

ENHANCING TRUST IN PUBLIC HEALTH: QUICK RESULTS FROM A FOUNDATIONAL SURVEY

In partnership with ASTHO and NPHIC, the Harvard Opinion Research Program is conducting a series of surveys to understand public views of trust in public health and to provide robust evidence that can help build the foundation for overarching strategy and messaging across many activities in the coming year. This memo showcases select results utilizing data from a nationally representative foundational survey among 4,208 U.S. adults conducted February 1 to 22, 2022. Key implications for state, territorial and local health departments were developed from the results and can be used to shape communications and outreach.

KEY FINDINGS:

Views of Public Health

A majority of U.S. adults feel public health agencies are important to the health of people in the U.S. and feel “mostly positive” about CDC and their state and local public health departments.

Public health agencies at the federal, state, and local level are relatively well-trusted for COVID-19 information; however, trust has declined somewhat since a peak in Feb 2021.

Reasons for Trust

Trust in public health institutions during COVID-19 is driven by four intersecting themes. People believe they

- Provide clear, consistent information
- Are following scientific evidence
- Are delivering on protective resources
- Act with compassion

The emphasis on a given theme changes with the level of government- e.g., scientific expertise is more central to trust in CDC, while direct service provision is more central to trust in local public health departments.

Reasons for Distrust

There is a gradient of public trust in public health agencies, and the amount of trust makes a difference in actions people take (e.g., vaccination).

Those who “somewhat” trust public health primarily cite political influence and what they feel are conflicting recommendations as reasons for distrust. The least trusting cite many more reasons for distrust.

Those who are least trusting are more likely to believe politics influenced changes in recommendations during the pandemic, while those who are more trusting believe the changes were driven by science.

Foundational Framing

IMPLICATIONS FOR COMMUNICATIONS

Remember that there is a strong foundation of positive perceptions of public health among the general public, particularly when media often emphasize distrust.

Supporting those who already feel positively about public health with frequent communications is critical to maintaining current levels of trust, so investing in communications is essential.

Messaging for those who Trust

Providing clear, consistent situational information and recommendations for action is critical to maintaining and enhancing trust in public health among those who are more trusting.

- Emphasize the scientific expertise that public health brings to the table, particularly federal-level expertise, and keep clear boundaries from politics as possible.
- Showcase actions taken, particularly those at the local level for state and local public health departments.
- Highlight compassionate care.

Messaging for those who Distrust

Consider the gradient of trust in your jurisdiction- who are the most and least trusting?

Remember that while the media often pays attention to those who are least trusting, this group need not always be the focus of communications.

Maintaining consistent communications is key for those who have some – but not a great deal- of trust in public health.

- When recommendations change, always explain that they keep consistent principles by following emerging scientific evidence.
- Aim for a non-partisan approach whenever possible.

KEY FINDINGS:

Trusted Sources

Doctors and health professionals are highly trusted for health information among a majority of the public. Local, state, and federal public health are less well trusted, but are still trusted by a majority.

Elected officials and friends and family are among the least trusted for health information.

Those who are least trusting of information from public health agencies are broadly distrustful of many sources of health information.

Partners to Build Trust

IMPLICATIONS FOR COMMUNICATIONS

Bringing in trusted spokespeople can help build on a foundation of trust in public health institutions for health information.

- Care providers can provide a key, personalized voice that brings both expertise and compassion.
- Elected officials serving as spokespeople for public health may not contribute to building trust.

Reaching those who are the least trusting will likely require a specialized approach using locally embedded partners.

METHODOLOGY

Results are based on survey research conducted by Harvard T.H. Chan School of Public Health, in partnership with the Association of State and Territorial Health Officers (ASTHO), the National Public Health Information Coalition (NPHIC), and funded by the Centers for Disease Control and Prevention (CDC). Representatives from all four organizations worked closely to develop the survey questionnaires, while analyses were conducted by researchers from Harvard and the fielding team at SSRS of Glen Mills, Pennsylvania.

The project team at Harvard was led by Gillian K. SteelFisher, Ph.D., Research Scientist and Deputy Director of the Harvard Opinion Research Program and included Hannah Caporello, Senior Research Projects Manager.

Interviews were conducted with a representative sample of 4,208 adults, ages 18 and older, in English and Spanish online (n=3,986) and by telephone (n=222). Online respondents were reached through the SSRS Opinion Panel and the Ipsos Knowledge Panel, each of which are nationally representative, probability-based web panels. Telephone respondents were screened for being non-internet users and they were selected from the SSRS Omnibus, a bilingual survey of cell phone and landline users selected through RDD. Telephone interviews were conducted to ensure that people who do not access the internet were included. To understand the opinions and perspectives of U.S. adults on public health institutions at three levels- federal, state, and local- respondents were randomly assigned to one of three tracks corresponding to these three levels within the survey (federal-level track, n=1405; state-level track n=1402, local-level track n=1401). The interviewing period was February 1 to 22, 2022.

When interpreting findings, one should recognize that all surveys are subject to sampling error. Results may differ from what would be obtained if the whole U.S. adult population had been interviewed. The margin of error for the full sample is ± 1.9 percentage points.

Possible sources of non-sampling error include non-response bias, as well as question wording and ordering effects. Non-response in web and telephone surveys produces some known biases in survey-derived estimates because participation tends to vary for different subgroups of the population. To compensate for these known biases and for variations in probability of selection within and across households, sample data are weighted in a multi-step process by probability of selection and recruitment, response rates by survey type, and demographic variables (race/ethnicity, sex, age, education, region, internet access, civic engagement, and urban status) to reflect the true U.S. population. Other techniques, including random sampling, multiple contact attempts, replicate subsamples, and systematic respondent selection within households, are used to ensure that the sample is representative.

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