



*Original Research*

# The Role of Primary Care in Advancing Civic Engagement and Health Equity: A Conceptual Framework

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## Policy Points:

- Health and civic engagement are reciprocally and longitudinally linked: Poor health is associated with less civic engagement. Well-established social drivers of health and health inequality such as inadequate access to health care, poverty, racism, housing instability, and food insecurity are also drivers of lower civic engagement.
- A robust primary care system can play a key role in advancing civic engagement (e.g., voting, volunteerism, community service, and political involvement) at the population level but has received little attention.
- Policy and practice solutions at the individual and structural levels should support and leverage potential synergies among health equity, civic engagement, and primary care.

**Context:** Health and civic engagement are linked. Healthier people may be able to participate more fully in civic life, although those with poorer health may be motivated to address the roots of their health challenges using collective action. In turn, civically active people may experience better health, and societies with more equitable health and health care may experience healthier civic life. Importantly, a robust primary care system is linked to greater health equity. However, the role of primary care in advancing civic engagement has received little study.

**Methods:** We synthesize current literature on the links among health, civic engagement, and primary care. We propose a conceptual framework to advance research and policy on the role

of primary care in supporting civic engagement as a means for individuals to actualize their health and civic futures.

**Findings:** Current literature supports relationships between health equity and civic engagement. However, this literature is primarily cross-sectional and confined to voting. Our integrative conceptual framework highlights the interconnectedness of primary care structures, health equity, and civic engagement and supports the crucial role of primary care in advancing both civic and health outcomes. Primary care is a potentially fruitful setting for cultivating community and individual health and power by supporting social connectedness, self-efficacy, and collective action.

**Conclusions:** Health and civic engagement are mutually reinforcing. Commonalities between social determinants of health and civic engagement constitute an important convergence for policy, practice, and research. Responsibility for promoting both health and civic engagement is shared by providers, community organizations, educators, and policymakers, as well as democratic and health systems, yet these entities rarely work in concert. Future work can inform policy and practice to bolster primary care as a means for promoting health and civic engagement.

**Keywords:** civic engagement, health equity, primary health care, social determinants of health, voting.

**W**E ARE AT A CRUCIAL MOMENT TO ACKNOWLEDGE AND LEVERAGE THE synergies between health and civic engagement to improve population health, well-being, and opportunity in the United States. Inequities at the intersection of health and civic engagement have become increasingly apparent during the COVID-19 pandemic.<sup>1,2</sup> Social determinants of health (SDoH) such as racism and economic marginalization have been closely related to the incidence and severity of COVID-19 as well as to political disenfranchisement.<sup>3,4</sup> Although the pandemic undermined some opportunities for civic engagement, other civic engagement strategies (e.g., voting and protesting) remained active.<sup>1,2</sup> As the strained primary care system in the United States has adapted in the face of the pandemic, many have called for increased attention to SDoH to more effectively address the short- and long-term impacts of COVID-19.<sup>3,5</sup> This moment in history, therefore, offers a window of opportunity to combine heightened awareness of inequity with the need and motivation for innovative solutions. Primary care structures are potentially key agents of change in this agenda.

The 2021 National Academies of Sciences, Engineering, and Medicine (NASEM) consensus report highlighted the role of a high-quality primary care system as a foundation of the health care system.<sup>6,7</sup> The report by NASEM stated the following:

High-quality primary care is the provision of whole-person, integrated, accessible, and equitable health care by interprofessional teams that are accountable for

addressing the majority of an individual's health and wellness needs across settings and through sustained relationships with patients, families, and communities.<sup>6p46</sup>

By focusing on whole-person, community-based, and equitable care over time, primary care fills an essential and unique role in the health care system; primary care supports individuals and communities by building the resources they need to thrive as well as preventing and managing health conditions.

Compared with countries that invest heavily in primary care, the United States spends more on health care but experiences worse health outcomes and greater health inequality.<sup>8</sup> Only 5% of American health care spending is devoted to primary care, but primary care accounts for 35% of all health care visits.<sup>6</sup> The current state of primary care reflects long-standing and systematic disinvestment,<sup>6</sup> which manifests in not only low rates of health care spending but also low rates of regular primary care visits, decreased public trust in physicians, and fewer medical students pursuing primary care.<sup>9–13</sup> In 1996, an Institute of Medicine (IOM) report detailed the need and opportunity to shift the course of health care away from increasing specialization and acute care.<sup>14</sup> NASEM similarly details five implementation objectives to improve primary care in the future,<sup>7</sup> yet change has been inadequate.

The COVID-19 pandemic laid bare the cost and consequences of the failure to prioritize primary care in the United States. Alarming disparities in COVID-19 mortality by race and ethnicity have emerged.<sup>6,15,16</sup> The disproportionate impact of COVID-19 mortality in minoritized racial and ethnic groups coincided with high-profile protests against long and violent histories of social injustice and racism across the United States.

Calls for social justice and increasingly high-profile efforts to mobilize public support have occurred against the backdrop of accelerating efforts to restrict the political power of marginalized and minoritized communities, particularly Black and Indigenous people.<sup>17</sup> In 2013, the US Supreme Court struck down provisions of the 1965 Voting Rights Act, the federal law that prevents systematic voter suppression. Since then, 20 states have passed laws to restrict or suppress voting.<sup>18</sup> In 2022, the John R. Lewis Voting Rights Advancement Act, which would have restored provisions of the Voting Rights Act, was voted down in the Senate.<sup>18</sup> Gerrymandering, restrictions on voting by mail, closure of polling places in communities where minoritized groups vote, and restrictions on absentee ballots have all been used as tools to suppress the vote.<sup>18</sup> Meanwhile, community organizations and social movements have formed to counter these threats.<sup>19,20</sup> Nonetheless, in a 2022 commentary, Han highlighted “frustratingly slow” progress in addressing SDoH, which can be addressed, in part, by civic engagement and collective action.<sup>21</sup> Collective action and other forms of civic engagement are instrumental for building resilience into interconnected systems of care, supporting political action to reduce SDoH, and, as Han notes, “[equipping] people to become architects of their own (health) future.”<sup>21</sup> Iton and colleagues (2022)

similarly describe a “democratic approach to health improvement”: Social determinants drive health inequities, the conditions underlying social determinants result from policies that are disproportionately health protective for privileged groups, and thus, population health efforts rely on communities holding policymakers accountable to enact policy reform.<sup>22</sup>

Indeed, there is ample evidence that health and civic engagement are linked. In a review of more than 150 studies, Nelson, Sloan, and Chandra (2019) found a consistent relationship between better health and more civic engagement (e.g., voting, volunteering, membership in community organizations, and community activism).<sup>20</sup> A limited number of longitudinal studies suggest that poor health in early life is associated with less civic engagement later in life, and, reciprocally, more civic engagement is associated with better health in subsequent years.<sup>20</sup> Similarly, civic engagement strengthens communities and empowers citizens, better positioning communities to demand better health resources from their representatives and influence policy.<sup>23,24</sup>

In this paper, we highlight ways that a robust and invigorated primary care system could drive not only population health and health equity but also democracy and citizen engagement beyond voting over time. We build on prior reviews that have summarized the evidence for the relationship between health and civic engagement<sup>20</sup> and interventions to promote voting in health care settings.<sup>25</sup> We extend previous work by synthesizing literature that informs opportunities to use primary care to advance individuals’ ability to actualize their health futures through greater power, voice, and agency.<sup>21,26</sup> We begin by briefly defining key concepts before summarizing the literature that links health equity and civic engagement. We then conduct a narrative review of the evidence for the relationship between health and dimensions of civic engagement and outline how primary care structures might be leveraged to improve population health and reduce inequality. Finally, informed by existing literature, we propose a conceptual framework that posits how primary care can drive health equity and civic engagement, with benefit to patients and their communities. We conclude by highlighting important gaps in the existing literature as research opportunities to guide future research and policy.

## Key Constructs

### *Individual and Community Health*

The World Health Organization (WHO) defines health as “a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.”<sup>27</sup> More recently, there has been a growing focus on health as a resource that allows adaptability to a range of circumstances.<sup>28,29</sup> These definitions conceptualize health as a resource to draw on for everyday life, described initially by WHO (1984) as “a

positive concept emphasizing [sic] social and personal resources, as well as physical capacities.”<sup>30p4</sup> The health of individuals is closely linked with the collective health of their communities because of health’s status as a resource for success in other areas.<sup>31</sup> Community health reflects proximity and access to shared social connections, actions, and experiences as well as common perspectives, norms, and values; these shape collective experience and individual health outcomes in turn.<sup>32,33</sup>

### *Health Equity*

Health equity is achieved when everyone has the opportunity to achieve their full health potential.<sup>34</sup> Inequity is closely linked to social and structural conditions that either inhibit or promote individuals’ ability to achieve their fullest health potential.<sup>34–37</sup> Achieving health equity requires a focus on SDoH, defined by WHO as “the conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life.”<sup>38</sup> Threats to health include poverty, economic marginalization, lack of social power, disenfranchisement, social isolation, discrimination, low-quality education, and unsafe housing/neighborhoods.<sup>34,39</sup>

Place is also a powerful social determinant. Urban environments have been linked to more crowding, residential segregation, and community violence.<sup>40</sup> Similarly, rural environments have been linked to greater social isolation and poorer geographical access to health care services.<sup>41–43</sup> These social factors have tangible impacts on people’s health, which in turn affect civic engagement, social power, and the likelihood of collective action to drive changes in health and social circumstances.

### *Civic Engagement*

In Healthy People 2030, the US roadmap for public health, civic engagement is conceptualized as a key component of social and community context—a social determinant of health.<sup>44</sup> Civic engagement encompasses the ways that citizens participate in their communities and shape their communities’ futures.<sup>45</sup> Brooks (2009) reflects on the complexity and expansiveness of the term by explaining, “Civic engagement is about both process and results—it engages diverse constituencies in decision making; promotes and sustains a platform for action and policy change; and advances social and economic equity.”<sup>46p37</sup> Voting is the way most Americans conceptualize civic engagement.<sup>47–49</sup> Increasingly, however, conceptualizations of civic engagement have moved beyond this narrow focus to include citizens’ active participation in addressing power, inequality, and human rights.<sup>50,51</sup> For instance, Adler and Goggin (2005) note that civic engagement encompasses a much broader array of activities, including community service, collective action, political involvement, and social

change.<sup>45</sup> Collective action in particular helps conceptualize civic engagement in terms of voice, power, and agency.<sup>21,26</sup>

Civic engagement may manifest in at least three domains: civic (e.g., volunteering, fund-raising, making charitable contributions, donating blood products, working with neighbors to fix a community problem), electoral (e.g., voting, making campaign contributions), and political voice (e.g., protesting, contacting congress, writing letters to the editor).<sup>48,52–55</sup> Not all forms of civic engagement demand the same effort or capital (social, political, economic), and most types of civic engagement are unequally distributed because of inequalities in power, time, or money.<sup>56</sup> The advent of the internet and the popularization of social media now allow individuals to engage virtually, broadening the scope of community participation and reducing access barriers for some types of civic engagement.<sup>50,57–59</sup> More broadly, civic engagement is inextricably linked with culture; democracy and civic engagement derive meaning in the context of ideas, practices, and technologies that change over time and afford varying degrees or different forms of expression and empowerment.<sup>60</sup> In fact, civic engagement requires the development of a democratic imagination in which citizens are fully equipped to deliberate critically and creatively as well as act accordingly to make changes in their communities.<sup>61</sup>

Like health, there are unequal opportunities for civic engagement on the basis of social and structural determinants such as racism and implicit bias, unequal access to education, sexism, and socioeconomic status (SES).<sup>62–65</sup> Although most empirical evidence for the uneven distribution of civic engagement focuses on voting, some research suggests inequalities in other dimensions of civic engagement as well.<sup>66</sup> Promoting equitable access to civic engagement involves focusing efforts on people who face structural barriers. For instance, people of color, people with disabilities that limit mobility, people with less education, people living in rural areas, and people with low incomes are less likely to vote.<sup>25,67–71</sup> Likewise, their views are less likely to be reflected in policy, in part because of unequal access to resources that can be used to influence policy decisions.<sup>19,72,73</sup>

## Health, Primary Care, and Civic Engagement: A Narrative Review

In this section, we review the literature linking the concepts in our model. We begin by exploring the relationship between health and civic engagement. We focus first on voting because of the large body of existing literature, although it is a less active, engaged form of citizenship than other, less well-measured forms such as contacting elected officials, deliberating, and possessing “democratic imagination.”<sup>61</sup> We then address connections between health and other forms of civic engagement. After a brief discussion of the mechanisms linking health and civic engagement and an overview

of literature discussing health equity and civic engagement, we move on to exploring the role primary care can play in advancing health equity and civic engagement.

### *Health and Voting*

Overall, there is an established positive and mutually reinforcing relationship between health and voting. Existing research shows a significant association between population health (mental and physical) and voting, with poorer health generally related to lower voter turnout.<sup>20,25,74–78</sup> However, this relationship varies by health condition, with some conditions such as heart and neurodegenerative disease being linked to less voting (because of functional limitations)<sup>76</sup> and other conditions such as cancer being linked to increased voting (potentially because of the influence of patient advocacy associations).<sup>79,80</sup> Although research generally supports the association between physical or mental health conditions and lower voter turnout, there are some exceptions.<sup>67,76,81–84</sup> For example, Couture and Breau (2017) found that mental health was more strongly associated with local electoral turnout, whereas physical health was more strongly associated with voter turnout at the national level.<sup>83</sup> The association between health and voting also varies by age; it is stronger in early adulthood than in middle age.<sup>78</sup>

There are important limitations in the existing body of research assessing the link between health and voting. Notably, most studies are cross-sectional, limiting inference regarding the temporality and directionality of associations.<sup>20,85</sup> For example, using data from the British National Child Development Study, Denny and Doyle (2007) found that poor physical and mental health and smoking were associated with lower voter turnout.<sup>77</sup> Similarly, in an analysis of data from 30 European counties, Mattila and colleagues (2013) found that better individual self-rated health was linked to higher voter turnout.<sup>75</sup>

A limited number of studies have examined the longitudinal relationship between voting and health status. Ojeda and Pacheco (2019) assessed voting and health patterns in young adults in the United States over time.<sup>84</sup> They found that depression was associated with a lower likelihood of initial voting, and decreasing depressive symptoms were associated with a greater likelihood of turnout over 6 years compared with those with similar or increasing symptoms over time. Conversely, poorer self-rated health was associated with a lower initial probability of voting but not voting over time, and physical health did not have a significant effect on voter turnout for young adults.<sup>84</sup> Gagne and colleagues (2019) used an age-graded, longitudinal approach and found that poor health impacted voting patterns in early adulthood more so than in middle adulthood.<sup>78</sup> Using sibling fixed-effects models, Burden and colleagues (2017) found that better health and general functioning were each associated with a higher probability of voting in middle and older adulthood, but not with the likelihood of making campaign contributions.<sup>74</sup>

### *Voting and Health*

Voting may influence health in two key ways. First, research suggests an intrinsic benefit of voting on individual health; voting is positively associated with mental health and health behavior.<sup>17,25,86,87</sup> Second, voting can advance policies that benefit individuals' health and various SDoH (e.g., affordable housing, clean environments, and wages).<sup>17</sup> This is significant because ~80% of health at the population level is attributable to social and economic factors, health behaviors, and environmental factors.<sup>88</sup> Local elections determine how vital resources are allocated—from healthy food to housing, transportation, and employment opportunities.<sup>17</sup> Although political efficacy (the collective belief in the ability to influence government) varies, most Americans believe that voting gives people at least some say in government decision making,<sup>89</sup> and research shows that high political efficacy translates to increased voting behavior.<sup>90</sup> Meanwhile, polls consistently show that Americans prioritize and acknowledge the importance of health care policy, and voting is a crucial tool for actualizing change in these priorities.<sup>91,92</sup> Thus, voting can be a conduit for people's policy preferences, which, in turn, shape health outcomes, either directly or indirectly.

### *Health and Civic Engagement Beyond Voting*

Although most research to date has focused on voting, some research has also examined the relationship between other forms of civic engagement and health. Some examples of these nonvoting civic activities are participating in a political club/organization,<sup>93</sup> contributing campaign money,<sup>74,93</sup> contacting an official,<sup>93</sup> running for office,<sup>93</sup> attending a rally,<sup>93</sup> signing a petition,<sup>83</sup> searching for political information,<sup>83</sup> and belonging to community groups and organizations.<sup>94</sup> Despite an overall trend linking poor health with less civic engagement, this relationship may vary by civic activity.<sup>85</sup> Poor mental health is linked to a lower likelihood of engaging in a broad range of civic activities such as participating in a political club or organization, contributing money to a political party, contacting an official, running for public or nonpublic office, or attending a rally.<sup>93</sup> Conversely, one study found an association between poorer mental health and greater likelihood of signing an online petition,<sup>83</sup> and another found that mental and physical health were unrelated to the likelihood of making campaign contributions.<sup>74</sup>

Like research on voting, most of this broader literature is cross-sectional, limiting the ability to draw conclusions about temporality.<sup>85</sup> However, in one example using longitudinal cross-lagged models, Fang and colleagues (2018) found that greater levels of happiness predicted future civic engagement.<sup>95</sup> In another longitudinal study of people aged 50 and older across 13 European countries, worsening health conditions such as depression and disability were associated with less volunteerism, particularly



in countries where volunteering is more prevalent, after accounting for factors such as age, gender, education, income, employment, and religious participation.<sup>96</sup>

### *Civic Engagement Beyond Voting and Health*

The existing evidence also supports health benefits of civic engagement more broadly. In a review, Nelson, Sloan, and Chandra (2019) highlight evidence for links between membership in community organizations, direct community service, and various forms of physical and mental health.<sup>20</sup> For example, belonging to civic groups (e.g., religious, health, neighborhood, arts) is associated with greater likelihood of physical activity through improved social connectedness.<sup>94</sup> Moreover, membership in local religious organizations, which can be particularly important in rural areas, is associated with a stronger sense of community, civic skills, social capital, and longer life expectancy.<sup>97–100</sup>

Across myriad countries and contexts, volunteering has been associated with both better self-rated health and lower risk of cognitive impairment among older adults after controlling for various demographic factors.<sup>20,86,101–106</sup> Volunteering has also been associated with more preventive care service use and less hospital usage after controlling for other factors that may be expected to vary with volunteerism, such as age, gender, race, marital status, educational attainment, wealth, and health insurance status.<sup>107</sup> In one study of US adults, volunteers spent 38% fewer nights in a hospital and were more likely to receive services such as flu shots, cholesterol screening, mammograms, and prostate exams as compared with nonvolunteers; moreover, use of these preventive services is likely to result in less hospital time in the future.<sup>107</sup>

At the same time, disadvantaged groups may lack the discretionary time, funds, transportation, or other resources to engage in volunteerism, compounding inequality.<sup>66</sup> College graduation is associated with more volunteering,<sup>108</sup> an important differentiator of class advantage. Although many studies account for various demographic factors that may be associated with volunteering and health status, factors that confer social disadvantage to an individual are simultaneously associated with lower volunteerism and poorer health, necessitating further research to clarify and confirm these relationships.

Civic engagement can also be a tool to promote individual and population health. Participating in protests, choosing which voluntary organizations to support with time and funds, and engaging key representatives and policymakers are avenues for influencing health policy priorities and improving health equity beyond the ballot box. At the same time, committing time to voluntary organizations and solving problems with others in the community, among many other civic activities, can impact overall individual and community well-being.

### *Potential Mechanisms Connecting Health and Civic Engagement*

Current literature also hints at potential mechanisms linking better health and various forms of civic engagement; however, given the cross-sectional design of most existing research, tests of mediation remain rare. Among the most prominent proposed mechanisms is enhanced ties to others. For example, in a review, the positive impact of voting on mental and physical health was observed to operate through associations with social connectedness and self-efficacy,<sup>87</sup> both of which may be connected to a broad range of positive health outcomes.<sup>109–111</sup> Similarly, better health predicts greater social connectedness, which, in turn, is linked to increased voter turnout, particularly among older adults.<sup>67,75,112,113</sup> In adolescents and young adults ages 16–26, Cicognani and colleagues (2015) found that a sense of community and empowerment mediated the relationship between organizational membership and social well-being.<sup>114</sup> Community power was identified in one article as a crucial, yet unevenly distributed, lever of change for influencing policy and improving health outcomes.<sup>22</sup> Similarly, in adults, Buck-McFayden and colleagues (2018) found positive associations among a sense of belonging, civic engagement, and self-rated health.<sup>115</sup> Reciprocally, Putnam (1995) has demonstrated a link between social capital and civic engagement via direct involvement with community and local organizations.<sup>116</sup> Participating in voluntary organizations, then, may facilitate social capital, which is associated with a wide range of positive health indicators.<sup>117</sup>

Enhanced self-efficacy and sense of purpose may also help to explain reciprocal links between health and civic engagement, although research remains sparse.<sup>114,118</sup> For example, Fenn and colleagues (2021) found that university students' belief in their ability to contribute to their community and sense of purpose mediated the relationship between civic engagement (civic, electoral, sociopolitical, and social support domains) and mental well-being.<sup>118</sup> More generally, Denny and Doyle (2007) suggest that people with poor health are less likely to vote because the barriers and perceived cost of voting (in terms of effort necessary) exceed the perceived benefits (in terms of the perceived policy implication of getting out to vote).<sup>77</sup> A better understanding of key mechanisms linking civic engagement and health as well as their directionality is a critical research gap.

### *Health Equity and Civic Engagement*

There is significant evidence that civic engagement is linked to not only individual health but also the distribution of health in the population. Stopka and colleagues (2022) connected SDoH to inequalities in both health and civic engagement.<sup>119</sup> Other work has confirmed that disparities in civic participation are linked to social and structural factors, age, and survivability.<sup>120</sup> For instance, citizens with lower

SES are expected to vote for redistributive health policies<sup>121</sup> but experience higher mortality rates in middle age—i.e., when they are most likely to vote.<sup>120</sup> As voting decreases in socioeconomically marginalized communities later in life, voting remains prevalent in communities with high SES, perpetuating health inequalities.<sup>120</sup> Brown, Raza, and Pinto (2020) point out the following:

If inequities in access to healthcare services and in health outcomes can change who wins elections, a vicious cycle can emerge: worse health leads to lower voting rates, leading to policy that does not prioritize addressing inequities, leading to worsening health inequities.<sup>25p17</sup>

Indeed, low SES is associated with and perpetuated by poor mental health,<sup>122</sup> which has negative implications for voter turnout.<sup>25,77,84</sup> Besides SES, other factors such as racial discrimination affect voting outcomes over time. Racial inequality leads to excess mortality, loss of votes, and thus reduced political voice for minoritized racial and ethnic groups.<sup>123–125</sup> Civic engagement in all of its forms, including but not limited to voting, is a means to drive policy action on health issues, stimulate systemic change, and ultimately improve health.<sup>17,25,104</sup> These influences vary by demographics and health condition<sup>25,76,79</sup> and apply to physical,<sup>20,67,84,126</sup> mental,<sup>20,82,84</sup> and social health (i.e., the robustness of interpersonal and community relationships as well as support and capital within larger social networks).<sup>25,75,85</sup> However, opportunities for civic engagement differ on the basis of common social and structural determinants.<sup>62,63,66</sup> On the other hand, voting inequality is associated with poorer health,<sup>124</sup> and restrictions on voting influenced by factors such as racism and classism are linked to being less likely to have health insurance.<sup>125</sup> Iton and colleagues (2022) argue that community power, unevenly distributed as a result of systemic racism and other structural inequities, is critical to shaping health outcomes.<sup>22</sup> By extension, health benefits derived from civic engagement and inequitable distribution of community power are also inequitably distributed. Social connectedness, a putative mediator of this relationship, is unevenly distributed by factors such as class, urbanicity, race, and gender and thus further contributes to inequities in both health and civic engagement.<sup>116,127,128</sup> The unequal distribution of social capital may, therefore, amplify positive or negative health and civic outcomes.

Together, existing research suggests a reciprocal relationship between health and civic engagement. Although literature is most heavily concentrated on voting, research on broader components of civic engagement supports the same conclusion: Overall, healthy people are more engaged citizens, and more civically engaged individuals are more likely to have better health. Social and structural determinants play a key role in shaping both health and civic outcomes.

### *The Primary Care System*

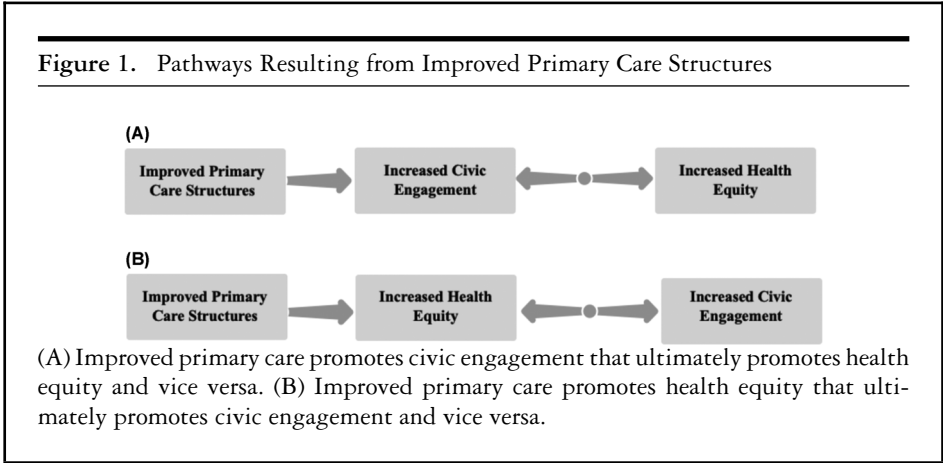
We now focus on primary care as an important and strategic lever for influencing both health equity and civic engagement. A key feature of primary care is an emphasis on community empowerment and involvement to shape health needs prioritization and inform solutions.<sup>129–131</sup> Primary care bears responsibility for community care (through identifying and addressing community needs with the input of community members), which it fulfills through long-lasting partnerships and personal relationships.<sup>130</sup> Primary care is unique in its provision of first-contact, continuous, comprehensive, and holistic person-focused care over time as well as its ability to build relationships, promote trust among patients, and address patient and community needs.<sup>132</sup>

Supplementing formal health systems with community-specific initiatives, such as community health workers or multicultural health brokers, is a major step toward improving community health equity,<sup>133</sup> which can be facilitated by civic engagement.<sup>134,135</sup> More than individual-level advocacy, community- and structural-level changes can target the root causes of health inequities.<sup>134</sup> Integrating the culture of a community into the American health system can improve health care access and enhance culturally competent health care delivery among members of the entire community.<sup>136</sup>

### *The Role of Primary Care in Advancing Health Equity and Civic Engagement*

Primary care is positioned to promote both civic engagement and health equity in communities, as illustrated in Figure 1. Primary care structures can influence both civic engagement and health equity, reducing inequality by addressing individual and community needs (Figure 1, A and B). We propose that one way that primary care can increase civic engagement is by addressing civic barriers (e.g., through voter registration and efforts to increase the connection of patients with their communities), which then improves health outcomes (Figure 1A). Because better health is linked to better civic engagement, there is an added positive effect on civic engagement (Figure 1A). Primary care may also improve health equity by identifying and addressing health risks, managing chronic health conditions, identifying and addressing SDoH, and providing adequate and contextually relevant treatment to patients (Figure 1B). Better health is associated with better civic engagement, which has a mutually reinforcing relationship with health (Figure 1B).

The role of the community primary care provider can be leveraged in various ways. For example, according to the integrated voter engagement model, health organizations should seek to bolster voter registration, mobilization, education, and protection in the communities they serve.<sup>137</sup> Understanding, adapting, and applying



these four components according to community context can help bolster the sense of primary care clinics as entities integrated with and trusted by their communities. Because patients both recognize the history and anticipate a future of interactions with primary care providers acting in patients’ best interests, according to Tarrant and colleagues (2010), primary care provides “a context that makes it possible for trust to build and become secure.”<sup>138p445</sup> Primary care clinics can thereby play a crucial role in advancing mutually reinforcing health and civic outcomes through relevant and effective interventions.

Because social advantage, health, and civic engagement are already concentrated in groups with social power, it is important to acknowledge the potential for new resources, if allocated equally across primary care settings and populations, to exacerbate existing inequity. Thus, we suggest prioritizing communities with the least social power and advantage. Because health and civic engagement are important to foster, groups with existing social power will still benefit from these interventions; however, significantly more resources must be provided for those in disadvantaged and excluded groups to benefit.

There are calls for health care providers to see civic health promotion as part of their role and responsibility.<sup>17</sup> Most commonly, civic health promotion has focused on voter registration. The National Voter Registration Act stipulates that any agency that provides services under public assistance programs must offer voter registration services (e.g., Supplemental Nutrition Assistance Program; Special Supplemental Nutrition Program for Women, Infants, and Children; Medicaid offices).<sup>139</sup> Increasingly, hospitals and emergency departments have been included in these efforts because they are settings where medically underserved patients and those who are least likely to register to vote (e.g., 18- to 24-year-olds, people living near the poverty level, and

Black and Indigenous people) commonly receive care.<sup>17</sup> Bajaj, Martin, and Stanford (2021) argue that encouraging patients to register to vote “offers the opportunity to address underlying political determinants of health, such as special interests, partisan ideologies and policy more broadly.”<sup>17p1662</sup>

Accordingly, some programs have explicitly set out to support civic engagement in the context of health care. Programs such as *VotER* and *Democracy at Discharge* have integrated nonpartisan voter registration and voter education in health care settings.<sup>17</sup> Although primary care voter registration programs that encourage and provide information about voting—critical steps to facilitate voting above and beyond registration—have gained some traction, these settings remain underleveraged. One 12-week program implemented in waiting areas of two New York Medical academic family medicine clinics, for example, resulted in 89% of eligible patients being registered, suggesting that supporting voter registration in primary care clinics can help overcome some barriers to civic engagement, such as lack of individual initiative, time constraints, work schedules, limited income, and lack of transportation.<sup>140</sup> The proportion of patients who ultimately go on to vote, however, remains unclear.

The existing evidence suggests that both patients and providers support efforts to advance a variety of aspects of civic engagement, not just voting. A study in three academic pediatric primary care clinics showed that just over half of parents wanted pediatric providers to encourage voting among age-eligible family members, and at least three-quarters of parents wanted their provider to talk with them about child health policies or federal legislative issues that might impact their child and family.<sup>141</sup> Likewise, most pediatricians believe that it is empowering to discuss policy issues affecting their patients, but physicians are often unable to do so because of barriers such as feeling uninformed about relevant issues, concerns about partisan bias, and time constraints.<sup>142</sup>

Although more literature provides suggestions on voting specifically, health care workers can promote civic engagement beyond voting. Cooper and colleagues (2022) state the following:

“...health professionals can incorporate the value of civic participation in [relationships with patients, research participants, coworkers, and other community residents] by expressing concern about what is happening in the community. They can also advise those with whom they interact about the personal and social value of participating in interest groups, civic groups, and advocacy groups, and even running for political office.”<sup>143p2</sup>

Particularly for marginalized individuals, health care workers can collaborate with other social justice professionals (e.g., educators and social workers) to solve community problems more holistically.<sup>143,144</sup> At the population level, clinician partnerships with community-based groups and urban planners aim to create healthy spaces and mitigate structural health inequities caused by redlining and gentrification.<sup>145</sup> At

the individual level, the National Center for Medical-Legal Partnership and Medical-Legal Partnership Boston assist low-income patients experiencing food, housing, and employment insecurity by integrating legal guidance with health care.<sup>146,147</sup> “Through their knowledge of how laws and policies work and their advocacy for the rights of historically marginalized communities,” according to Cooper and colleagues (2022), “these professionals have the skills to help people identify ways they can exercise their autonomy.”<sup>143p2</sup>

Many primary care settings rely on community health workers (CHWs): front-line health workers with deep knowledge of their communities, who help establish healthy behaviors, advocate for health needs and overall community health, and, at times, provide basic preventive care.<sup>148–150</sup> CHWs are making a resurgence;<sup>149</sup> the US Bureau of Labor Statistics estimates the CHW population in the United States to be ~61,000 in various roles within outpatient centers, hospitals, insurance carriers, and local governments.<sup>150</sup> Because CHWs often share similar experiences with many of the patients whom they support,<sup>151</sup> the American Public Health Association (2009)<sup>148</sup> states that they are “uniquely positioned to address issues of health care access, quality, cost, and disparities,” often by promoting civic engagement.<sup>134</sup> CHWs act as a bridge between health care and communities as part of primary care, connecting vulnerable individuals to support systems,<sup>135</sup> conducting outreach, providing education and counseling, ensuring resource linkages, and providing social support.<sup>148</sup> Indeed, CHW advocacy is associated with better community conditions through policy change aimed at mitigating health disparities.<sup>135</sup> Ingram and colleagues underscore the often overlooked potential for CHWs to not just improve individual health outcomes but also affect social change in communities more broadly.<sup>134</sup> Hence, the growing role of CHWs and the focus on community more generally may play a role in combating the root causes of health inequity that would otherwise go unaddressed.<sup>134,152</sup>

More broadly, primary care structures serve a critical community empowerment role. As described by Eng and colleagues (1992), they are key to both civic and health promotion inasmuch as they can “create conditions and opportunities for people to recognize that they can take power simultaneously as individuals and as a community.”<sup>153p5</sup> Primary care providers can support the development of community agency, power, and holistic well-being; they may help patients set their own health and civic goals; engage in locality development, social planning, social action, public advocacy, and consciousness raising; collaborate with other traditional and nontraditional health providers; actively listen to and observe their communities; and work with and on behalf of community members so that patients can achieve their own success and empowerment.<sup>153</sup> The role of primary care emphasizes equipping and supporting patients as agents of individual and community change,<sup>153</sup> which can facilitate both positive health and civic outcomes while addressing underlying structural inequities and social determinants.

### *Summary*

A summary of key findings from the literature and gaps in current knowledge is in Table 1.

### *Conceptual Model*

Based on the literature, we propose a conceptual model that illustrates how a robust primary care system could drive civic engagement and health equity (Figure 2). This model reflects the extant literature, which is currently limited in many respects. The contributing factors and mechanisms shown in Figure 2 are intended to be illustrative and are not exhaustive. This model is, however, an important first step toward elucidating the foundational relationships among civic engagement, health equity, and primary care structures. Our goal is to facilitate further research into these relationships and their mechanisms, nuanced policy related to each of the main constructs (civic engagement, primary care, and health equity), and practice via informing interventions that address one, or ideally more, of these constructs.

The model depicts two closely related levels: the population (Figure 2A) and the individual (Figure 2B). Each of the main constructs (health, civic engagement, and primary care) has a counterpart at each level. For example, “Health Status” is depicted at the individual level (Figure 2B), whereas “Health Equity” is specified at the population level (Figure 2A); both are emblematic of the “Health” construct. Figure 2C demonstrates the connection between the two levels. Because the population level represents, essentially, the sum of individual experiences, individual health, civic engagement, and primary care will affect population outcomes. However, collective experience and interaction of individuals and institutions at the population level related to health, civic engagement, and primary care will, in turn, influence the conditions individuals experience.

The literature describes a strong, bidirectional relationship between health and civic engagement; the inequitable distribution of health and civic engagement may shape the need for primary care systems as well as the tools and capacities required of them, just as primary care structures may be a force for addressing systemic health inequities and differences in civic engagement. These relationships are present at both individual and population levels.

The model also hypothesizes these relationships with some mechanistic specificity based on findings in previous literature. Civic engagement, health equity, and primary care delivery are part of complex relationships with many influential factors. These factors are noted around each of the three outer arrows. For example, health and civic outcomes are mediated by social connectedness, self-efficacy, empowerment, and community power. We have portrayed illustrative mechanisms with some specificity with respect to individual and population levels. For example, an

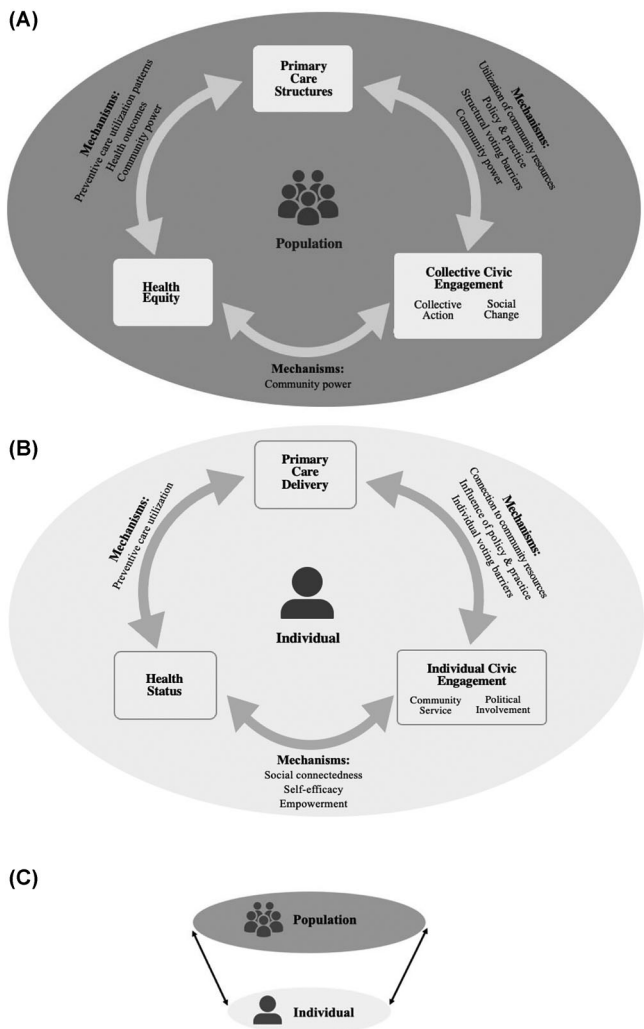


Table 1. Summary of Literature on Health, Civic Engagement, and Primary Care and Gaps in Current Knowledge		
	What Is Known	Gaps
Health and voting	<ul style="list-style-type: none"><li>• There is a positive and mutually reinforcing relationship between health and voting, varying by health condition and age.</li><li>• Voting is associated with better health both through intrinsic benefits and policy change.</li></ul>	<ul style="list-style-type: none"><li>• There are few longitudinal studies, limiting insight into temporal relationships.</li></ul>
Health and civic engagement beyond voting	<ul style="list-style-type: none"><li>• There is a positive and mutually reinforcing relationship between health and civic engagement activities other than voting; this relationship varies by type of civic engagement activity.</li><li>• Volunteering has been studied most.</li></ul>	<ul style="list-style-type: none"><li>• Literature on forms of civic engagement other than volunteering is limited.</li><li>• Less research exists on civic engagement as a means of empowering people to take control of their own health futures.</li></ul>
Mechanisms and influencers connecting health and civic engagement	<ul style="list-style-type: none"><li>• Social connectedness and self-efficacy are putative mediators of the relationship between health and civic engagement.</li><li>• Community power may influence control over policy and health outcomes.</li></ul>	<ul style="list-style-type: none"><li>• More varied investigation of different social and political contexts is needed.</li><li>• Research on the role of trust and self-efficacy in health is particularly lacking.</li></ul>
		<i>Continued</i>

Table 1. (Continued)

	What Is Known	Gaps
Health equity and civic engagement	<ul style="list-style-type: none"><li>• Healthier people are generally more engaged citizens, and more civically engaged individuals are more likely to have better health.</li><li>• Social structures impact health and opportunities for meaningful civic participation; many of the social determinants of health and civic engagement are shared.</li></ul>	<ul style="list-style-type: none"><li>• There is less research connecting structural factors to unevenly distributed health and civic outcomes.</li><li>• Research considering a broader definition of civic engagement beyond voting is needed.</li></ul>
The role of primary care in advancing health equity and civic engagement	<ul style="list-style-type: none"><li>• Primary care is a tool for promoting civic and physical health.</li><li>• Civic interventions in primary care settings could include voter registration, mobilization, and education and protection of communities.</li><li>• Community health workers help connect health care with communities and help patients link with community assets and resources.</li><li>• Parents and pediatric clinicians support health care providers discussing issues such as voting and health policy during health care visits.</li><li>• In empowering patients and communities to be change agents, primary care providers can promote civic and health equity while addressing underlying structural inequities and social determinants.</li></ul>	<ul style="list-style-type: none"><li>• More research should investigate whether primary care-based voter registration strategies are translated into voting.</li><li>• Evaluations of interventions other than voter registration in primary care settings are needed.</li><li>• Research should elucidate the best way to integrate civic interventions in various clinical and community contexts.</li><li>• The relationship between health care workers' civic engagement and patient outcomes should be clarified.</li></ul>

Figure 2. Health Equity, Civic Engagement, and Primary Care Framework



Health, civic engagement, and primary care interact on both population (A) and individual (B) levels. These two levels interact with each other (C). On each level, various mechanisms have been suggested by current literature, illustrated on top of the arrows between each concept. These sampled mechanisms can generally be binned into five general categories: behavioral, medical, political, psychological, and social. Mechanisms may fit into one or more of these general categories. Social determinants of health, although not explicitly present in the model, play a crucial role in influencing these constructs and mechanisms.

individual's self-efficacy may influence the relationship between health status and civic engagement, and community power may influence a population's health equity and collective civic engagement.

Although literature on mechanisms is generally lacking, we posit that the sample mechanisms illustrated in the figure may be categorized more broadly; mechanisms connecting health equity, civic engagement, and primary care will generally fit within one or more of these general categories: behavioral (e.g., increasing preventive care use), medical (e.g., improving health outcomes), political (e.g., influencing policy and practice), psychological (e.g., improving self-efficacy), and social (e.g., bolstering social connectedness). Of note, many of the proposed mechanisms will be described by multiple of these categories; for example, voting barriers could be considered political, social, or behavioral. Although applicable to currently identified mechanisms, as displayed in Figure 2, this list is not meant to be determinative or exhaustive; primarily, it serves to spark and frame further inquiry into extant and additional proposed mechanisms.

Although not explicitly depicted in Figure 2, SDoH play a key role in shaping all constructs and relationships depicted. SDoH (poverty, lack of social power, disenfranchisement, discrimination, and low-quality education, to name a few), whose distributions are shaped by structural oppression, will influence not only health, civic engagement, and primary care but also some of the proposed mechanisms.<sup>154</sup> Although the relationships between the main constructs and their mechanisms constitute the focus of the figure, SDoH operate in the background, shaping opportunities, experiences, and outcomes and catalyzing inequities that must be considered in the application and interpretation of the model. As noted by Brown and Homan (2023), policies and practices that focus on addressing structural inequities are key to advancing health equity and population health.<sup>154</sup> Our model is responsive to their call to use equity-oriented theory to ground further research and practice, the need to conceptualize health as connected to other policy domains (in our case, civic policy) because of the deep-rooted and cross-cutting impacts of structural oppression, and the need to investigate the complex, multilevel, and interconnected ways in which inequities, and therefore population health disparities and outcomes, often manifest.<sup>154</sup>

The model depicts the connections between generally siloed bodies of literature in health and political disciplines. Although our conceptual framework makes clear that interventions in one of the three areas (health equity, civic engagement, or primary care) can have a meaningful impact on all other areas (an impact that is amplified by appreciating the role of social determinants), the model uniquely highlights the underexplored role of primary care structures as a catalyst for improving cross-sectoral equity. Civic engagement initiatives delivered in health care settings represent powerful opportunities to advance health equity and civic engagement; the primary care system is best suited to facilitate and encourage sustained, community-based, multi-level interventions to broadly support all aspects of civic engagement.

## Discussion

In this paper, we summarize the evidence for the interconnectedness of primary care structures, health equity, and civic engagement and suggest that funding and enabling primary care systems to advance civic engagement could have mutually reinforcing effects on health equity. Our model positions primary care structures as a key connector of individuals with community members, organizations, and resources to advance health and civic engagement. By providing health services and supporting individuals in achieving better health, primary care also empowers individuals to be more civically active and cultivates people's agency for their own health and well-being.<sup>104</sup> Civic engagement initiatives within primary care settings may also more directly improve civic outcomes.<sup>17</sup> Although primary care providers and CHWs may take on a more patient-facing role, primary care management and policymakers will need to play a part by incentivizing relevant initiatives, opportunities, and funding.

This work highlights the crucial role that the primary care workforce can play in promoting civic engagement, but allocating additional tasks to an already stressful, time-intensive profession invites deeper scrutiny. Bajaj, Martin, and Stanford (2021) argue that “[h]ealth-based civic engagement is a professional responsibility,”<sup>17p1661</sup> but the complex question of which roles should be assigned to which professionals remains unanswered. Currently, burnout and disillusionment are prevalent, with members of the primary care workforce spread thin among multiple competing priorities.<sup>155,156</sup> Because an estimated one-third of physicians are experiencing burnout,<sup>157</sup> the addition of more responsibilities on top of an already demanding profession would need to be seamless, rejuvenating, and/or linked to increased reimbursement.

However, health professionals should be well versed in civic engagement topics, remain objective in promoting civic engagement free of their own political biases, and not allow supplementary roles to detract from their health professional duties or make them feel overwhelmed. Increasingly, training for health care professionals acknowledges the role of factors beyond clinical care and builds providers' capacity to understand, engage with, and address these factors. For instance, many medical schools offer instruction on topics such as religion and ethics. Helping providers appreciate the role of civic engagement in individual and population well-being should be among these topics. Medical and nursing schools as well as residency programs can underscore the role of providers in supporting activities outside of the clinical setting that enhance individual and population health and health equity. There is some existing research to suggest how this might be accomplished. For example, Alicea-Alvarez and colleagues (2016) proposed the following:

“...a graduate level community engagement course, developed within an academic medical center located in an urban setting, that demonstrates promise in

effecting change in the extent to which clinicians are able to engage communities and practice ‘neighborhood-engaged care’ with the central goal of mitigating disparities.”<sup>158p732</sup>

After training, professional societies can continue to help health professionals hone their skills via continuing medical education and conference programs.

Training must also address potential bias in providers imposing their own political beliefs on their patients and potentially not wanting to empower patients with whom providers disagree. Civic engagement, at its core, is an essential democratic value. Although there are risks of increasing politicization in primary care, there are real costs to democracy as well as individual and population health associated with avoiding conversations about civic participation. For example, Rossi (2014) states that, because of the social authority of physicians within a physician–patient relationship, “the profession of medicine should focus on providing relevant and objective information to the public and public servants about the consequences of policies so as to aid democratic decision-making.”<sup>159p898</sup> There is reason to believe that primary care providers can rise to this challenge because of the personal connection that only primary care can access: Providers commonly treat patients with differing value systems, whether those differences are based on politics, religion, or cultural values (e.g., patients who refuse life-saving intervention for religious or other personal reasons).<sup>132,138</sup> Antibias training regularly implemented by medical systems nationwide could be expanded to include political affiliation among the many potential biases health care workers must consciously avoid. Formal training should nevertheless emphasize the need for providers to remain open-minded and support the whole patient, including their civic voices; providers need not jeopardize their own beliefs to do so. We argue that by focusing on the need for patients to be broadly civically engaged, not just by voting or working on behalf of political candidates but by volunteering and advancing community priorities, primary care need not be politicized. Certainly, there is the risk that primary care becomes yet another setting for highly politicized rhetoric, but our goal is to underscore the essential benefits of civic participation for the health and well-being of communities and individuals.

As described above, primary care providers are especially well-suited to address civic and health inequities because of primary care’s provision of first-contact and continuous care, as well as the unique capacity to build relationships and trust.<sup>132,138</sup> Primary care organizations’ integration in their respective communities also enhances their ability to provide resources and address gaps. Substantial additional work is needed to determine how to transform primary care systems to take on this new scope.

To serve this critical function, primary care structures must operate with sufficient infrastructure and resources. This use of resources is prudent because funding primary care decreases health care costs<sup>132</sup> and increases its capacity for positive spillover on both health equity and civic engagement outcomes; in funding primary care, we also

fund improved public health, civic well-being, and population equity. Thus, any additional scope must be accompanied by commensurate investments. To be sure, the IOM vision for the transformation of primary care is the first step.<sup>14</sup>

Research must also improve our understanding of civic engagement so that primary care can adequately fulfill this role. Notably, current literature is disproportionately focused on voting as a form of civic engagement (Table 1). Although voting is an important metric of civic activity, described by Perrin (2008) as representing at once a way of “expressing political individuality” and linking us to our broader community,<sup>49p23</sup> citizenship is much broader than this. Perrin (2006) argues that citizenship requires imagination and creative thinking in addition to action and dialogue,<sup>61</sup> and other researchers note the particular importance of collective action and agency in civic engagement.<sup>21,45</sup> The limited scope of civic engagement research may reflect the fact that voting and volunteering are easier to measure than democratic imagination or agency. Future research should focus on conceptualizing, measuring, and intervening in civic engagement beyond voting.

As the medical community continues to better understand the impacts of the SDoH, providers may increasingly realize the importance of addressing upstream factors as a means for mitigating later health outcomes. In one survey of US physicians conducted by the American Academy of Family Practitioners, 95% of physicians noted that SDoH impacted at least some of their patients’ health outcomes, and 87% of physicians reported wanting more time and ability to address the SDoH in their practice.<sup>160</sup> Providers may feel greater satisfaction being part of a system that aims to build and support healthy communities and citizens through addressing the SDoH, thus potentially reducing burnout. Promoting civic engagement may be seen as a way of encouraging patients to work toward changing policies that affect the SDoH in their everyday lives, thus improving patient health.

Our model promotes the implementation and/or expansion of several interventions beyond primary care structures, as well. Absentee and proxy voting, for example, are key evidence-based civic engagement policies that have the potential to bolster health and civic engagement. Delegating an individual’s voting rights to someone else, or proxy voting, can increase voter participation for those suffering from poor health or disability.<sup>25,161</sup> Accommodations such as proxy voting and access to voting information are particularly important for elderly patients in rehab or nursing homes because civic engagement may improve their health and well-being.<sup>162</sup> Beyond proxy voting, policies such as online voter registration or absentee voting, which facilitate political engagement, may mitigate decreases in voting associated with low SES and disability, thus positively impacting health.<sup>81,163–165</sup>

Interventions related to individual health have the potential to benefit civic engagement. For example, prior studies have found that the expansion of Medicaid was associated with higher voter turnout,<sup>166</sup> and declines in Medicaid enrollment were associated with decreases or smaller increases in voter turnout.<sup>167</sup> Thus, health policy

can be a crucial tool for both increasing health equity and empowering voters. Voting may result in direct health benefits to individuals as well as the opportunity to influence the policies that shape their future health and opportunity.<sup>25,86,87</sup>

Health care leaders seeking to expand civic engagement in health care settings must be wary of potentially widening the gap in engagement between people with and without access to care. In addition to primary care capacity building, we advocate for expansion of primary care to communities with low access to care and outreach to patients who do not necessarily interact with the health care system regularly but have nevertheless made contact with a health care provider such as in the emergency room.

On a broader level, our findings support the idea that steps taken to ameliorate inequities related to health and civic engagement can be mutually reinforcing; at the same time, however, interventions that leverage aspects of both may be particularly strategic. For example, interventions at the clinic level may be most effective in increasing civic engagement if they both 1) support the civic engagement of patients who can subsequently better influence their future health through influencing policies that affect them and 2) account for SDoH to more effectively treat patients, who may then be further inclined or able to vote. Assessing SDoH and their effects may allow primary care providers to better diagnose, treat, and empower patients and tailor communication about civic engagement.<sup>168,169</sup> Andermann (2016) explains that there are many ways that health professionals can account for SDoH in their practice at the patient level (e.g., referring patients to community resources), practice level (e.g., hiring professionals to help patients navigate support services), and community level (e.g., partnering with community groups across sectors on collaborative, health-related initiatives such as school violence prevention programs or addressing food deserts), which can, in turn, improve the quality of care as well as patients' health and civic engagement.<sup>169</sup> Furthermore, addressing upstream causes of health disparities through accounting for SDoH in policy and practice is crucial for improving health outcomes and increasing health equity.<sup>154</sup> Integrated initiatives, drawing on the feedback loops inherent in the relationships between health equity and civic engagement, may therefore have a bigger impact than initiatives that do not recognize the interconnectedness of health equity and civic engagement.

This work ultimately calls for bolstering health and civic initiatives in tandem while emphasizing primary care structures. Metrics for assessing improvements in primary care exist, many of which assess civic components as well.<sup>130</sup> Specifically, primary care metrics have been established to measure the integration of health into all sectors (public policy reforms), pursuit of collaborative models of policy dialogue (leadership reforms), public engagement, increase in stakeholder participation, and reduction of exclusion and social disparities in health (universal coverage reforms).<sup>130</sup> Health can only be advanced so much while underlying problems remain. Hence, Stange and colleagues (2014) call for the use of metrics outside the traditional realm



of health to “foster reflection, experimentation, and assessment”<sup>130p433</sup> that will not only promote civic engagement, personal development, and the realization of people’s potential but also advance health by addressing barriers at both the foundational and higher levels of primary care. In sum, bolstering primary care could be an efficient and effective solution for myriad pressing issues stemming from health and civic inequities, many of which have widened in the last decade.

## Future Directions

The wide-ranging implications and importance of health equity and civic engagement in the United States invite many avenues for future exploration. A recent scoping review identified three topics that require more research: the impact of voting on longitudinal health outcomes, the impact of civic engagement beyond voting on health, and the impact of community-level interventions on voting communities.<sup>25</sup> More research is needed to advance the measurement of civic engagement so that crucial and consequential aspects of engagement are represented alongside voting in the literature. Despite some work on advocacy and volunteering, the short-term impacts of voting on health are disproportionately represented in the literature compared with long-term effects of voting as well as the effects of other forms of civic engagement.

Our work highlights several opportunities for future research. Research is needed on the impacts of health care–based programs such as *VotER*, *Patient Voting*, and local *CHW* initiatives on voter turnout (not just registration). Future studies should also investigate ways primary care can strengthen civic engagement (and that civic engagement may strengthen primary care) beyond voting. Research into best practices for engaging primary care physicians in promoting civic engagement among multiple competing demands and priorities is an important next step. To ensure efforts are deployed where they will have the most impact, future research can help identify health care settings in which interventions to improve civic engagement are most needed or would be most effective. Finally, research is lacking on potential behavioral, medical, political, psychological, and social mechanisms. Better mechanistic understandings can inform interventions that best leverage inherent synergies among primary care, civic engagement, and health equity.

## Conclusion

Our work demonstrates reciprocal relationships among health equity, civic engagement, primary care structures, and *SDoH*. Understanding the common role of social factors in influencing health and civic outcomes is thus an important framing point for shaping policy, practice, and research. The conceptual framework proposed in this

paper supports moving away from the sharp distinction between health and civic engagement, suggesting instead that health systems can impact civic engagement, just as civic engagement can influence health. The COVID-19 pandemic represents a crucial opportunity for reflection and action at the intersection of health equity, civic engagement, and primary care, as well as a call for addressing social factors with integrative solutions at the individual and structural levels.

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