

Trust made the difference for democracies in COVID-19

Richard Horton¹ argues that COVID-19-related struggles of leading democracies, especially the USA, necessitate reassessing the claims made regarding healthful effects of that form of government, including the ones we put forward in 2019.² Horton's Offline elicited several responses, and we write to contribute to that ongoing debate.

The government capacities needed to successfully confront health challenges vary by cause and context. We² found that a nation's democratic experience was associated with mortality reductions from cardiovascular diseases, cancers, transportation injuries, and tuberculosis—causes for which the effect of quality health care on mortality is highest³ and which are not heavily targeted by international development assistance for health. In contrast, we found no significant link between democracy and deaths from malaria, HIV, and most other endemic infectious diseases.² Reducing deaths from these communicable causes depends on deploying targeted interventions, such as bednets and antiretrovirals, rather than by governments enforcing excise taxes or sustaining public investment in doctors, nurses, hospitals, and surgical facilities.

The COVID-19 crisis has reaffirmed the value of eschewing simple dichotomies when assessing the role of politics in population health. Some democracies have struggled in this pandemic, but so have many autocracies, including Iran, Russia, and Venezuela.

Yet, although democracy alone might not be a panacea for every pandemic of an emerging infection, evidence suggests it has helped against COVID-19, especially when there is public trust. Here, we build on our previous analysis of cross-country differences in estimated SARS-CoV-2 infection rates between Jan 1, 2020, and Sept 30, 2021 (figure).⁴ Nations

with high electoral democracy and high government trust (ie, ranking in the 75th percentile of nations on both measures) had lower infection rates than other nations, even when adjusted for factors such as population density, gross domestic product, altitude, and previous exposure to betacoronaviruses.

When confronted with a novel virus for which there is no pre-existing treatment or vaccine, the most effective way for a government to protect its citizens is by convincing them to take measures to protect themselves and one another. Especially in free societies, compliance with government guidance on mask-wearing, physical distancing, contact tracing, or a new vaccine depends on citizens' confidence that the government is trustworthy—a belief that the government knows what it is doing and is acting for the common good—and that public health programmes will be administered fairly and competently.⁵

Clear, accurate, and timely risk communication can help build the public's trust during a crisis, and so can investing in community engagement strategies to respond to the specific needs and concerns of marginalised subgroups. Horton is right, however, that the longer-term agenda on increasing public trust and social solidarity in democracies runs deeper. Our research suggests low interpersonal trust is most correlated with income inequality, government ineffectiveness, and government corruption—problems that plague the USA presently.⁴

Perhaps this pandemic can be a catalyst for the societal reforms needed to earn and nurture public confidence and social solidarity. COVID-19 has shown that the democracies that can mobilise public trust are best placed to survive and thrive even in the face of great adversity.

TJB receives funding from Bloomberg Philanthropies. JLD receives funding from the Bill & Melinda Gates Foundation. OA and SW declare no competing interests.

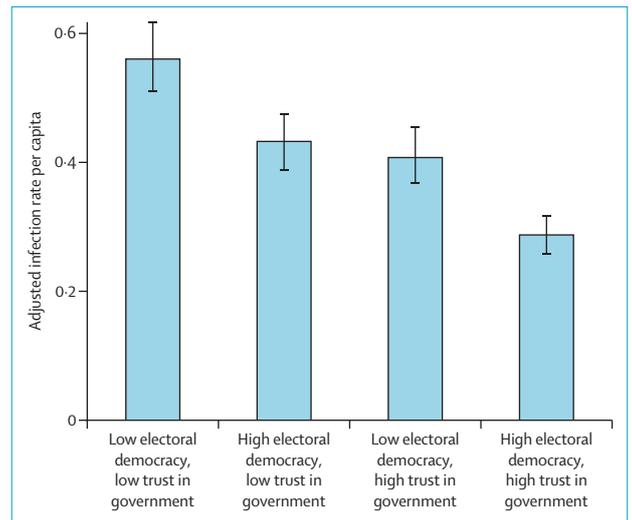


Figure: Adjusted SARS-CoV-2 infection rate given low and high levels of electoral democracy and trust in government, from Jan 1, 2020, to Sept 30, 2021

This figure shows adjusted infection rates based on the average observed association between infections and electoral democracy and trust in government during the specified time period. Adjusted infection rate reflects cumulative infections per capita that cannot be accounted for by seasonality, altitude, gross domestic product per capita, population density, and a proxy for pre-exposure to betacoronavirus. Low levels of a measure are defined as the 25th percentile of observed values; high levels are the 75th percentile. The heights of the bars are the median values with accompanying error bars representing 95% uncertainty intervals.

*Thomas J Bollyky, Olivia Angelino, Simon Wigley, Joseph L Dieleman
tbollyky@cfcr.org

Council on Foreign Relations, Washington, DC 20006, USA (TJB); Institute for Health Metrics and Evaluation, Seattle, WA, USA (OA, JLD); Bilkent University, Ankara, Türkiye (SW)

- Horton R. Offline: Is democracy good for your health? *Lancet* 2021; **398**: 2060.
- Bollyky TJ, Templin T, Cohen M, Schoder D, Dieleman JL, Wigley S. The relationships between democratic experience, adult health, and cause-specific mortality in 170 countries between 1980 and 2016: an observational analysis. *Lancet* 2019; **393**: 1628–40.
- Kruk ME, Gage AD, Joseph NT, Danaei G, García-Saisó S, Salomon JA. Mortality due to low-quality health systems in the universal health coverage era: a systematic analysis of amenable deaths in 137 countries. *Lancet* 2018; **392**: 2203–12.
- Bollyky TJ, Hulland EN, Barber RM, et al. Pandemic preparedness and COVID-19: an exploratory analysis of infection and fatality rates, and contextual factors associated with preparedness in 177 countries, from Jan 1, 2020, to Sept 30, 2021. *Lancet* 2022; **399**: 1489–512.
- Fukuyama F. The thing that determines a country's resistance to the coronavirus. March 30, 2020. <https://www.theatlantic.com/ideas/archive/2020/03/thing-determines-how-well-countries-respond-coronavirus/609025/> (accessed July 18, 2022).