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Self-rated health, generalized trust, and the Affordable Care Act: A US panel study, 2006–2014

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ABSTRACT

Previous research shows that generalized trust, the belief that most people can be trusted, is conducive to people's health. However, only recently have longitudinal studies suggested an additional reciprocal pathway from health back to trust. Drawing on a diverse body of literature that shows how egalitarian social policy contributes to the promotion of generalized trust, we hypothesize that this other 'reverse' pathway could be sensitive to health insurance context. Drawing on nationally representative US panel data from the General Social Survey, we examine whether the Affordable Care Act of 2010 could have had influence on the deteriorating impact of worsening self-rated health (SRH) on generalized trust. *Firstly*, using *two-wave* panel data (2008–2010, N = 1403) and employing random effects regression models, we show that a lack of health insurance coverage negatively determines generalized trust in the United States. However, this association is attenuated when additionally controlling for (perceived) income inequality. *Secondly*, utilizing data from two separate *three-wave* panel studies from the US General Social Survey (2006–10; N = 1652; 2010–2014; N = 1187), we employ fixed-effects linear regression analyses to control for unobserved heterogeneity from time-invariant factors. We demonstrate that worsening SRH was a stronger predictor for a decrease in generalized trust prior (2006–2010) to the implementation of the Affordable Care Act. Further, the negative effect of fair/poor SRH seen in the 2006–2010 data becomes attenuated in the 2010–2014 panel data. We thus find evidence for a substantial weakening of the previously established negative impact of decreasing SRH on generalized trust, coinciding with the most significant US healthcare reforms in decades. Social policy and healthcare policy implications are discussed.

1. Introduction

On 23rd March 2010, Barack Obama as the United States (US) President signed into law the *Patient Protection and Affordable Care Act* (ACA). The enactment of the ACA represented a massive paradigm shift in North American healthcare policy (Jacobs and Skocpol, 2010), shifting from a strongly commodified system (Caplan, 1989) towards a more egalitarian healthcare system. The overarching aims of the ACA were to expand healthcare coverage, to lower healthcare costs, and to make health insurance companies more accountable (Medicaid.gov, 2017). Recent research shows that it was young adults up to 26 years, minorities, and low-income earners that benefitted most from the ACA in terms of improved self-rated health (SRH) and greater access to affordable healthcare (Sommers et al., 2013, 2015). By 2014 – the year coinciding with the last observations of our panel data studies – at least an additional 20 million people had gained healthcare coverage (Blumenthal and Collins, 2014).

Inspired by a recent US longitudinal study based on Los Angeles data *pre*-ACA (McKay and Timmermans, 2017), which showed that high community-levels of "uninsurance" undermined social cohesion, our study pays attention to a key social capital dimension with established public health implications, namely generalized trust (Jen et al., 2010; Kawachi et al., 1999; Moore and Kawachi, 2017; Nyqvist et al., 2008; Subramanian et al., 2002). Generalized trust is the belief that most people, even strangers, can be trusted. It is frequently considered an important – if not even the *most* important (Rothstein and Stolle, 2008) – part of social capital because it facilitates cooperation between strangers, making it an invaluable solution for major collective action dilemmas (Berkman and

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Kawachi, 2014), for example fighting antibiotic resistance (Rönnerstrand and Andersson Sundell, 2015) and immunization against pandemics (Rönnerstrand, 2016). Of major interest to us is that one key experience associated with fluctuations in individual trust is a *change* in individual health status (Giordano et al., 2012). More specifically, we deal with the question how changes in people's SRH are associated with changes in individual generalized trust (Giordano et al., 2012; Giordano and Lindström, 2016) and whether the enactment of the ACA could influence the US health-trust nexus.

Since the seminal study by Kawachi et al. (1999), the past two decades have seen vast amounts of empirical evidence demonstrating positive associations between SRH and generalized trust (Gilbert et al., 2013; Murayama et al., 2012). Applying a diverse range of methods and data, most studies have implicitly assumed a causal pathway from generalized trust to health (e.g. Giordano et al., 2012; Snelgrove et al., 2009). However, scholars have only recently begun to question the (simplistic) unidirectional model of causation (Ljunge, 2014; Oshio, 2016; Rocco et al., 2014). Most recently in a temporality study employing multi-wave data from the British Household Panel Study, Giordano and Lindström (2016) provided empirical evidence for a complex *circular* relationship between generalized trust and SRH over time, i.e. a causal path from generalized trust to SRH *and* a 'reverse' path leading from SRH to generalized trust. They further suggested that this *circular* health/trust relationship appears more complex than the mutually reinforcing feedback loop previously postulated by Rocco et al. (2014), with those individuals with poor SRH having the greatest propensity not to trust later. This 'reverse' path from health to trust is the focus of this study.

Since the use of three-wave panel data, as employed in this study, restricts the possibilities to disentangle the causal order of two attitudinal variables (Vaisey and Miles, 2017), we refrain from re-addressing the causality question. Assuming the existence of the established positive path from generalized trust to health (Ljunge, 2014; Rocco, 2014), we focus exclusively on the 'reverse' path from health to generalized trust, which can be interpreted twofold: *i*) Improving SRH leads to an increase in trust; and *ii*) Worsening SRH leads to a decrease in trust. The latter shall be studied here. There is a broad scholarly consensus that *destroying* generalized trust is much easier than *creating* it (Levi, 1998), hence our interest in the potentially deteriorating impact of worsening health on trust.

We argue that poor health translates into a decrease in trust only under certain circumstances. Following Seligman (1997) and Uslaner (2002), generalized trust is rooted in optimism and a sense of control (see also Ross, 2011), factors that are primarily shaped during the 'impressionable years' of childhood and adolescence. Put differently: Generalized trust tends to be relatively resistant to changes during adulthood. Consequently, only life-events of significant impact, e.g. falling seriously ill or becoming unemployed (e.g. Laurence, 2015), could have the potential to turn adults from 'trusters' into 'distrusters'. We further argue that the negative impact of worsening health on generalized trust could be buffered by social policy. Egalitarian social policy measures may, for example, be targeted to provide greater access to appropriate medical support, fair sick pay, maternity/paternity leave, and opportunities for increased participation in society (Starfield and Birn, 2007). Such elements are already commonplace in most Western industrialized countries (Olafsdottir and Beckfield, 2011), and their presence may contribute to attenuating the 'reverse' pathway association between poor health and lower trust in these contexts.

Previous research shows that universal welfare states, as represented for example by the Nordic countries, create egalitarian contexts that foster generalized trust (e.g. Rothstein and Stolle, 2008). People living in liberal welfare states such as the US are, conversely, less likely to trust others (Coburn, 2000; Rostila, 2013). We argue that the ACA constitutes an egalitarian milestone in US healthcare history, with the potential to mitigate the deteriorating impact of worsening health on generalized trust. More precisely, we assume that universal healthcare systems may potentially buffer any spillover effects from poor health into other domains of life, such as labor force participation, family well-being, political participation and social life. Contexts where the welfare state adopts egalitarian healthcare provision to cushion any downward spirals caused by deteriorating health should promote more optimism and sense of control – and therefore generalized trust – than contexts characterized by a marketization of healthcare. Before the healthcare reform of 2010, large parts of the population remained either under- or uninsured, despite the three-fold increase in healthcare costs over the two decades *pre*-ACA (Moses et al., 2013). The healthcare reform of 2010, unfortunately, failed to realize truly universal healthcare coverage (see also Béland et al., 2016), possibly due to the Supreme Court decision in June 2012 allowing *optional* Medicaid expansion for states (Rosenbaum and Westmoreland, 2012). As a result, an estimated 28 million Americans remained uninsured three years after its enactment (Kantarjian, 2016). Nevertheless, the ACA was a 'game changer' in that it dramatically increased the number of US residents eligible for healthcare insurance schemes.

While the US has suffered from a substantial and steady decline in generalized trust since the early 1970s (Fukuyama, 1999; Putnam, 2000; Twenge et al., 2014; Uslaner, 2002), empirical evidence regarding possible interventions how to stop or even reverse this negative trend is scarce. We seek to address this literature gap by re-visiting the US health-trust nexus and investigating whether associations between poor SRH and low generalized trust in the US have been affected by the 2010 healthcare reforms. Observing such a period-effect would further support the claim that by buffering the adverse effects of worsening health on generalized trust, increasing access to affordable healthcare positively contributes to community well-being and social cohesion beyond health effects alone (McKay and Timmermans, 2017; Sohn and Timmermans, 2017). Importantly, we assume that it is less any *direct* experience of 'Obamacare' that should matter for mitigating the effect of worsening health on generalized trust but rather the optimism stemming from the prospect of an upcoming, more egalitarian healthcare system designed to benefit previously marginalized groups.

We hypothesize that the negative impact of worsening health conditions on generalized trust was stronger *pre*-ACA than *post*-ACA. By employing longitudinal survey data from two different three-wave panel studies of the US General Social Survey, we:

i) Analyze whether individual health insurance coverage impacts generalized trust,
ii) Investigate if the health-trust relationship in the US holds using a three-wave panel design;
iii) Examine whether the negative impact of fair/poor SRH on generalized trust was stronger *pre*-than *post*-healthcare reform
iv) Test whether any effects regarding the impact of SRH on trust are stratified by age, distinguishing between those that were immediately affected by the ACA (18–25 year olds) vs. those aged 26+ (affected by the ACA from 1 January 2014)