

Rebuilding Public Trust in Health Systems: A Strategic Response to Crisis-Driven Mistrust

Flora Ceyda Knapp

DE240004

Health threats in Tourism

EIIET

25.06.2025

Table of Contents

Title Page	Page 1
Abstract	Page 3
1. Introduction	Page 4
2. Literature Review	Page 5
2.1 Introduction	
2.2 Theoretical Frameworks: Understanding Trust in Health Systems	
2.3 Causes of Public Health System Distrust	
2.4 Case Study: Brazil During COVID-19	
2.5 Lessons from Global Trust Failures	
2.6 Summary and Gaps in Literature	
3. Methodology	Page 8
4. Findings	Page 9
4.1 Brazil: Politicization and Health System Paralysis	
4.2 United States: Trust in Science Undermined by Politics	
4.3 India: Mistrust Driven by Inequality and State-Level Gaps	
4.4 Common Patterns Across Contexts	
5. Discussion	Page 12
5.1 Short-Term Trust Recovery Measures	
5.2 Long-Term Institutional Reform	
5.3 Media and Digital Strategy	
5.4 Community Participation and Stakeholder Inclusion	
6. Conclusion	Page 15
7. References	Page 17

Abstract

A significant public mistrust in national health systems may be one of the more significant challenges during and after health crises, specifically the COVID-19 pandemic. Governments and health agencies in Brazil, the United States, and India have experienced particularly significant declines in public trust and confidence, mainly due to misinformation, mixed messages, and a perceived inability to lead with trust and transparency. This report examines the socio-political factors that have led to institutional distrust in national health systems and proposes a multi-dimensional strategy to regain trust via public health communications, leadership ethics, community engagement, and institutional change. Based on theoretical mechanisms from risk perception theory, social trust theory, and case studies, the report identifies the main areas of trust erosion and suggests practical approaches to regain trust. Short-term actions involve transparent public messaging, the credibility of crisis spokespersons, and counter-narratives in the media. At the same time, the long-term strategy focuses on institutional accountability, reforming digital communications, and promoting meaningful public participation in health governance. The study employed a qualitative secondary data approach to gather materials, including an academic literature review, global health agency reports, and social trust research articles. The findings suggest that trust cannot be solely restored through technical efficiency but rather through cultural understanding, inclusion, and a new social contract between governments and their citizens. The proposed strategy aims to inform ethically sound and resilient health governance for the next crisis.

Introduction

Recent global health crises, most significantly the COVID-19 pandemic, have had a devastating impact on public trust in national health systems. Misinformation, absentee political leadership, political meddling, absence of transparency, and a lack of public trust have helped to establish widespread skepticism of healthcare authorities and campaigns for vaccination across states, as was the case with Brazil, India, and the United States during the pandemic (Freimuth et al., 2014; Lazarus et al., 2021). Public trust is not only an ethical capital for government health authorities during pandemics and other emergencies but also a measurable determinant of health status and outcomes during a pandemic, as well as adherence to preventive measures.

The World Health Organization (WHO) defines trust in public health authorities as the population's belief that their public health authorities will act in the public good, be transparently honest with regard to authoritative information, and distribute public health care equitably (WHO, 2021). When trusting relationships break down, public compliance also tends to break down. Population studies on COVID-19 during the pandemic have shown that low-trust populations demonstrated lower vaccine uptake, greater opposition to compliance with lockdowns, and higher exposure to health misinformation (Lazarus et al., 2021; OECD, 2021). For instance, in Brazil, the Datafolha and Ipsos surveys from 2020 to 2022 reported that participants distrusted national COVID-19 data and vaccine data to varying degrees across different geographic areas, with varying levels of intensity related to socio-economic status and Indigenous participants.

The breakdown of public trust through poor public health communication by governments is neither a combination of weaknesses nor a spontaneous event; rather, it is illustrative of a broader health governance challenge. Low population trust in public health authorities and health systems often reflects systemic and structural inequities, chronic marginalization, and the political exploitation of health communications. Gilson (2003) and Ozawa and Sripad (2013) argue that no amount of correct information, health communication, and intensive education will lead to restoring trust; instead, it is required for institutions to change their relationship with communities, accountability, transparency of how the institution manages resources, and a more participatory-based, rather than individualist, to community member experience. Trust is relational, emergent, and deeply historical; once violated, the ramifications of injustice continue

to shape community perceptions of institutions as they pursue legitimacy and advantage institutional mandates.

This report will assess the determinants of distrust in health systems during crises and offer a multifaceted strategic response to rebuilding public trust. This drawing will incorporate various established theories related to risk perception, institutional trust, and ethical considerations in public health. Additionally, we will include examples based on public health practices, particularly in countries with similar capacities and accountability structures. In particular, Brazil will be used as a lens to not only demonstrate manifestations of the breaking of trust but also highlight some pathways to rebuilding institutional (public health) trust.

The report structure includes a literature review (in Section 2) on the determinants of trust in health systems, overviewing academic literature and global governance sources; we outline our methodology in Section 3; our research findings on the determinants of distrust are found in Section 4; Section 5 discusses strategic approaches to regain trust, including short- and long-term approaches; and finally we conclude the report with our recommendations to rebuild ethical, sustainable and equitable trust in public health systems and institutions.

Literature Review

Restoring trust in health systems after a crisis is an incredibly complex undertaking that involves understanding how trust develops, how it is destroyed, and how institutional behavior, social context, and communication interact. This literature review examines the scholarly and institutional literature that has investigated public trust in health systems, including studies that focus on public trust in health systems during crises. This literature review provides the theoretical background on how trust works in health governance, examines documented explanations for distrust, and analyzes global case studies, highlighting some of the documented failures and gaps in past recovery approaches.

The purpose of this section was to provide a broad base of the scholarly literature on trust to inform the strategic trust recovery framework later in the report.

Theoretical Frameworks: Understanding Trust in Health Systems

Trust is something more than just a feeling. It is based on the perceived trustworthiness, competence, and fairness of the institutions involved (Gilson, 2003). In health governance, trust facilitates public acceptance, cooperation, and continued involvement with health interventions (Ozawa & Sripad, 2013). In the literature, scholars distinguish between institutional trust (trust in a government or health organization) and interpersonal trust (trust in an individual health care provider). Both have implications for patient behaviors and public receptiveness to health policy (Mechanic & Schlesinger, 1996).

Risk perception theory can also help explain why individuals respond differently to enforced guidelines on health behavior during times of crisis. When citizens experience low levels of trust in public institutions, they are less likely to passively agree to health interventions, especially when these interventions involve elements of uncertainty or carry risks (Siegrist & Zingg, 2014). On the contrary, when individuals experience high levels of trust, they are more likely to rely on integral narratives from public institutions when responding to enforced health guidelines. Otherwise, individuals with low levels of trust seek alternative assessments and narratives, replacing the reality of the mandate with either complacent (resistant) or opportunistic (misinforming) action.

Causes of Public Health System Distrust

Distrust in the health system grows from several overlapping sources:

Historical injustice (e.g., unethical experimentation, neglect of Indigenous peoples)

Poor communication (e.g., inconsistent or politicized messaging)

Discrimination and marginalization in service delivery

Perceived incompetence or dishonesty in the face of crises

Freimuth et al. (2014) showed that, among other factors, African American populations in the U.S. have levels of medical distrust heightened by a history of abuse (e.g., the Tuskegee Syphilis Study). Similar documented patterns exist globally, for example, in the case of Dalit and tribal communities in India or favela residents and Indigenous peoples in Brazil (Lazarus et al., 2021; Ventura, 2021).

The mistrust is compounded by disinformation, media bias, and online echo chambers. The WHO (2021) noted that the COVID-19 “infodemic” added confusion and distorted the credibility of official sources, especially when health sciences were not static or evidence-based but were continually evolving in real time.

Case Study: Brazil During COVID-19

Brazil vividly illustrates how political leadership, health communication, and agency divides can diminish public trust. During the pandemic, the federal government's response to the severity of the virus was inconsistent, legitimizing therapies that had not been approved and delaying the purchase of vaccines (Castro et al., 2021). Trust in the health system collapsed even more dramatically among urban poor and Indigenous populations (Ipsos, 2021).

The Sistema Único de Saúde (SUS), formerly respected and emulated worldwide, suffered unforeseen reputational damage due to political intervention that compromised its independence. Local health authorities' sincere efforts to deliver health messages were undermined by the mixed messages from national leaders, further eroding confidence in public health systems and vaccine uptake (Massarani & Neves, 2021).

Lessons from Global Trust Failures

Other countries are known to provide cautionary lessons. In the United States, the politicization of the pandemic response eroded public trust in institutions such as the Centers for Disease Control and Prevention (CDC) and the Food and Drug Administration (FDA) (Gollust et al., 2020). In India, the perception of COVID-19 deaths being underreported (Kumar & Praths, 2021) and inequities in vaccine distribution (Dutta, 2021) triggered public anger and resistance, particularly in the impoverished and oppressed states, such as Uttar Pradesh and Bihar.

International organizations, such as the OECD (2021) and UNDP (2022), warn that the recovery of trust needs to consider the governance surrounding the information shared. Communities need to observe the governing authority demonstrate meaningful reforms, including being culturally responsive and creating opportunities for engagement and participation in deliberative processes that shape health policy if we are to cultivate trust in health organizations and systems.

Summary and Gaps in Literature

The literature suggests that there are four prominent principles for trust-building: transparency, consistency, fairness, and acknowledging cultural sensitivities. Several studies on trust suggest that trust is primarily understood as a communication issue rather than a systemic one. Policy frameworks still tend not to include community co-design, ethical governance, and structures for long-term accountability into national health trust recovery.

This gap serves to reinforce the strategic approach employed in this report, which combines ethical communication, participatory governance, and institutional reform to build trust sustainably in the aftermath of the crisis.

Methodology

This report employed a qualitative secondary research strategy, relying on peer-reviewed articles, global health examinations, and institute policy documents to understand how health systems in many countries were eroding and rebuilding public trust following a crisis. The use of secondary documents helps to build not only the breadth but also the depth of the analysis, as it combines ethical and practical considerations that limit the ability to gather primary data on public attitudes in different jurisdictions. This approach utilizes secondary documents.

The research framework is developed through a thematic analysis of a selection of academic peer-reviewed articles, public case studies, and multilateral or global institutional governance reports sourced from global health organizations, which includes the World Health Organization (WHO), the Organisation for Economic Co-operation and Development (OECD), and United Nations Development Programme (UNDP) involving their examination and recommendations following a health crisis. Academic search engines and databases, including PubMed, Google Scholar, and Scopus, were used to identify peer-reviewed articles published between 2003 and 2023 that explored research on public trust in institutions, health crisis response, risk perception, and vaccine hesitancy.

Selection criteria we felt were important included:

- peer-reviewed articles focused on health policy, public trust, and crisis communication
- public trust case studies focused on the country level (specifically Brazil, the U.S., and India)

- reports published by global health institutes with data on pandemic trust or public trust and pandemic data for COVID-19 and other health crisis data from H1N1 and Ebola.

The data was reviewed and thematically categorized into four themes:

- theoretical models of trust (e.g., Gilson, 2003; Ozawa & Sripad, 2013);
- empirical evidence on the breakdown of trust (e.g., Freimuth et al., 2014; Castro', 2021);
- global comparisons for case studies;
- Strategic approaches for rebuilding trust (e.g., recommendations from the WHO, OECD, and/or UNDP).

While the secondary methodological approach provides a rich background on trust use across various contexts, it still relies on prior interpretations of the dynamics regarding public trust versus health institutions and the use of representative public opinion. The peer-reviewed article reviews research across all academic and institutional sources, enhancing quality through the triangulation of data and analysis to ensure that these strategies for rebuilding public trust can be considered evidence-informed, with validity to conclude that they are globally relevant and valuable across a range of jurisdictions.

This secondary approach positions the report's goal as building a multifaceted strategic response to the breakdown of public trust in health systems, utilizing existing knowledge, and communicating potential approaches for future crises. It also ensures that we remain consistent with contemporary best practices in policy analysis across global health while allowing us the flexibility and adaptability to minimize the complexity of the political and cultural differences faced by country systems.

Findings

This section outlines emerging research findings on the erosion of public trust in national health systems during recent health emergencies, particularly in the context of COVID-19. The section draws on a series of international case studies—mainly from Brazil, the United States, and India—to outline patterns of institutional failure, sociopolitical impact, and demographic

differences in trust erosion. The findings justify the development of a tailored, evidence-based strategy for recovering lost trust, which will be explored in subsequent sections.

Brazil: Politicization and Health System Paralysis

Brazil's response to COVID-19 illustrates how political intervention can rapidly erode public trust in a well-established health system that had previously enjoyed a reasonable reputation. A laudatory universal health model, the Sistema Único de Saúde (SUS), was designed to promote care in the community and beyond, reaching areas that the government often neglected (Castro et al., 2021). The Bolsonaro Administration downplayed the threat of COVID-19, rejected scientific consensus, advocated dubious treatments, including hydroxychloroquine, and delayed acquiring viable vaccines (Massarani & Neves, 2021).

By mid-2021, a Datafolha poll found that almost 40% of Brazilians expressed distrust in the official COVID-19 data and believed the government was hiding COVID-19-related deaths (Ipsos, 2021). Trust in COVID-19 communications was especially low among lower-income populations and documented trust gaps exist in Indigenous populations who often have little or no access to health care. Conflicting messages from national leadership and state and local public health departments only exacerbated public health communication, with some communities trusting their health agents far more than national leaders.

United States: Trust in Science Undermined by Politics

Public trust in institutions such as the Centers for Disease Control and Prevention (CDC) and the Food and Drug Administration (FDA) declined sharply in the United States during the COVID-19 pandemic, especially among politically polarized populations (Gollust et al., 2020).

Misinformation campaigns, media information siloes, and inconsistent mask and vaccine recommendations sowed confusion, eroded trust in federal guidance, and wreaked havoc on public belief in CDC (and sometimes FDA) guidance. According to a study by the Pew Research Center (2022), only 52% of Americans reported trusting the CDC at the end of 2021, down from a 76% trust rate in early 2020. Distrust was highest among Republican voters, rural populations, and communities of African Americans, which are three populations that are historically marginalized or distrustful of the U.S. Government's involvement in health care (Freimuth et al., 2014).

India: Mistrust Driven by Inequality and State-Level Gaps

In India, perceived discrepancies around vaccine access, transparency around data, and delivery of health services eroded trust. During the second wave of COVID-19 in 2021, hospitals in cities like Delhi and Mumbai buckled under the strain of patient loads, while many rural areas struggled to provide even the most basic care. Claims of underreported death tolls and lack of oxygen that caused mortality led to widespread skepticism of the official COVID-19 reports (Dutta, 2021).

Survey data from the Indian Council of Medical Research (ICMR) indicate lower trust in government health messaging in states with weaker public health system infrastructure (e.g., Uttar Pradesh and Bihar) compared to states with better public health infrastructure (e.g., Kerala and Tamil Nadu), for both religious minorities and lower castes, vaccine hesitancy was noted, in part due to historical experiences of medical neglect and a lack of outreach specific to their cultural context.

Common Patterns Across Contexts

While there are differences in how governance and health systems are organized, we observed some consistent themes emerge across the three case studies:

Mixed or inconsistent communication from the national level to local actors eroded public trust in those actors.

Active political interference in science and public health communications damaged the credibility of institutions and their communication.

Existing structural inequalities (racial, geography, caste) were predictive of where public trust declined the most.

Insufficient engagement and involvement of communities meant public health efforts were top-down and culturally foreign.

These observations highlight that restoring public trust in health organizations does not only require "fixes" in communications. Instead, health systems need to be developed and organized with a focus on accountability, equity, cultural safety, and public participation.

Discussion

In this section, we build on our findings to develop a strategic, multi-level response to the crisis in public trust in national health systems. It considers both short-term and long-term responses to the crisis, grounded in evidence-based international best practices, behavioral science, and global public health policy. The discussion is structured around key strategic themes: immediate recovery, systemic change, media relations, and community partnerships.

Short-Term Trust Recovery Measures

Short-term strategies should focus on repairing the public's trust, which has been significantly damaged in a crisis. The World Health Organization's (2021) guidance makes it clear that transparent communication, acknowledging past mistakes, and consistency of approach from government entities are prerequisites for re-establishing credibility.

In Brazil, for instance, CDC and coronavirus pandemic response team members interviewed reported that local healthcare workers had more credibility with the public than federal authorities during the pandemic; yet, some local leaders, such as faith leaders, were still highly credible. Trust in credible individuals who are considered messengers in the community, such as community leaders, faith leaders, or respected health professionals, was noted as an opportunity to help rebuild trust and public enthusiasm for health interventions (Massarani & Neves, 2021). Important guidance from the WHO also emphasizes the use of risk communication and community engagement (RCCE) tools to facilitate discussion and collaborative dialogue rather than relying on foundational, top-down, one-way messaging.

Another short-term option for governments to restore trust is around transparent public access to data. Governments need to be actively providing and sharing, in real-time, clearly disaggregated data about infection rates, where resources are allocated, and where people's results are from receiving a vaccine. The OECD (2021) showed that countries that scored highest for public trust

(Finland and South Korea centralized dashboards and made regular public announcements to maintain public trust and accountability.

Long-Term Institutional Reform

Restoring the public's perception of health system competency and the trustworthiness of public health agencies is paramount to long-term recovery. It requires more than messaging; it necessitates a specific shift in how health systems are governed, as well as a change in the culture of these systems. Gilson's determination to reinstate trust is not simply about communication but rather a combination of procedural fairness, institutional integrity, and responsive service delivery. Some potential actions include depoliticizing public health agencies. This could include statutory independence for public health intermediaries such as health ministries and pandemic response task forces, analogous to the independent operation of central banks (Gollust et al., 2020). Another potential act is to develop mechanisms for institutional accountability (e.g., independent boards of oversight, citizen or public audits, Ombudsman roles, or similar comparable emancipatory methods). Furthermore, the health system should also adopt an equity-centered design, which may include reconfiguring services to address barriers faced by marginalized populations, such as language access, cultural competency, and anti-discrimination protocols, in addition to adapting to changing public perceptions (Ozawa & Sripad, 2013). For example, Canada and New Zealand have embedded equity audits into their public health strategies to ensure inclusive practices in both their planning processes and public health outcomes.

Media and Digital Strategy

The well-established role of misinformation and media environments is only one facet of the loss of trust. The lack of trustworthy science narratives will often fuel the fires of uncertainty and mistrust. Online disinformation spread rapidly and widely during the COVID-19 pandemic, and it can fuel vaccine hesitancy, conspiracy theories, and distrust of health authorities (Pew Research Center, 2021).

National health systems should engage in a proactive digital strategy, which should include:

Rapid response units for false viral narratives

Collaborations with social media platforms to identify and remove dangerous content

Public campaigns to increase media literacy

For example, Finland's government has partnered with schools to teach digital literacy starting as early as age 10. The UN is partnering with countries worldwide for the "Verified" program, providing access to fact-checked health content in multiple languages as a way of combating infodemics globally (United Nations, 2021).

Community Participation and Stakeholder Inclusion

Public trust is also increased when communities see themselves not just as receivers but as creators and co-creators of health policy. Participation by communities in health processes can contribute to increased relevance, accountability, and local buy-in for public health programs (WHO, 2021). Examples of strategies/approaches to community engagement include, but are not limited to, the following:

Creating community health councils at the district level

Conducting consultations with citizens before major health policy decisions

Providing funding for community-led grassroots health promotion programs for the communities impacted by the issues

During the COVID-19 pandemic in India, Kerala's Kudumbashree program mobilized women's self-help groups to lead local-level health outreach, garnering unprecedented levels of trust in state-level health messaging (UNDP India, 2021).

Using these participatory strategies enables health systems to engage affected communities in ways that address both clinical needs and social and cultural norms, social tensions, and emotional recovery, all of which are necessary for rebuilding trust with the public.

Concluision

Trust in national health systems is vital for both short-term emergency responses and long-term oversight of health systems. As this report has illustrated, trust is often fragile and complex, governed by numerous intertwining social issues. Specifically, trust is influenced by inter-organizational communication, leadership, inequality, and the broader historical development of the health system. Data collected through an empirical lens, as well as published case studies from Brazil, the USA, and India, have shown that communication failures do not simply dissolve trust but rather involve systemic failures in terms of accountability, transparency, and responsiveness to social and cultural disparities.

The report highlighted that populations that already experience structural disadvantage - for example, Indigenous peoples in Brazil, the rural population in India, or [those being] politically polarised in the United States - display disproportionately higher vulnerability to trust erosion during the COVID pandemic. Distrust was primarily driven by misinformation, inconsistent leadership, and a perceived lack of attention. These features reaffirm that trust is multi-modal and relational legitimacy, whereby trust in institutions is contingent on how well they include, listen to, and respect the populations they serve.

The report suggested a multi-tiered plan to dismantle that trust. The immediate focus should be on consistent messaging, transparency, and local, trusted health agents. Building trust created by reforming Health Systems requires rebuilding it at a deeper level of reform that is, enhancing accountability systems built into any health system, removing or mitigating the impact of health system leaders politicizing their role, and fundamentally putting equity at the center of all policy and service design.

In the realm of development setups, these community engagement approaches are imperative as a reality. When people feel that they are involved in healthcare decision-making (active engagement versus passive), they are more likely to trust health authorities and make a greater effort to engage. Real-world examples surrounding the participatory and community-based approaches, where the essence of active participation tangibly builds public trust and corresponding health outcomes, include Kerala's Kudumbashree and the UN's Verified

campaign. In conclusion, this report demonstrates that trust is not a soft value but rather a strategic asset in recovery following a crisis. Health systems that do not invest in ethical, inclusive, transparent, and genuine governance will face challenges, not only from future pandemics, as highlighted above, but also from the legitimacy of the institutions that are supposed to protect public health. Hence, rebuilding trust should be recognized as a first principle for all health resilience planning in every nation.

References

- Castro, M. C., Kim, S., Barberia, L. G., Ribeiro, A. F., Gurzenda, S., Ribeiro, K. B., ... & Werneck, H. (2021). Spatiotemporal pattern of COVID-19 spread in Brazil. *The Lancet Regional Health – Americas*, 1, 100062. <https://doi.org/10.1016/j.lana.2021.100062>
- Freimuth, V. S., Jamison, A., An, J., Hancock, G. R., & Quinn, S. C. (2014). Determinants of trust in the flu vaccine for African Americans and Whites. *Health Education & Behavior*, 41(2), 190–199. <https://doi.org/10.1177/1090198113505812>
- Gilson, L. (2003). Trust and the development of health care as a social institution. *Social Science & Medicine*, 56(7), 1453–1468. [https://doi.org/10.1016/S0277-9536\(02\)00142-9](https://doi.org/10.1016/S0277-9536(02)00142-9)
- Gollust, S. E., Nagler, R. H., & Fowler, E. F. (2020). The emergence of COVID-19 in the US: A public health and political communication crisis. *Health Affairs*, 39(6), 1051–1055. <https://doi.org/10.1377/hlthaff.2020.01298>
- Massarani, L., & Neves, L. F. F. (2021). Public perception of science communication on the pandemic in Brazil. *Ciência & Saúde Coletiva*, 26(6), 2061–2070. <https://doi.org/10.1590/1413-81232021266.04702021>
- OECD. (2021). *Building trust to reinforce democracy: Main findings from the 2021 OECD survey on drivers of trust in public institutions*. Organisation for Economic Co-operation and Development. <https://www.oecd.org/gov/building-trust.htm>
- Ozawa, S., & Sripad, P. (2013). How do you measure trust in the health system? A systematic review of the literature. *Health Policy and Planning*, 28(5), 505–518. <https://doi.org/10.1093/heapol/czs058>
- Pew Research Center. (2021). *Americans' views of the pandemic and COVID-19 vaccines*. <https://www.pewresearch.org/science/2021/09/15/>
- Siegrist, M., & Zingg, A. (2014). The role of public trust during pandemics: Implications for crisis communication. *Journal of Risk Research*, 17(1), 83–91. <https://doi.org/10.1080/13669877.2013.808686>
- UNDP India. (2021). *Kerala's women-led Kudumbashree model in pandemic response*. United Nations Development Programme India. <https://www.in.undp.org>
- United Nations. (2021). *Verified: Fighting misinformation with truth during COVID-19*. <https://shareverified.com/en>
- World Health Organization. (2021). *Behavioural considerations for acceptance and uptake of COVID-19 vaccines*. <https://www.who.int/publications/i/item/9789240016927>

