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How should we manage political instability in our standard of care? A global emerging issue around the world

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Dear Editor,

In many high-income countries, the growing influence of politics and public administration over health system governance is fueling public discontent. This problem transcends the divide between public and private healthcare: in public systems, national or regional political decisions often shape strategies for disease prevention and treatment; in private systems, pharmacoeconomic pressures and financial forecasts increasingly influence diagnostic and therapeutic choices.

In the United States, recent reporting in *The Lancet Respiratory Medicine* underscored how political directives and administrative constraints can reverberate through public health. The resurgence of measles, amid federal restrictions that limited communication and weakened public health capacity, illustrates how politicization can hinder outbreak control and erode public trust, especially when transparency is curtailed and agencies are prevented from communicating promptly and credibly.[1]

In Italy, the debate over the composition of national advisory bodies on immunization policy has intensified public scrutiny and undermined confidence in decision-making processes.[2] Clinicians' concerns have focused less on individual appointees and more on governance: the need for transparent criteria in selecting experts, insulation of technical committees from political influence, and clearer, faster pharmacovigilance pathways for vaccine-related adverse events. Practical lessons from Italy's COVID-19 vaccination campaign, including improved integration between general practitioners, vaccination hubs, and hospitals, remain highly relevant as immunization programmers evolve.

However, political interference extends well beyond pandemic preparedness. The intersection of politics and healthcare increasingly shapes access to innovative therapies, raising profound ethical and equity concerns. A recent *BMJ* report by Kate Bowie highlighted the alarming prospect that the UK list price of tirzepatide (Mounjaro) could nearly triple, prompting urgent questions about which patients will ultimately bear the burden of this internationally "aligned" cost.[3]

Tirzepatide, a dual glucose-dependent insulinotropic polypeptide and glucagon-like peptide-1 receptor agonist, has demonstrated remarkable efficacy in reducing body weight, body mass index, and waist circumference, with many patients achieving ≥20-25% weight loss, far beyond outcomes seen with older agents.[4] Its safety profile appears favorable, and it holds enormous potential to reduce the cardiovascular and metabolic burden of obesity worldwide. Yet the steep rise in price threatens to limit access to those able to pay, effectively dividing healthcare systems into "rich" and "poor" ones. In some countries, economic decisions made without meaningful input from the clinicians responsible for patient care may lead to certain therapies being deemed "too expensive", regardless of clinical need.

Beyond economics, political interference has also begun to distort the integrity of scientific research itself. As *The Lancet* recently warned, political and ideological pressures have fueled unjustified criticism, downgrading, and even calls for the retraction of peer-reviewed studies for reasons that are political rather than scientific.[5] Such actions erode both scientific independence and public trust, jeopardizing the credibility of academic medicine.

The inflated international price of tirzepatide may thus represent another step backward in the struggle for equitable care. These dynamics risk undermining physicians' ethical responsibility to ensure equal access to effective therapies, while reinforcing a tiered healthcare structure where innovation becomes a privilege rather than a right. Health, universally recognized as a common good, cannot be protected without safeguarding the autonomy of those directly responsible for it—clinicians, scientists, and the institutions they represent.

Constructively, we propose several cross-context measures to insulate public health and biomedical research from political and economic interference.[6]

First, codify transparent, merit-based criteria for appointments to national advisory groups, and publicly disclose members' expertise, roles, and conflicts of interest.

Second, protect scientific communication and public-facing data from political constraints, enabling agencies to inform the public rapidly and accurately during emergencies.

Third, maintain clear separation between technical decision-making and political oversight, so that evidence, not ideology, guides policy.

Such measures do not pre-empt democratic accountability; rather, they ensure that technically complex, time-sensitive decisions remain grounded in evidence and communicated with clarity

by experts selected for competence and integrity. The recent experiences of Italy, the United States, and the United Kingdom remind us that when health governance becomes a proxy for political conflict, the first casualties are public trust and the people's health.

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