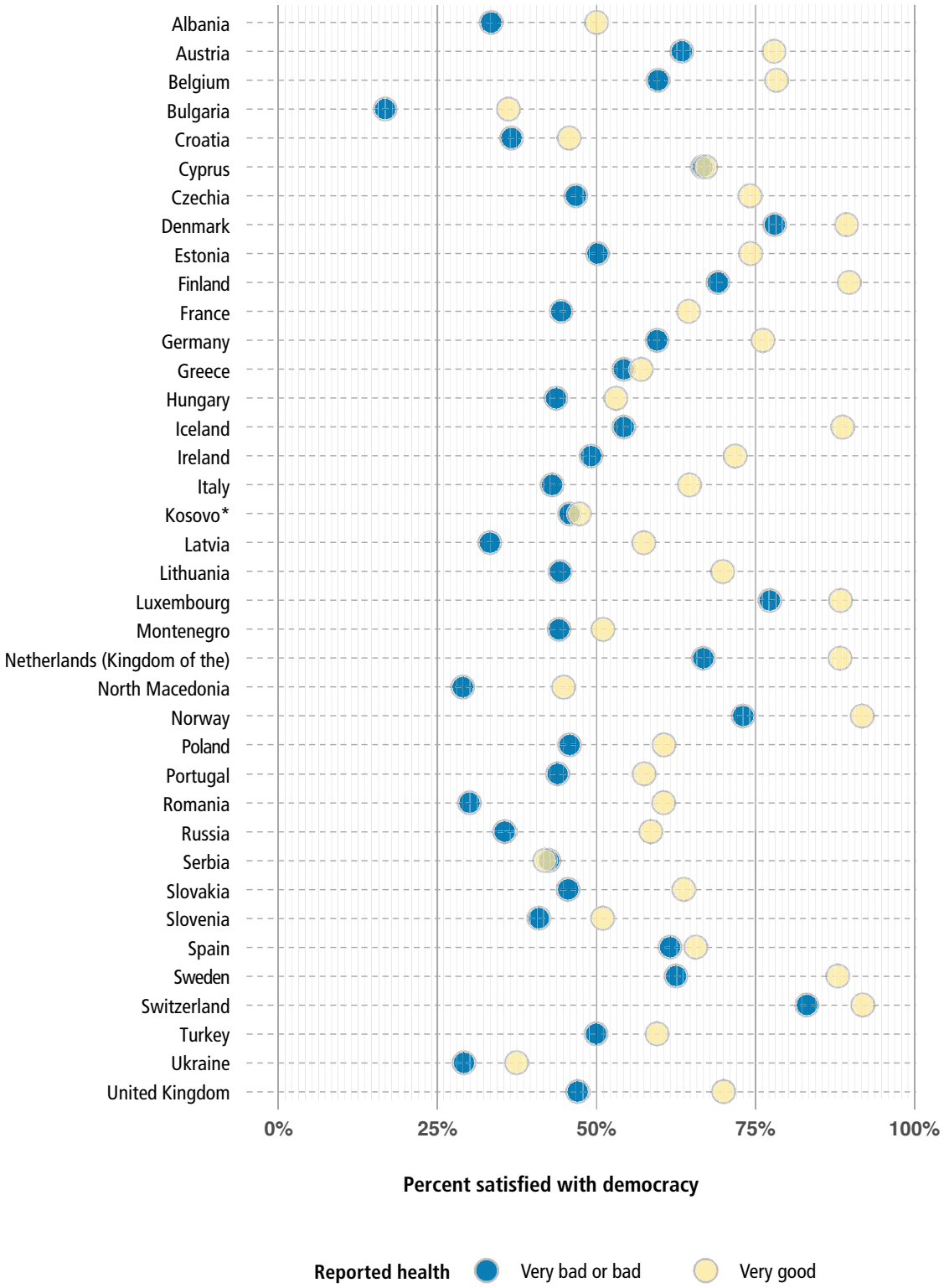
The academic literature emphasizes the consistently lower trust, satisfaction and confidence in public institutions of people in poor health. As described throughout **Section 4**, this population has more negative attitudes about the health system, social programmes, the government and the political processes that maintain these institutions.

However, what is the 'right' amount of trust for people to have in their public institutions? This topic has been debated for decades (Clark & Lee, 2001). Some scepticism in the government is healthy, as it ensures that people regularly assess its performance and correct it by voting out underperforming officials. Too much scepticism, however, and people may no longer expect their institutions to meet their needs; instead, people may disengage from these institutions or even work toward their destruction (Almond & Verba, 1963).

It is hard to know whether the institutional mistrust of Europeans in poor health is too high or 'just right', at least using existing evidence. However, one signal that it may conflict with healthy democratic responsiveness is that many people in this population have disengaged from politics (**Section 3**) or gravitated toward anti-democratic parties (**Section 5**).

Importantly, low levels of faith reflect the shortcomings of the public institutions, not the people whom they (have failed to) serve. The onus is on the 'system' to win back the trust of this population with better-performing health systems, social programmes and inclusive political processes. Doing so is essential for maintaining a responsive democracy.

Figure 4: The gap in satisfaction with democracy between people who report better and worse health is present across European countries



Notes: Based on pooled, unadjusted responses to the European Social Survey from 2002 to 2022, using post-stratification weights (N= 139,395). Respondents rated their satisfaction with the way democracy works in their country from 'extremely dissatisfied' (0) to 'extremely satisfied (10). All values from 5–10 were coded as satisfied. Due to small sample sizes, responses for 'very bad' and 'bad' health were grouped together. Missing countries did not have data.

* In accordance with Security Council resolution 1244 (1999).

5. How does health shape political preferences and support for parties?

Until recently, people in poorer health gravitated toward left-leaning ideologies and mainstream left political parties.

In studies using data from the 1990s and early 2000s, people in poor health typically gravitated towards left-leaning ideologies and mainstream left parties, which supported greater protections for health, health care and other social services. This pattern has been documented across Europe, the USA and Japan (Huijts, Perkins & Subramanian, 2010; Subramanian et al., 2010; Pacheco & Fletcher, 2015). It has also been documented for other measures of health, including mental health (Bernardi, 2021), as well as difficulty accessing health care (Ziegenfuss, Davern & Blewett, 2008). These associations are not fully explained by either demographic or socioeconomic characteristics.

Similar results have been documented for community-level mortality and support for mainstream left-wing parties in the UK, Ireland and the USA, using data from before 2000 (Smith & Dorling, 1996; Kondrichin & Lester, 1998; Kelleher et al., 2002).

As noted in **Boxes B and D**, it is difficult to disentangle whether a person's socioeconomic conditions, their health or another influence drives their political preferences. Poor health might be one manifestation of a broader socioeconomic decline experienced by people who feel 'left behind'. But, as detailed throughout this brief, a growing body of work suggests that health is an important political influence, even if entangled with others.

However, as right-wing populist parties that disparage the political establishment have risen in popularity, they have attracted the support of people in poor health.

People in poor health tend to have lower trust in the health system and government institutions. When less trusting voters have no parties that give voice to their frustrations, they often do not vote (Hooghe, Marien & Pauwels, 2011). However, the rise of populist parties has provided an outlet for voters – including those in poor health – to express their frustrations with the political establishment (Petrarca, Giebler & Weßels, 2022).

The academic literature has several definitions of populism (Laclau, 2005; Mudde, 2007; Inglehart & Norris, 2016; Jones & Menon, 2024). Despite differences, they generally agree that populists conceive of a 'common man' opposed to 'elites'. Populists have risen on the ideological left and right, with most modern populist parties opposing globalization. Right-wing populists also oppose the expansion of the rights of immigrants and other minoritized groups. Several typical examples of European populist parties include the National Rally in France, the Alternative for Germany (AfD) and Vox in Spain.

Several studies have documented a tendency for people in poor health to gravitate towards populist parties, especially on the right (Backhaus et al., 2019; Kavanagh, Menon & Heinze, 2021). Across 24 European countries from 2002 to 2020, people who reported poor general health or a disability were more likely to support right-wing populist parties (Kavanagh, Menon & Heinze, 2021). In unadjusted analyses, support for right-wing populists was 12% among people reporting 'very good' general health – and nearly 20% among those in 'very bad' health. The relationship remained after accounting for many demographic, socioeconomic and political characteristics of respondents.

One published study has examined whether declines in individuals' health over time increase their support for populist parties. Using Dutch data, they retrieved conflicting results depending on their modelling choices (Oude Groeniger et al., 2022).

Together, these studies reveal that people in poor health are more likely to vote populist across Europe. Individual-level studies have the advantage of identifying who supports populist parties and disentangling the impact of health from other socioeconomic influences. It is less clear whether this relationship is causal, as limited longitudinal data have made causal studies difficult (**Boxes B and D**). Even so, these findings make clear that people in poor health prefer a distinct set of parties than people in better health.

Similarly, pre-pandemic declines in community health have been connected to increased support for right-wing populist parties.

Health is not merely the experience of individuals; it also reflects the conditions of a community. As a result, health problems experienced within communities, including early deaths, substance abuse, and the like, can also politically mobilize communities.

Several studies have associated declines in community health with support for right-wing populist movements. Much of this work is focused on Donald Trump in the USA. The former US president and the Republican Party gained more support in localities with lagging life expectancies, especially among white Americans (Bor, 2017; Bilal, Knapp & Cooper, 2018); with more deaths of despair, i.e. deaths due to drugs, alcohol and suicide (Goldman et al., 2019); with higher rates of chronic opioid use (Goodwin et al., 2018); and with worse county health on a composite measure (Wasfy, Stewart & Bhambhani, 2017).

In Europe, one Dutch study explored the relationships between worsening community mortality or self-reported health and support for populists in the 2000s and 2010s (Oude Groeniger et al., 2022). Declining community health boosted support for right-wing, but not left-wing, populists.

The link between health and far-right parties is not unique to modern health crises either. In studies using historical data, German communities with worsening mortality in the 1930s became more supportive of the Nazi Party (Galofré-Vilà et al., 2021a,b), and Italian cities with more influenza deaths in the 1918 pandemic were more supportive of the Fascist Party in the 1924 election (Galofré-Vilà et al., 2022).

Box D: Which direction is the causal pathway: health to politics, or politics to health?

Much of this brief is focused on the impact of people's health on their political preferences and behaviours. However, people's politics may shape their health, not just the reverse. Political ideologies might drive people to engage in healthy (or unhealthy) behaviours, and social networks aligned by politics might reinforce norms for health-related behaviours.

For example, a few studies have found smoking to be more common among left-leaning voters, e.g. Labour supporters in the UK and Democrats in the USA (Subramanian & Perkins, 2010; Cox et al., 2021). In the USA, Republicans have been less likely to take up health insurance offered to them as part of legislation passed by Democrats (Sances & Clinton, 2019).

During COVID-19, at least in some countries, conservatives and conservative communities were less likely to engage in social distancing and other protective behaviours (Barbieri & Bonini, 2021; Becher et al., 2021; Kavanagh, Goel & Venkataramani, 2021), resulting in higher mortality due to COVID-19 (Wallace, Goldsmith-Pinkham & Schwartz, 2023). Similarly, regions of Europe whose elites were more opposed to the European Union had higher mortality due to COVID-19 (Charron, Lapuente & Rodríguez-Pose, 2023).

However, identifying the exact causal direction is challenging since health and politics are rarely 'randomly' assigned (see **Box B**). Even so, these studies raise the possibility that health and politics exist in a self-reinforcing cycle – changes in health may shape political dispositions that, in turn, reinforce distinct health behaviours and health outcomes.

Together, these studies suggest that when a community's well-being is threatened or lags behind that of other communities, it may react against establishment political parties. A strength of many community-level studies is that they connect changes in health with changes in party support, not just overall levels. Although confounders likely remain, they may provide stronger evidence of a causal relationship. By the same token, a weakness is that they cannot identify whether people in poor health or their neighbours drive the relationship. Even so, these studies make clear the importance of a community's health to its politics.

Additionally, declines in community health have been linked to lower support for the European project.

One study examined the association between community health and voting 'Leave' in the 2016 UK referendum, or Brexit. Localities with more 'deaths of despair', i.e. suicides and drug-related deaths, were more supportive of leaving the European Union (Koltai et al., 2019). The relationship did not persist after controlling for community demographic and socioeconomic characteristics, underscoring the tight relationship between a community's health and its social, economic and other structures. Even so, this study raises the possibility that declines in community health may damage trust in not only national institutions but also international institutions like the European Union.

Many populist parties in Europe oppose health protections, raising the prospect of a feedback loop between declining health and rising populist support.

A recent book surveyed the policy agendas of right-wing populist parties in Europe and documented numerous anti-public health policies supported and implemented by these parties (Falkenbach & Greer, 2021). Several parties, such as the United Kingdom Independence Party (UKIP) and the Party for Freedom (PVV) in the Netherlands, have used anti-immigrant rhetoric to promote restrictions on access to health care, health insurance and other health services. Other parties have rolled back evidence-based public health policies, as the Austrian Freedom Party (FPÖ) did with a restaurant smoking ban.

To be clear, not all policy positions of right-wing populists threaten public health. However, those that do so raise the prospect of a self-reinforcing cycle: if right-wing populists weaken health-promoting institutions, communities may become increasingly dissatisfied with those institutions and further turn towards these anti-establishment actors.

COVID-19 may have shifted people's political preferences away from populist parties, but the evidence is mixed and limited to the early months of the pandemic.

Several studies have focused on support for incumbent parties during the early pandemic, with mixed results. For example, after the lockdowns in Italy, support for incumbent parties in several other European countries rose (De Vries et al., 2021). Meanwhile, more stringent lockdowns in French localities led to greater support for incumbent candidates in municipal elections (Giommoni & Loumeau, 2022). By contrast, county-level infection rates in Croatia did not seem to affect support for the incumbent Croatian Democratic Union (HDZ) (Sircar, 2021).

In the USA, several studies have examined the connection between local COVID-19 burden and support for then-President Trump. Most studies, including several plausibly causal ones, have shown that localities hit by more COVID-19 cases and deaths decreased their support for the former president in the 2020 election (Baccini, Brodeur & Weymouth, 2021; Mendoza Aviña & Sevi, 2021; Shino & Smith, 2021; Algara et al., 2024).

The size of the effect is not trivial: per one analysis, Trump would have won re-election if COVID-19 cases had been just 5% lower (Baccini, Brodeur & Weymouth, 2021).

Other studies have examined the pandemic's impact on the support of right-wing populist parties that were not in power. A German study showed that the AfD party lost more ground in localities hit worse by COVID-19 (Bayerlein & Metten, 2022). In France, turnout dropped in areas exposed to more COVID-19, but the drop was largest in towns that leaned toward the far right (Leromain & Vannoorenberghe, 2022). Less rigorous analyses of polling data suggest mixed effects on other populist parties (Wondreys & Mudde, 2022), but the overall picture remains largely unclear.

Interestingly, one study comparing government responses to the pandemic argues that European countries with stronger pre-pandemic protections in place for democratic norms were less likely to pursue restrictive public health policies (Engler et al., 2021).

However, whereas the pandemic may not have boosted populist parties, it may still have boosted populist attitudes. One study in the USA suggested that individual and community-level exposures to COVID-19 increased support for a health reform proposal primarily championed by left-wing populists (Kavanagh & Menon, 2024). Notably, this policy proposal was opposed by the incumbent right-wing populist President Trump.

To date, it remains unclear in the academic literature how the COVID-19 pandemic and governments' responses shifted the public's political preferences (**Box E**).

Box E: Are the political consequences of COVID-19 different from those of other health crises?

Pre-pandemic health shocks disproportionately helped populists. At first glance, the pandemic may have provided an opportunity for populists to consolidate power by emphasizing the shortcomings of the public health establishment (Kavanagh & Menon, 2021). However, early evidence provides mixed evidence on this point. Why?

For one, the political context may be different: as populists have risen in power, people may have identified them as (partly) responsible for the pandemic response. Alternatively, some populists may have struggled to claim issue ownership over the pandemic (Bobba & Hubé, 2021a). Meanwhile, the pandemic shifted attention away from the preferred topics of populist parties, such as immigration (Wondreys & Mudde, 2022).

Second, the health shock itself may be different: the acute threat of COVID-19 entails a distinct experience from that of long-standing illnesses and disabilities that previous studies have examined. Relatedly, a much greater proportion of the public was directly affected by COVID-19 than is affected by chronic illness and disability.

The exact consequences of the pandemic for populist parties remain largely unclear. However, as the acute alarm of COVID-19 has faded, the mistrust in the health system and public institutions that developed in the pandemic's early years appears to remain. Meanwhile, acute infections have given way to long-standing chronic illness in the form of 'long COVID-19'. Both forces portend political consequences that do not favour mainstream parties.

6. Implications for policy-makers and political actors

Since health is important to people's politics, policy-makers and political actors have an opportunity to promote health alongside trust in democratic institutions.

As reviewed in this brief, growing evidence suggests that health is an important dimension on which voters assess their elected representatives. While the pandemic has brought health to the political forefront, it was on voters' minds long before. The political salience of health gives policy-makers and political actors an opportunity to use health policies to promote trust in public institutions and re-engage people in the democratic process. In this last section, we will review the direct policy implications of these research findings.

Given the close connections between health and our social and economic contexts, policy initiatives across diverse domains can improve population health.

Many policies are directly designed to improve population health, including improvements to the health system, expansions of health insurance coverage, and the like. But given the close interconnectedness between health, social structures and economic well-being, many policies end up impacting health – even those designed for other purposes.

As a result, policy-makers have a wide array of options for improving the health of their populations, including social policies that expand the social safety net or economic policies that improve households' financial well-being. For example, local social spending has been linked to decreased mortality (Martin et al., 2021), as has the expansion of schooling, even in high-income European settings (Lager & Torssander, 2012). Raises to the minimum wage and cash transfer programmes have improved the health of adults and children (Reeves et al., 2017; Wehby et al., 2022; Batra, Jackson & Hamad, 2023). Even neighbourhood beautification has a causal effect on community health (South et al., 2023).

To continue exploring opportunities to pursue 'Health for All Policies', please see another policy brief in the European Observatory's series (Greer et al., 2023).

The public often rewards elected officials for health-promoting policies.

Health policies can 'feed back' into the political process in several ways (Campbell, 2012,2020). For one, they can directly improve people's well-being, including their health, financial stability, and so on, and voters may reward political actors for this. Second, they can equip the public with resources that overcome some costs of political participation. Third, they can signal positive (or negative) connotations onto beneficiaries that imply who is 'deserving' (or 'not deserving') of participating in the political process.

For example, expansions of health insurance in the USA have increased voter registration, turnout and public support for these insurance programmes, especially among beneficiaries (Clinton & Sances, 2018; Hopkins & Parish, 2019; Sances & Clinton, 2021). By contrast, incumbent political actors were often punished for mishandling the COVID-19 pandemic (Baccini, Brodeur & Weymouth, 2021; Shino & Smith, 2021).

The public is more likely to reward officials for policies when their benefits are visible, the programmes are universal, and they convey respect to beneficiaries.

A health-promoting policy alone may not be enough for the public to reward political actors. Several features of government policies and programmes can make them more – or less – likely to cultivate positive responses from the public (Hertel-Fernandez, 2020).

First, programmes should be visible – with benefits that are meaningful to recipients, clear branding and wide publicity – so that beneficiaries can attribute them to the government and responsible political actors (Hertel-Fernandez, 2020). Some government benefits get 'submerged' for political ease: buried in tax codes, delegated to private companies, or otherwise stripped of government identifiers. However, hiding the government's involvement can make it less obvious to beneficiaries whom they should reward for their well-being (Mettler, 2011; Grogan, 2023; McIntyre, McCrain & Pavliv, 2024).

Second, universal programmes tend to be more politically impactful and resilient than means-tested or targeted programmes (Hertel-Fernandez, 2020). By affecting large groups of people, universal programmes make it easy for beneficiaries (and the rest of the public) to identify one another and politically mobilize against threats to the programme. For this reason, retirement-age entitlements are some of the most politically mobilizing policies (Campbell, 2003; Lerman & McCabe, 2017). By contrast, targeted programmes produce much smaller, less visible constituencies that can find it challenging to coordinate mass political action.

Third, programmes should 'convey messages that their beneficiaries are worthy citizens whose voices matter' (Hertel-Fernandez, 2020). Another part of the reason that retirement-age policies are politically mobilizing is that they make clear that senior citizens are worthy of respect and welcome to participate in politics. By contrast, demeaning and stigmatizing means-tested programmes can turn people off from the government and make them less likely to participate in politics (Watson, 2015; Barnes, Michener & Rains, 2023).

Policy-makers can better engage people in poor health in the political process by reducing barriers to their participation, soliciting their opinions and supporting groups that represent them.

The research summarized in **Section 3** conveys the many barriers to voting and otherwise participating in the political process that people with poor health or disabilities face. For this reason, this population often finds itself less represented by elected officials than their healthier or more able-bodied counterparts (Pacheco & Ojeda, 2020). However, several strategies could make participation easier and for more attractive to this population.

First, policy-makers can lower the barriers to political participation that disproportionately burden people in poor health, for example, by making voter registration easier, increasing the accessibility of polling places, or expanding early and mail voting (American Public Health Association, 2022). Policy-makers can also engage health professionals in these efforts, given that the public has high trust in their individual providers (Blendon, Benson & Hero, 2014). Consider the example of Vot-ER, a nonpartisan organization in the USA that equips providers with tools to encourage their patients to vote (see **Box E**).

Second, policy-makers can directly solicit the opinions and preferences of people in poor health, especially on issues they care most about. This population often has distinct preferences for economic and social policies (Pacheco & Ojeda, 2020). As a result of their experiences with health systems and social policies, they may be best positioned to suggest improvements. By taking on issues that this population cares about and clearly advertising those positions, policy-makers and political actors can signal to people in poor health that their concerns are not only appreciated but also prioritized.

Third, policy-makers can promote and partner with patient advocacy groups, health professional societies and other civic society groups. These organizations directly mobilize people in poor health and indirectly represent them in the political process. Policy-makers can solicit these groups' input on proposed policies, reduce barriers to their organization, and directly provide them with resources or legal protections. Such 'selective benefits' have been shown to boost organizations' longevity and political power (Hartney, 2022).

Relatedly, policy-makers can also support initiatives to collect better data on the political needs and policy preferences of people in poor health.

We need better data on health and politics. While many surveys, polls and administrative datasets collect information on politics, and many examine health, few collect information on both together. Without understanding the political needs of people in poor health, policy-makers cannot respond to them. Funding initiatives to collect data on health and politics together would improve not only our understanding of how the two forces interact but also how we can democratically engage this population and respond to their needs.

Lastly, policy-makers must be mindful of the political power granted to private interests, which can become entrenched in health-related policies.

Health policies are not just about individuals; they are also big business. The European Union spends over 10% of its gross domestic product (GDP) on health, or about €2 trillion per year (OECD & European Commission, 2022). As a result, private companies have a vested interest in the outcome of health reforms – and often participate in the political process.

Private interests, including drug companies, hospitals and insurers, spend considerable sums on advertising to the public and lobbying public officials (in nations that allow these activities) (Gollust, Fowler & Niederdeppe, 2020; Schpero et al., 2022). Private advertising has been shown to shape the public's understanding and attitudes about health policies (Fowler et al., 2017). Although it is difficult to causally evaluate, private lobbying likely influences the design and passage of health reforms (Oberlander, 2010,2020).

To that end, researchers have noted that once private interests become entrenched in a health policy or programme, it can be difficult to reclaim public ownership. For example, the expansion of employer-based health insurance in the USA sparked an industry of private lobbying that stymied the expansion of public insurance for decades (Hacker, 2002).

Indeed, delegating the provision of critical services like health care or insurance to private interests grants these businesses considerable power. Ominously, some observers have worried that private interests could hold the health system to ransom (by threatening to 'disrupt' service provision) in order to achieve policies that are favourable to themselves (Kelly, 2023).

On the flip side, inviting private interests to participate in the design of health reforms may not only neutralize potential opposition but also promote desirable outcomes (Oberlander, 2010,2020). After all, hospitals, insurers and other stakeholders are often best suited to assess how a proposed reform might facilitate or hinder care and programme delivery.

In this way, private interests can either support or threaten health policies. As such, policy-makers must mind how health policies not only shape the public's politics but also how they might empower – or hinder – the political activities of private interests.

Box E: One model for politically engaging people in poor health is Vot-ER

Vot-ER is a nonpartisan US organization that 'develops nonpartisan civic engagement tools and programmes for every corner of the healthcare system' (https://vot-er.org). It is led by Dr Alister Martin, an emergency medicine physician, and other health professionals.

One of its most successful initiatives is focused on voter registration. Vot-ER educates health care providers on how to discuss the importance of civic engagement with their patients. Then, the organization equips providers with QR codes on their identification badges that link to an online voter registration tool. That way, providers can encourage patients to register to vote while they wait in an emergency room or doctor's office – and while the importance of civic engagement to their well-being is on their minds.

This initiative recognizes that civic engagement requires resources like time, motivation and knowledge, all of which people in poor health can struggle with (Brady, Verba & Schlozman, 1995; Schur & Kruse, 2000). It lowers these costs by taking advantage of wait times in health facilities and using an easily accessible QR code. Also, by leaning on trusted health care providers, it may increase motivation for and decrease the stigmas associated with participating in politics (Susman, 1994; Mattila & Rapeli, 2018).

The organization has several related initiatives, all focused on aligning patients' health, the well-being of the health system and the functioning of participatory democracy.

7. Conclusions

Until recently, the influence of health on our political outlook has received limited attention. However, as this brief has highlighted, a growing body of work has identified the many ways in which an individual's and community's health can shape both the direction and intensity of our political participation, preferences and other engagements.

Taking this evidence together, a decline in health or ability reduces rates of voting but not necessarily all engagement in the political process. Meanwhile, it appears to channel energies toward political parties that espouse anti-democratic platforms. More work is needed to assess the causal strength of these findings and to understand the processes underlying these relationships. Even so, the evidence is that people in poor health disproportionately mistrust the political establishment and want to see it reformed.

Looking forward, it is important to consider the interaction of health with ongoing crises and structural changes, and the consequences of these interactions for the political landscape. For example, anthropogenic climate change has been linked to severe and wide-ranging health consequences, which are likely to worsen as rising temperatures affect larger segments of the population (Rocque et al., 2021). Tackling this challenge will require a clear appreciation of how health, politics and social structures interact.

Similarly, migration due to conflict and climate change is a pressing issue that threatens the health of both migrant and native populations (Mazhin et al., 2020). It may strain health systems, economic resources and cultural anxieties, interacting to fan the flames of sociopolitical grievances that might be exploited by anti-democratic actors.

Finally, consider rising income inequality. The redistributive power of globalization, automation and other economic forces have raised millions of people out of poverty, yet can also leave communities without the necessary resources to protect their health (Pickett & Wilkinson, 2015; Venkataramani et al., 2020). In this setting, economic anxieties may interact with health-related anxieties, feeding one another and potentially intensifying the public's democratic dissatisfaction (Algan et al., 2017; Menon & Osgood, 2024).

Governments are moving through uncharted waters, facing new crises that threaten both health and the long-standing political order. A better understanding of the interplay between these forces and their impact on political thought and action can help policy-makers protect not only the health of populations but also democratic institutions.

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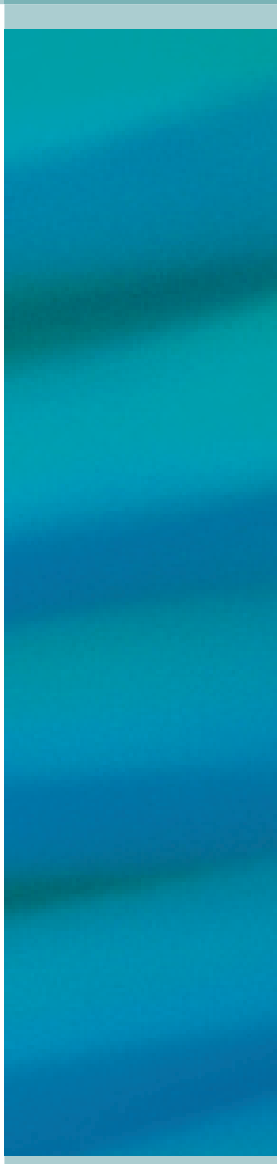

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