



Predictors of confidence and trust in government and institutions during the COVID-19 response in Australia

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Concern about misinformation and inattention to population health advice has highlighted the need to understand public confidence and trust in government and institutions during the COVID-19 pandemic. With the recent surge of the Omicron variant (BA.1) and its sub-variant (BA.2), primarily affecting younger people in Australia; alongside rapidly changing policies and advice surrounding booster vaccinations, testing, restrictions, isolation, and uncertainties around emerging variants this understanding is now more important than ever. Public confidence and trust in governments and institutions is particularly vital in understanding the persistent issue of vaccine hesitancy.¹ Although Australia has a highly vaccinated population, uptake of boosters (third dose) has been low² and immunity to COVID-19 is waning. Previous reports have indicated that a lack of confidence and trust are fundamental drivers of vaccine hesitancy.³ This analysis explored correlates of confidence and trust in government and institutions during the COVID-19 response in Australia.

In July–August 2021 in Australia as the Delta outbreak began to peak, we conducted a national survey of 2050 Australian adults aged 18–49 years. The sample characteristics were comparable to national estimates, with only slightly higher levels of education. At the time, this age group had been under-studied during the COVID-19 pandemic and vaccination roll-out in

Australia in this age group had just begun, hence we only included those who had not yet received a COVID-19 vaccine. Along with a number of measures to understand barriers to COVID-19 vaccine uptake,⁴ participants indicated their confidence (4-items) and trust (2-items) in government, and trust in institutions (scientists, researchers and medical institutions) (3-items) in managing the COVID-19 response, with items having a particular focus on vaccine development, distribution and information. Items were measured on a 7-point scale from previously published and validated measures,^{5,6} with higher scores indicating higher confidence and trust (Appendix 1). Descriptive statistics were generated for sample characteristics and outcome measures. Pearson pairwise correlations were used to assess the association between confidence in government, trust in government, and trust in institutions. A multivariate regression model was constructed incorporating all three outcome measures with all sample characteristics (Appendix 2) as explanatory variables.

We found that mean confidence in government was 4.52/7 (SD 1.41), mean trust in government was 4.36/7 (SD 1.66) and mean trust in institutions was 5.06/7 (SD 1.52; Appendix 2). There were strong positive associations between confidence in government and trust in government ($r=0.699$, $p<.001$) and trust in institutions ($r=0.700$, $p<.001$). Similarly, trust in institutions and trust in government were strongly correlated ($r=0.694$, $p<.001$). After adjusting for all other explanatory variables, lower confidence and trust were associated with older age, lower education, inadequate health literacy, being born in Australia, lower perceived COVID-19 risk in Australia, not being personally concerned about getting COVID-19, the use of non-official (government) information sources as a top information source and having one or more chronic health conditions.

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Confidence and trust differed as a function of residential state (Appendix 3).

To our knowledge this is the first report examining factors associated with confidence and trust in government and institutions during the COVID-19 response amongst a nationally representative sample of younger adults; a group in which vaccine hesitancy has been at times disproportionately high in Australia.⁷ Compared to an earlier evaluation from a sample of Australian adults aged 18-90 years using the same measures, mean confidence and trust in our sample of younger adults (18-49 years) was lower.⁸ Interestingly, we specifically found that older participants in our sample (those aged 40-49 years) had lowest confidence and trust in the government and institutions. Similar to findings of those who are vaccine hesitant and endorse misinformation beliefs about COVID-19,^{8,9} lower levels of confidence and trust were associated with lower levels of education, lower health literacy, those who perceive COVID-19 to be less of a risk to themselves and the country, and notably those who primarily view COVID-19 information from non-official (government) sources such as social media. This further emphasises the need to focus communication efforts and improve community engagement and positive interactions with the healthcare systems¹⁰ in these cohorts. While differences in confidence and trust across states is understandable due to differing COVID-19 responses, it highlights the need for greater national consistency in how information is communicated to the public in order to have enhanced widespread reliance on government and institutions.

Throughout the COVID-19 pandemic, having public confidence and trust has been vital to effectively implement public health measures. This analysis identifies important subgroups to consider, such as middle-aged Australians, those with lower education and health literacy, and those obtaining information from non-official sources, for targeted research and communication. This will enable better understanding of public trust and identify strategies for how it can be bolstered to support future public health responses.

Contributors

KP, EC, TC, RD, CB, HS, MS, GMK and KM were involved in study design and data collection. BN and EC conducted the data analysis. BN, EC, TC, RD, CB and KM were involved in data interpretation. BN led the writing of the manuscript with all author authors contributing to revising the manuscript and approving the final manuscript for publication.

Declaration of interests

GM-K is a volunteer committee member of the Australian Sceptics Society. All other authors declare no competing interests.

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Supplementary materials

Supplementary material associated with this article can be found in the online version at doi:[10.1016/j.lanwpc.2022.100490](https://doi.org/10.1016/j.lanwpc.2022.100490).

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