

FACT SHEET

WHAT PUBLIC HEALTH SHOULD KNOW ABOUT VOTING RIGHTS IN 2026

OVERVIEW

Civic participation, including voting, is a social determinant of health. Who gets to vote, and whose vote counts, shapes every downstream health decision. From access to health care; the quality of the air we breathe and water we drink; where our kids can safely play and learn; the data systems we rely on to understand the health status of individuals, communities, and our nation; and the funding needed to make those things happen, our votes determine who is empowered to make what decisions, and how. When communities are drawn out of power or excluded from voting, their health needs become easier to ignore, and elected officials become less accountable to the public they are supposed to serve. Systemic failures like this hurt everyone, especially those whose voices continue to be silenced at the ballot box, and our collective health pays for it.

Alongside voting rights organizations like the [League of Women Voters](#), national Health & Democracy Partners advocated to make increased voter participation a core health objective of the U.S. Department of Health and Human Services's Healthy People 2030, which sets 10-year data-driven national objectives to improve health and well-being. Backed by a growing body of research and the Health & Democracy Index, voter participation became an important public health metric alongside measures like vaccination rates, smoking rates, and the number of nationally accredited health departments.

THE EVIDENCE CONNECTING VOTING AND HEALTH IS STRONG AND GROWING

[The Health & Democracy Index](#) compares 12 public health indicators against the [Cost of Voting Index](#), a measure of how difficult each state makes it to vote. States with more inclusive voting policies and greater civic participation enjoy better health while restrictive voting policies and lower voter turnout are consistently linked to worse health outcomes, including higher premature mortality, more chronic disease, and worse self-reported health. As one example, state-level voting restrictions have been [linked](#) to increased odds of adverse birth outcomes, including preterm birth and small-for-gestational-age, with disproportionate harm to Black and Latina mothers.

Research also suggests that gerrymandering in particular limits access to health care through restrictive [Medicaid](#) policies and reduced [federally qualified health center](#) availability. Data itself, and thus our understanding of the public health burden, may also be distorted based on [research](#) that states showing greater evidence of gerrymandering were more likely to contain congressional districts with more extreme values of uninsurance rates than districts in states with less evidence of gerrymandering.

A [framework](#) for how voter suppression, which disproportionately impacts people of color, negatively impacts health suggests a self-reinforcing feedback loop. People experiencing poor health are less likely to vote; people who don't vote are ignored by policymakers; policy neglect worsens their health, further suppressing participation. Voter suppression turns that loop into policy.

THE 2026 VOTING RIGHTS LANDSCAPE HAS CHANGED DRAMATICALLY AND IS CONSTANTLY EVOLVING

From U.S. Supreme Court decisions to a flurry of state policymaking with local elections administration implications being [tracked](#) by the Voting Rights Lab [as well as](#) the Brennan Center for Justice and UC Berkeley Democracy Policy Lab, news headlines about the rapidly evolving 2026 voting rights landscape are difficult to keep straight. For example, **proposed changes to voter ID and documentary proof of citizenship rules** at the federal level, if passed and implemented, would require states to [overhaul](#) their election laws. And yet, there is less focus on the [outsized administrative and health burdens](#) such new requirements would place on state and local governments as well as populations least likely to hold the required documents (older adults, people with disabilities, people with low incomes, people of color, rural residents, and transgender Americans) or questioning of whether the new burdens match the statistically negligible problem of noncitizen voting such requirements allegedly address. Many of these same populations also experience the highest rates of chronic disease and other health burdens from systemic disenfranchisement, especially politically.

The Voting Rights Act of 1965 (VRA) is regarded as the [legislative crown jewel](#) of the civil rights era. Its [60-year success](#) in equalizing political participation opportunities for Black people and other communities of color, especially at the [local level](#), has also been eroded by U.S. Supreme Court decisions. Most recently, in a 6-3 [decision](#) handed down in April 2026 in ***Louisiana v. Callais***, the Court effectively erased and rewrote [Section 2](#) of the VRA, the only remaining provision under the VRA protecting against voter discrimination “on account of race.” The Court invalidated Louisiana's congressional map that created a second majority-Black district as an unconstitutional racial gerrymander because “no compelling interest justified the State’s use of race in creating [a new majority-minority district].”

Acknowledging “[st]ates’ prerogative to draw districts based on nonracial factors, including to achieve partisan advantage,” the *Callais* Court also concluded that successful [vote dilution](#) challenges under Section 2 of the VRA are possible only when there is evidence to support “a strong inference that the State intentionally drew its districts to afford minority voters less opportunity because of their race [i.e., intentional racial discrimination].” While the Court acknowledged it may be “hard to find” this newly required evidence, it also concluded that because of progress made under the VRA to eliminate racial discrimination, this difficulty “is cause for celebration.” In other words, states may now dilute the power of voters of color by drawing maps based on “whatever [non-racial] criteria the legislature chooses to use.”

In her dissent, Justice Kagan characterized the majority decision in *Callais* as setting an “impossible-to-meet evidentiary requirement,” which “greenlights redistricting plans that will disable minority communities—in Louisiana and across the Nation—from electing, as majority communities can, ‘representatives of their choice’.” In Justice Kagan’s words, “[t]he new *Callais* requirements ... effectively insulate any practice ... said by a State to have any race-neutral justification[, e]ven if the State has deprived [minority citizens] (but not their majority neighbors) of all opportunity to ‘elect

representatives of their choice’.” In fact, “the State need do nothing more than announce a partisan gerrymander[and leave] behind no smoking-gun evidence of a race-based motive[.]” This, Justice Kagan concluded, “renders Section 2 [of the VRA] all but a dead letter.” And, as Justice Kagan predicted, the *Callais* decision [triggered](#) a wave of last-minute map changes ahead of the 2026 midterms. Florida, Tennessee, Mississippi, South Carolina, and other states moved to redraw maps, in several cases eliminating majority-minority districts. Louisiana [suspended](#) a primary mid-election after more than 100,000 early votes had been cast, and Alabama [forced](#) its primary voters to the polls for a second time using maps previously determined to be discriminatory.

WHAT THIS MEANS FOR PUBLIC HEALTH

- **We lose our constituency.** Public health serves everyone, but when only some voices matter, and others do not have a fair shot at challenging discriminatory voting maps, the system feels rigged and trust erodes.
- **Data distortion becomes reality.** If maps scramble how need is measured at the district or jurisdictional level, formula-based and politically driven resource allocation miss the communities with the greatest burden.
- **Budget and policy priorities don’t match burden.** Having some communities continually drawn out of political power means appropriations for Medicaid, food supports, maternal and child health, community health centers, environmental health, and local health department capacity are easier to cut, or to never fund at all.
- **The public’s health suffers.** Access to health care and public health services decrease and health outcomes worsen.
- **Negative health status and lost political power compound.** Disenfranchised populations lose the political and health protections that come from an engaged and representative electorate. They become easier to ignore in budget and policy fights, and elected officials become less accountable to the public they are supposed to serve.

PUBLIC HEALTH CAN AND SHOULD PROMOTE HEALTH AND DEMOCRACY

Ensuring every voice and vote counts is a public health and health equity intervention. An increasing number of leading health organizations, including the [American Public Health Association](#), the [American Medical Association](#), and [County Health Rankings & Roadmaps](#) recognize voter access as a health issue and pathway for advancing health equity. Many health departments and health system partners also already promote voter participation through voter registration information on HealthCare.gov, civic participation objectives in state and community health improvement plans, and health provider interactions in clinical settings, or engage in [civic engagement](#) activities more broadly.

The law can be a tool for harming or improving the public’s health. It is also more critical now than ever to speak out when voting rights and equal political power are undermined and show support for more fair and inclusive voting [policies](#). The Network promotes the [connections](#) between health and democracy and educates about, and [advocates against](#), voter disenfranchisement laws because we are interested in the long-term work of earning public [trust](#) in government and health systems so they work for everyone. That north star also guides the [Health & Democracy Peer Group](#) (HDPG), a new collaborative space supported by the Network and the [Health & Democracy Partners](#), that is designed to bring together representatives of community-based organizations, health departments, and healthcare

organizations. With the help of members interested in co-designing the space, HDPG aims to develop and empower health and democracy leaders through peer support, resource sharing, learning sessions, and practice opportunities.

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