



Research Letter | Public Health

Change in Trust in US Government Health Agencies for Cancer Information in the COVID-19 Era

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Introduction

While public trust in the US government has been historically suboptimal, government health agencies have until recently enjoyed high levels of public trust.^{1,2} A study using national data from 2005 to 2015 revealed that the agencies were the second most trusted source of health information after physicians.³ However, recent studies revealed changes to this trust dynamic,^{2,4} especially since the COVID-19 pandemic.^{2,5} A study of population-level trust in general health recommendations from several health agencies found that high-level trust was low for the Centers for Disease Control and Prevention (37%) and the National Institutes of Health (33%).⁵ Several US government health agencies provide cancer information to the public; thus, trust in information from these agencies is critical for adoption of their recommendations. A recent study⁶ found that more than 20% of US adults had little or no trust in governmental health organizations for cancer-related information. Hence, we examined changes in public trust in cancer information from government health agencies as well as the sociodemographic correlates of this change.

Methods

We examined data from a national representative survey of noninstitutionalized civilian US adults: the US Health Information National Trends Survey (HINTS) 5 cycle 4 (2020) and HINTS 6 (2022). The response rate for HINTS 5 cycle 4 was 36.7% and 28.1% for HINTS 6. In accordance with 45 CFR §46, this cross-sectional study was exempt from institutional review board approval because the data are publicly available. We followed the [STROBE](#) reporting guideline.

The primary outcome was trust in government health agencies providing cancer information (eMethods in [Supplement 1](#)). Weighted prevalence and corresponding 95% CIs were calculated to estimate the level of trust in government health agencies providing cancer information for both study years within the overall study sample. Trust was also assessed by respondents' sociodemographic characteristics. Participant race and ethnicity were self-reported. Statistical analyses were performed using the survey package in R, version 4.3.1 (R Project for Statistical Computing).

Results

The study included 3582 respondents (mean [SD] age, 47.8 [17.9] years; 51.0% female and 49.0% male [weighted percentages]) in 2020 and 5979 respondents (mean [SD] age, 48.4 [17.9] years; 50.7% female and 49.3% male [weighted percentages]) in 2022 (**Table 1**). Weighted percentages of Hispanic, non-Hispanic Black, and non-Hispanic White respondents were 16.4%, 10.8%, and 64.8%, respectively, in 2020 and 16.5%, 11.0%, and 61.7% in 2022.

In 2022, a significant decrease in public trust in government agencies providing cancer information was noted, with 70.1% (95% CI, 68.1%-72.0%) of respondents expressing trust compared with 77.8% (95% CI, 75.4%-80.0%) in 2020. Trust also significantly decreased among

+ Supplemental content

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respondents aged 18 to 34 years (69.6% [95% CI, 63.5%-75.2%] in 2022 vs 82.7% [95% CI, 75.9%-87.8%] in 2020) (Table 2).

Among respondents with some college education, public trust in US health agencies decreased to 68.5% (95% CI, 64.6%-72.2%) in 2022 from 79.9% (95% CI, 75.2%-83.9%) in 2020. Similarly, a significant decrease was observed among Non-Hispanic White respondents (70.0% [95% CI, 67.7%-72.2%] in 2022 vs 77.8% [95% CI, 74.7%-80.6%] in 2020). Additionally, among respondents with an income of \$75 000 or more, trust decreased to 71.6% (95% CI, 68.5%-74.6%) in 2022 from 81.1% (95% CI, 77.3%-84.3%) in 2020. Significant decreases were also observed among male respondents and urban residents (Table 2).

Discussion

Findings of this cross-sectional study have important implications for cancer prevention, treatment, and outcomes given that trust is critical to the adoption of cancer health recommendations from these agencies. In turn, the ability of federal health agencies to implement public health interventions effectively is dependent on public trust. Therefore, targeted interventions at the population-level that further understanding and address factors contributing to the decrease in trust in US health agencies are essential.

Table 1. Descriptive Characteristics of the Study Population

| Characteristic | 2020 Respondents | | 2022 Respondents | |
|---------------------------------|------------------|----------------------|------------------|----------------------|
| | No. | Weighted No. (%) | No. | Weighted No. (%) |
| No. | 3582 | 241 050 744.9 (100) | 5979 | 249 349 949.0 (100) |
| Age, y | | | | |
| 18-34 | 477 | 65 318 346.8 (27.1) | 931 | 65 764 876.4 (26.4) |
| 35-49 | 682 | 62 634 645.3 (26.0) | 1219 | 64 368 894.9 (25.8) |
| ≥50 | 2322 | 113 097 752.8 (46.9) | 3743 | 119 216 177.7 (47.8) |
| Sex | | | | |
| Female | 2041 | 123 016 606.2 (51.0) | 3356 | 126 417 958.5 (50.7) |
| Male | 1464 | 118 034 138.8 (49.0) | 2231 | 122 931 990.4 (49.3) |
| Race and ethnicity ^a | | | | |
| Hispanic | 533 | 39 548 945.6 (16.4) | 919 | 41 175 435.1 (16.5) |
| Non-Hispanic Asian | 148 | 11 517 554.8 (4.8) | 276 | 14 000 621.9 (5.6) |
| Non-Hispanic Black | 433 | 25 980 595.2 (10.8) | 849 | 27 383 280 (11.0) |
| Non-Hispanic White | 2072 | 156 143 779.8 (64.8) | 3126 | 153837903.6 (61.7) |
| Non-Hispanic other ^b | 113 | 7 859 869.5 (3.3) | 180 | 12 952 708.4 (5.2) |
| Residence | | | | |
| Rural | 401 | 29 756 881.7 (12.3) | 785 | 31019661.7 (12.4) |
| Urban | 3181 | 211 293 863.2 (87.7) | 5194 | 218 330 287.3 (87.6) |
| Income, \$ | | | | |
| 0-9999 | 216 | 12 187 022.2 (5.1) | 441 | 17 698 764.1 (7.1) |
| 10 000-34 999 | 862 | 52 140 147.3 (21.6) | 1368 | 47 664 947.7 (19.1) |
| 35 000-74 999 | 1099 | 73 210 829.5 (30.4) | 1806 | 73 556 735.4 (29.5) |
| ≥75 000 | 1390 | 103 512 745.9 (42.9) | 2351 | 110 429 501.8 (44.3) |
| Educational level | | | | |
| <High school | 216 | 17 687 696.7 (7.3) | 313 | 14 698 675.5 (5.9) |
| High school graduate | 614 | 51 822 157.3 (21.5) | 988 | 53 310 207.4 (21.4) |
| Some college education | 1020 | 96 031 094.2 (39.8) | 1619 | 97 849 539.6 (39.2) |
| College graduate or higher | 1623 | 75 509 796.8 (31.3) | 2672 | 83 491 526.4 (33.5) |

^a Race and ethnicity data were collected for the US Health Information National Trends Survey to allow subgroup-specific analysis of the data by race and ethnicity.

^b Includes non-Hispanic American Indian or Alaska Native, non-Hispanic Native Hawaiian or Other Pacific Islander, and non-Hispanic multiple races.

Table 2. Trust in Government Agencies Providing Cancer Information

| | Trust among 2020 respondents, weighted % (95% CI) | Trust among 2022 respondents, weighted % (95% CI) |
|---------------------------------|---|---|
| Overall trust | 77.8 (75.4-80.0) | 70.1 (68.1-72.0) |
| Age, y | | |
| 18-34 | 82.7 (75.9-87.8) | 69.6 (63.5-75.2) |
| 35-49 | 76.7 (71.7-81.1) | 70.0 (65.7-73.9) |
| ≥50 | 75.7 (72.6-78.6) | 70.6 (68.6-72.6) |
| Sex | | |
| Female | 77.9 (75.0-80.6) | 72.8 (70.0-75.4) |
| Male | 77.7 (73.4-81.4) | 67.6 (64.4-70.7) |
| Race and ethnicity ^a | | |
| Hispanic | 82.2 (74.8-87.8) | 71.5 (64.8-77.3) |
| Non-Hispanic Asian | 88.8 (78.9-94.4) | 82.2 (66.4-91.5) |
| Non-Hispanic Black | 74.4 (66.6-80.9) | 72.4 (64.7-79.0) |
| Non-Hispanic White | 77.8 (74.7-80.6) | 70.0 (67.7-72.2) |
| Non-Hispanic other ^b | 65.0 (48.2-78.8) | 58.5 (41.3-73.9) |
| Residence | | |
| Rural | 74.8 (67.8-80.7) | 64.4 (59.7-68.8) |
| Urban | 78.2 (75.6-80.6) | 70.9 (68.8-72.9) |
| Income, \$ | | |
| 0-9999 | 73.8 (64.5-81.4) | 69.4 (59.8-77.5) |
| 10 000-34 999 | 77.7 (73.2-81.6) | 67.5 (62.6-72.1) |
| 35 000-74 999 | 73.6 (66.9-79.3) | 70.9 (66.9-74.5) |
| ≥75 000 | 81.1 (77.3-84.3) | 71.6 (68.5-74.6) |
| Education | | |
| <High school | 73.4 (60.3-83.4) | 64.6 (54.8-73.4) |
| High school graduate | 66.6 (60.6-72.1) | 61.3 (56.7-65.7) |
| Some college education | 79.9 (75.2-83.9) | 68.5 (64.6-72.2) |
| ≥College graduate | 83.6 (80.4-86.4) | 79.8 (77.4-81.9) |

^a Race and ethnicity data were collected for the US Health Information National Trends Survey to allow subgroup-specific analysis of the data by race and ethnicity.

^b Includes non-Hispanic American Indian or Alaska Native, non-Hispanic Native Hawaiian or Other Pacific Islander, and non-Hispanic multiple races.

Study limitations include possible low-response bias and the cross-sectional design of the survey, which precluded our ability to make causal inferences. Moreover, since respondents were not followed up longitudinally, we were unable to examine if there were shifts in individual respondents' trust over time.

ARTICLE INFORMATION

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SUPPLEMENT 1.

eMethods.

SUPPLEMENT 2.

Data Sharing Statement