The Physical Health Case for Religion

The strongest research links sustained religious participation with better physical health and longer life.

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HEALTH

August 10, 2026

Note: This piece is the second in a three-part series that reviews the best available science on the connections between religiosity and health. Part 1 discusses mental health; Part 2 discusses physical health; and Part 3 discusses social-relational health.

There is a resource, strongly tied to a longer and healthier life, that our health system rarely acknowledges.

The United States spends more per person on health care than any other nation, yet Americans live shorter lives than people in nearly every other developed nation. A 2025 Lancet analysis found the United States has made unusually poor progress against

chronic disease, with mortality rising among adults ages 20 through 45—the same generations now least connected to religious communities. These data should make us curious. Are there "model" groups or best practices that yield significantly better health results that we should consider?

A UCLA study that followed nearly 10,000 devout members of The Church of Jesus Christ of Latter-day Saints in California found that the men's death rate was roughly half that of comparable Americans. These men also lived 8 to 11 years longer than average. The pattern, however, was not unique to one faith. In another study of religion and health in Loma Linda, California—the only "Blue Zone" of exceptional longevity in the United States—Seventh-day Adventists outlive their countrymen by close to a decade, with markedly lower rates of heart disease and cancer. Additional research, however, has shown that the Latter-day Saints and Seventh-day Adventists do not have the religion and health market cornered. Later studies have revealed striking benefits, ranging from markedly lower cancer rates to additional years of life expectancy, among faithful weekly attenders across religions, races, and regions.

What else does the best available science tell us about the religion and physical health connection?

Medicine and social science recently reached a milestone with the publication of "The Handbook of Religion and Health," a multidisciplinary collaboration between Duke and Harvard University. Described as "stunningly ambitious" by former U.S. Assistant Secretary for Health Howard Koh, the text included only the most rigorous 5% of studies conducted on religion and health (about 2,800 out of 60,000). A second multidisciplinary team from BYU and Duke University recently completed three condensed reports on "Religion and Mental Health," "Religion and Physical Health," and "Religion and Social Health."

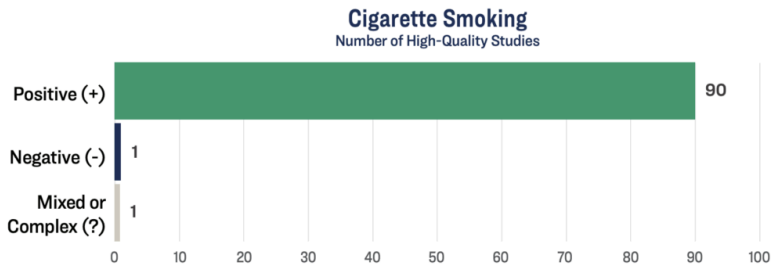
In this *Public Square Magazine* series, we offer highly compressed highlights of all three reports so that you can see the grand scope of the 1,100-page volume and decades of effort with just three long glances.

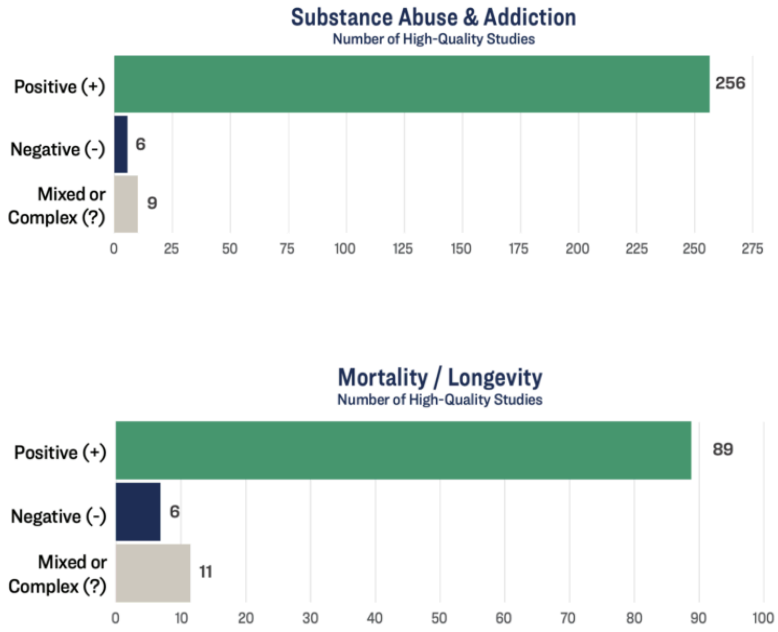
What the Best Science Reveals about the Religion-Physical Health Connection

Following the lead of the Duke–Harvard team, our BYU–Duke team divided the best studies into 15 different physical health foci:

1. Disease Prevention, Detection, and Compliance
2. Exercise and Physical Activity
3. Diet and Weight
4. Heart Disease
5. Hypertension/Blood Pressure
6. Cerebrovascular Disease (Stroke)
7. Alzheimer's Disease and Other Dementias
8. Immune Function
9. Stress Hormones
10. Cigarette Smoking
11. Cancer
12. Basic Physical Functioning
13. Chronic Pain
14. Substance Abuse and Addiction
15. Mortality and Longevity

When we examined 1,069 high-quality studies across 15 physical health domains, we found that *876 studies found positive associations between religious involvement and physical health, and only 124 found negative ones: a ratio of roughly seven to one*. The strongest signals come from the precise areas where American medicine spends the most time and money. Among high-quality studies of cigarette smoking, the ratios of favorable to unfavorable findings were 90-to-1 for cigarette smoking, 43-to-1 for substance abuse and addiction, and 15-to-1 for mortality and longevity.



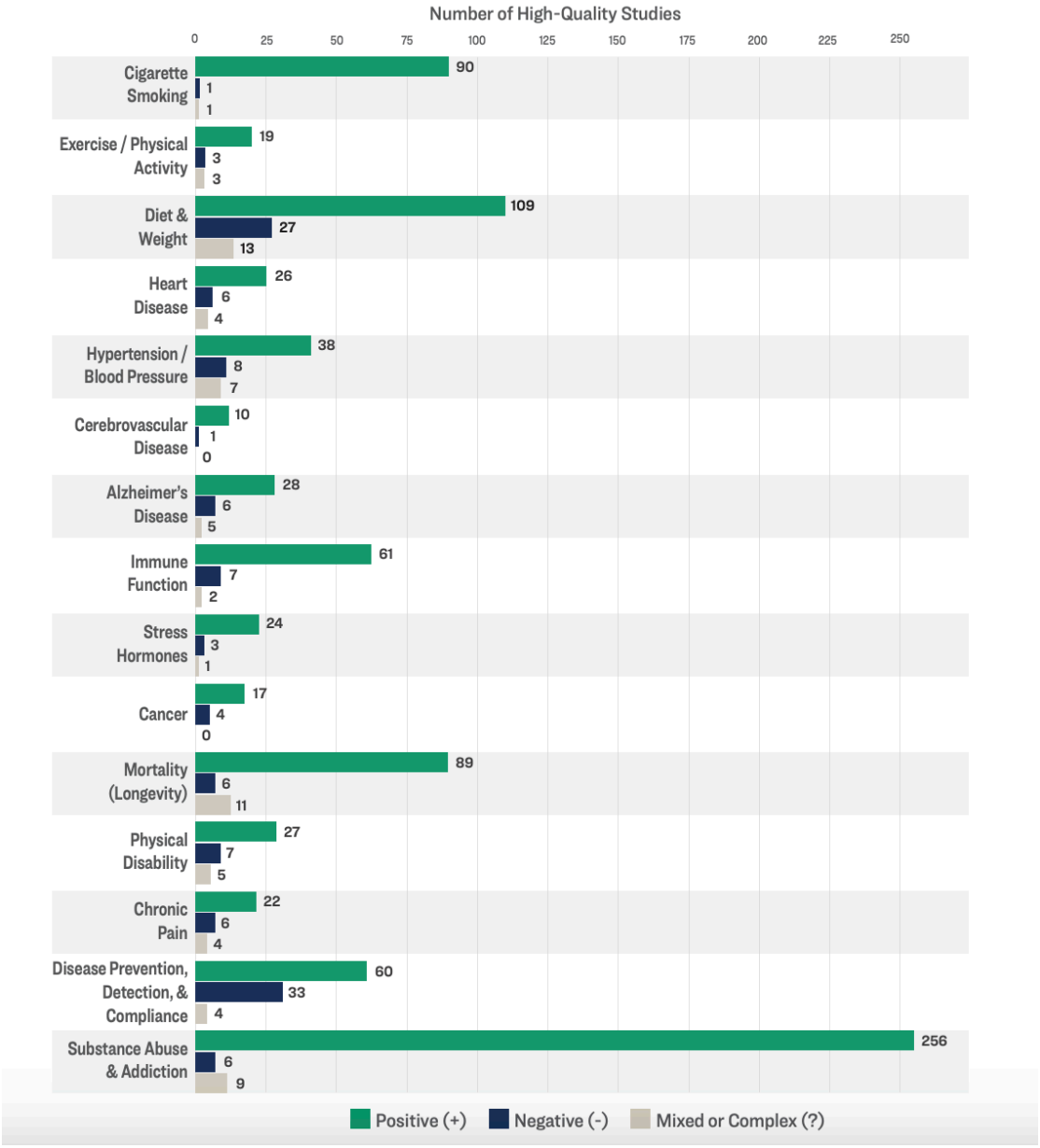


Why Might Religious Involvement Be Associated with Significant Health Benefits?

A look at Figure 4 reveals that for all 15 physical health outcomes studied, the ratios of positive over negative (healthy over unhealthy) correlates of religious involvement are pronounced. The ratios range from about 2-to-1 for disease prevention, detection, and

compliance to 90-to-1 for cigarette smoking.

FIGURE 4: Significant Positive & Negative Findings across 15 Physical Health Phenomena



We walk through the likely reasons one by one in our *Religion and Physical Health* report for readers who want the details. Here, however, we offer three broad strokes that help explain the "faith factor."

1. **Religious communities** shape behavior and accountability. They discourage the habits that fill cardiology wards (smoking, heavy drinking, sedentary living, social isolation) and reinforce habits that keep hearts and bodies healthy. They build networks of care that last for decades—far longer than an annual physical—and give people reasons to get up, get out, and look after a neighbor. Tellingly, the longevity advantage persists in major studies even after researchers account for

health behaviors and social ties; it is not merely that the faithful smoke less. Secular communities can strengthen health, too, especially through service. *But few institutions bundle all these supports in one place over a lifetime as effectively as a religious community does*.

2. **Religious practices** involve both action and abstinence. In terms of action, world religions promote prayer, ritual, worship, and the study of sacred texts in daily life and as core coping practices. In terms of abstinence, most world religions tend to promote avoidance or minimal use of addictive and damaging substances, as well as fasting and discipline in diet and avoidance of premarital and extramarital sex. Simply put, religious practice tends to encourage healthy behaviors and discourage unhealthy ones.
3. **Religious beliefs** can shape attitudes about the body. Most world religions emphasize the importance of caring for the body, often teaching that it is a sacred vessel or temple for the spirit. Many also hold that the condition of the body can either strengthen or hinder one's spiritual life. When these beliefs are understood and applied, they can serve as powerful motivators for physical activity, exercise, and self-care grounded in faith.

A Note on the "Threshold Effect"

A close look at the best science on the religion–health connection suggests a "threshold effect." In other words, the benefits of religion appear to be concentrated among those with sustained, high engagement. Hundreds of studies link religious involvement to better mental health, elevated physical health (including lower cancer rates), and significantly longer lifespan. Family-level gains have also been documented, including greater marital stability, higher marital quality and satisfaction, and stronger parent-child relationships.

However, only individuals with "significant commitment to their faith" seem to attain the threshold "where measurable benefits are discernible and often substantive." Occasional attendees do not enjoy the same benefits. In practice, the threshold is *at least weekly service attendance*, with associated health benefits observed from adolescence into older adulthood and across racial and ethnic groups and faith traditions.

Across the strongest studies on physical health, consistent weekly religious involvement is powerfully associated with significantly lower rates of cigarette smoking, heart

disease, hypertension, stroke, Alzheimer's Disease, cancer, physical disability, chronic pain, and markedly lower rates of substance abuse and addiction. The strongest studies also associate religious involvement with more exercise, healthier diets, better immune function, and longer, healthier lives. In addition to the quest for deeper spirituality, there are many bodily reasons to take faith community life seriously and to be actively involved in a sacred caravan of care.

There is a policy lesson here, too. We routinely assess patients' dietary habits, exercise levels, and tobacco use, yet we almost never ask a patient whether they belong to a faith community, even though the evidence places weekly religious involvement in the same league as those better-known health behaviors. Health systems, researchers, and lawmakers would do well to treat religious participation as the health asset the data show it to be.

Our team's invitation is two-fold: First, on a personal level, we can strive to live our faith beyond a "threshold level" where the faith factor thrives; and second, on a public level, we can support policies and practices that protect religious liberty and encourage people to live their faith in ways that bless their lives and improve their health.

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