

Understanding Institutional Trust. What Does It Mean to Trust the Health System?

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Abstract Research on trust in the health system has been given more importance, since Hardin's study (2006), which found a decrease in trust at the level of important democratic systems, (Canada, USA, UK, Sweden) and Fukuyama's work (1995), where societies are divided into high-trust societies and low-trust societies. Yet the notion of trust is often regarded as ambiguous, difficult to define and to investigate. Trust has only recently begun to be measured and analyzed in the health sector and almost no empirical investigation has been conducted in developing countries. In high income countries this interest is associated with concern for the decline of trust in governments and professionals, and in developing countries has been prompted by debates around the notion of social capital. Empirical studies found a decrease in the degree of trust in medical institutions, which can be explained by epistemological challenges about the authenticity of knowledge (Popay et al. 2003), by a drop in trust in the power of science (Irwin and Michael, 2003), and by an increase in individual and social reflexivity (Giddens 1994, pp. 194–197). The purpose of this article is to identify—in scientific literature—the way in which trust in health systems and the determinants of a relationship based on trust have been measured. In the analysis, we used the PubMed

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database, without specifying a certain time interval, and the reports of the European Commission referring to health. The following concepts were used: trust, institutional trust, health system, literature review.

Keywords Trust · Institutional trust · Health system

1 Introduction

Health system is more and more acknowledged as a predictor that reflects the values and priorities of a nation (Gilson 2003; Freedman 2005). Health system comprises the factors and organizations whose primary purpose is to promote health and to prevent and treat disease (WHO 2008). Health system—considered as social institution—is especially important because it structures relationships between the vulnerable population and the government of that country (Freedman 2005). According to WHO (2007), predictors that reflect a functional health system are as follows: the existence of an infrastructure for adequate medical service delivery; highly skilled health workforce; information accuracy (level of information of the population concerning health plans), adequate medical products, technical performance (medical personnel skills, equipment endowments, medication accessibility), proper financing, effective management, involvement of beneficiaries in health system design, accessibility of services (proximity and eligible costs), healthcare quality, medical system performance (equity, considering patient’s preferences: respect for the person and time of the patient, medical insurances). The purpose of this article is to identify—in scientific literature—the way in which trust in health systems and the determinants of a relationship based on trust have been measured. In the analysis, we used articles and reports ($n = 79$) from the PubMed database, without specifying a certain time interval, and the reports of the European Commission referring to health. The selections criteria we used was full access, full text and only English language, qualitative and quantitative methods employed. The following concepts were used: trust, institutional trust, health system, literature review (Fig. 1).

2 Why Is It Necessary to Study Trust?

The issue of trust in physicians, in the medical profession, in medical institutions, and in the healthcare system, implicitly, has been brought to the scientists’ attention lately, taking into account the erosion of trust, determined by the following: the aggressive display in the media of medical personnel migration, of medical malpractice cases, of underfunding and bad management, of the high pressure on the system due to population ageing and to the increase in chronic disease incidence. The erosion of trust is also caused by modifications in the attitudes, values, and expectations of the public concerning the healthcare system, the emergence of

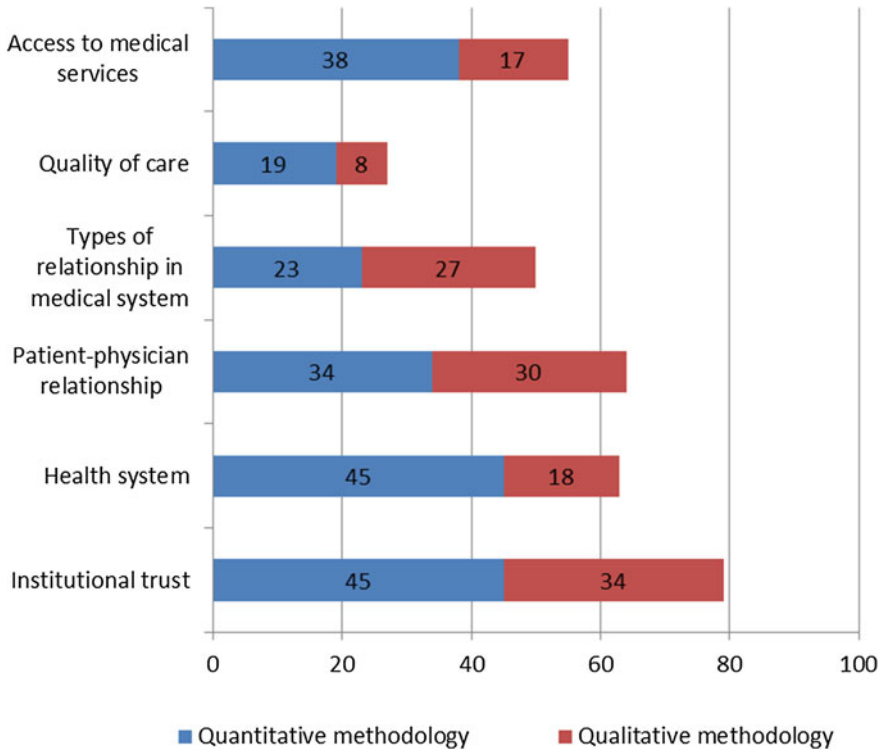


Fig. 1 The distribution of the reviewed articles by main dimensions and by the type of the research methods employed

private health insurances and of private institutions, the incertitude and economic crises, bombarding the population with ever changing messages and often-conflicting messages on health suggest that we are all in a state of liminality or in “no man’s land” (Armstrong 1993; Bauman 1987; Gifford 2002). The consequence of this behaviour is the public questioning the medical science and people comprising the medical system.

O’Neill (2002) describes lack of trust as a cliché of our times. The consequence of these behaviours is public doubt regarding the medical science and those involved in the medical system. Measuring trust and trust potential can be an important indicator and a support for the health system in its attempt to reform the system (Gilson 2005; Van der Schee et al. 2006). In their article entitled “The End of the Golden Age of Doctoring,” John McKinlay and Lisa Marceau capture the essence of the doctor-patient relationship and the impact of managed care on the erosion of patients’ trust. Perhaps the most notable measure of the change in this relationship lies in the words used to describe it. The “doctor” has become a “provider,” the “patient” has become a “client,” and the “relationship” is now an “encounter” (Table 1).

Table 1 Differences in doctor-patient relationship from mid- to late 20th century

	Mid 20th century	Late 20th century
Length of encounter	15–20 min	5–8 min
Duration of relationship	Continuity of care	Discontinuity of care (changes with employer and medical staff)
Treatment options	Physician does what the patient needs	Provider follows organizational policy
Confidentiality	Held to be inviolable	Threatened by the number of parties involved and computerized medical records

Source McKinlay and Marceau (2002)

Research on trust in the healthcare system has acquired significantly more importance in the recent period, starting from the works of Hardin (2006), which attest a drop in the level of trust in important democratic systems—Canada, USA, UK, and Sweden). By analyzing the study of Calnan and Rowe (2004) on trust, it is worth underscoring that the most numerous studies have been conducted in the USA (over 50 %), followed by the UK, Canada, and Australia.

In their paper *How do you measure trust in health system? A systematic review of the literature*, Ozawa and Sripad (2013) identified 45 instruments for trust measurement, each with 12 questions on average, instruments which measure levels of trust in different types of relationships with medical systems. The authors concluded as follows: most studies were conducted in the USA, and half of them actually analyzed the relationship between clinicians/nurses and patients. Honesty, communication, confidence, safety, and competence are most frequently correlated with trust. The study of Calnan and Sanford (2004)—that sought to measure the level of general trust in the medical system of England and Wales by using a questionnaire elaborated and applied in Germany and the Netherlands—found the lowest scores on the level of satisfaction in relation to how the health service was run and financed, waiting times, certain professional skills of physicians, as well as the implication of cost cutting for patients. The existence of private health insurance is a determinant of trust erosion in the public health system. The instrument used comprises 32 items grouped into 6 categories: patient centred care, macro policies, professional expertise, quality of care, communication, and information provision and cooperation quality.

The data within the Special Eurobarometer “Patient safety and quality of care” (EC 2014), 71 % of the respondents say the overall quality of healthcare (in their country) is good, one percent higher than within the 2009 study. Respondents in Romania ascribe a good score to the quality of medical services (only 25 %), significantly below the European average, along with Greece (26 %) and Bulgaria (29 %). In the same study, concerning healthcare quality in their country compared to other Member States, Romania is at the bottom: 78 % (the European average is

34 %) believe that medical services are worse. The criteria considered within service evaluation concerned the following: medical staff who are well trained, treatment that works, modern medical equipment, respect of a patient's dignity, access to medical services (accessibility and proximity), no waiting lists for being seen and treated, free choice of doctor and type of hospital, and a welcoming and friendly environment. Taking into account these criteria, we conclude that respondents in Romania ascribed scores higher than the European mean concerning respect of a patient's dignity (29 %, compared to the EU average of 25 %) and free choice of a doctor (28 % compared to 19 %), but also significantly comparable scores concerning the quality of medical personnel and equipments, as well as treatment that works, which suggests that the discontent is related mostly to causes pertaining to the system (underfinancing, bad management), rather than to the interaction/relationship with the medical personnel and all the aspects entailed by this interaction/relationship (evaluation, treatment). Furthermore, the study published by IRES (2014) shows that the medical profession ranks on top of professions that the population ascribes high and very high degree of trust, alongside the teaching and military profession; law enforcement, civil servants, and politicians benefit from the lowest levels of trust.

The assessment of perceived quality of health system (according to Global Health Survey 2011) shows that Romania, alongside Egypt, Colombia, Ukraine, Poland, and Greece, scored the lowest; the main causes are bad management and improper financing. In this study, the directions based on which they assessed perceived quality of services are the following: belief that the health system ensures the best quality for all categories of population (especial the vulnerable ones) and that medical research will evolve in such a way as to provide solutions for solving medical problems. The same study found that the Romanian patients' participation to decision making in the treatment plan is the lowest in Europe, which ranges the therapeutic relationship within the paternalistic paradigm.

By analyzing the findings of these studies, we ask ourselves whether institutional trust is related to norms, regulations, procedures, structure, organization, and financing of the medical system, or if it is related to the micro-analysis based on interpersonal relationships, such as quality of medical care, professional expertise, and care provider-patient relationship? The answer may be provided by qualitative inquiry that explores the way in which both patients and doctors perceive the concept of trust, how one pinpoints a trust relationship, how such a relationship is created and developed.

The results of qualitative inquiry facilitate the development and refinement of hypotheses about how trust functions and can be used to generate questions for use in structured questionnaires. Quantitative inquiry is valuable because it allows larger scale investigation and generates data that can be used, for example, to assess the statistical significance of different determinants to overall levels of trust.

3 Determinants of Trust in the Medical System, in the Context of Chronic Disease

The creation, development, and maintenance of trust are fundamental objectives for the fields of medical ethics, (Carter 1989; Pellegrino and Thomasma 1993) for healthcare legislations, and for public health policies (Mechanic and Schlesinger 1996; Mechanic 1998). Conceptually, we can measure trust in the public health system by comparing the way in which individuals access medical institutions, expressing their preference for public or private institutions. Preference for public institutions versus private institutions can reflect the degree of trust and the level of satisfaction for the first or for the latter. In developed countries, individuals access public health services more than twice a year for prophylactic purposes, and they expect not only medical services, but also a supportive environment, based on respect created by the government.

Trust is a fundamental component of the therapeutic relationship and it may be defined, in very simple words, as a patient's expectation for the care provider to act in his/her interest.

A literature review (McKnight and Chervany 2001) on the definition of trust identified 65 works, among which 23 pertaining to psychology, 23 to management and communication, and 19 to sociology, economy, and political sciences. Their analysis has concluded that the definition of trust concerns mainly the characteristics of the trustworthy person (including good will, honesty, morality, expertise, care, integrity, competence, and predictability) and the vulnerability.

Trust is defined as a process, consisting of varying levels, that evolves over time and is based on mutual intention, reciprocity, and expectations (Lynn-Mc Hale and Deatrick 2000).

Trust can be best understood as a multi-faceted phenomenon, with distinct dimensions: cognitive, emotional, and behavioural; all of them should be seen as bearing various meanings for each individual (Lewis and Weigert 2012). The relationship trust is built in the present, based on past experiences (person's reputation), in order to obtain rewards, (future actions) based on the belief that honesty and morality are attributes of both parties.

In the studies of Ensminger (2001) and Good (1988), the decision of having trust depends largely on previous experiences and on the reputation of parties involved in this relationship (Zucker 1986).

A relationship based on positive experiences is a trust relationship (Fig. 2) that will determine the patient to remain involved in the therapeutic relationship and follow the physician's recommendations (Thom et al. 1999). If premises for a positive relationship are not met, scepticism and mistrust will dominate the relationship' within such a mistrust climate, there are poor chances for any of the participants to discover the knowledge and expertise of the other.

Most often trust relationship is not considered a process-based relationship, but it is measured by studies and experiments that analyze trust as a dependent or independent variable. The independent variable focuses on the benefits of the trust

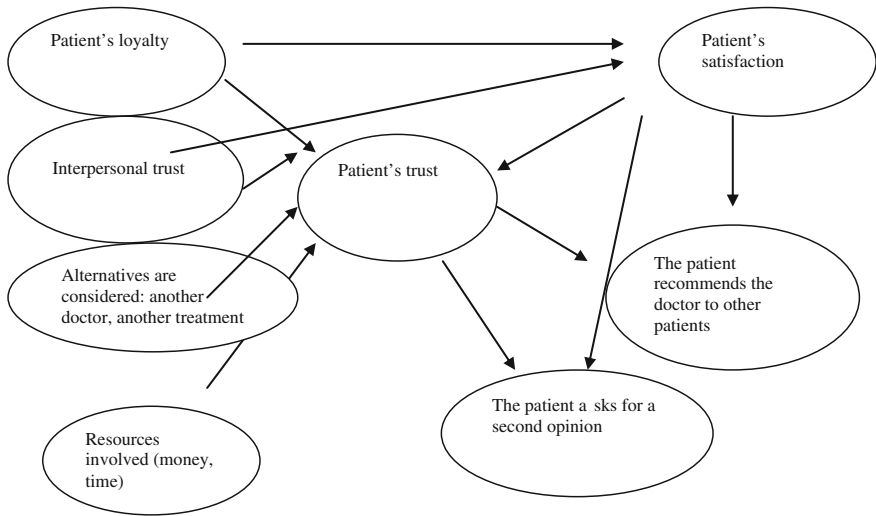


Fig. 2 Patient-practitioner relationship (Source Thom et al. 1999)

relationship, such as cutting costs (Noteboom 2000), facilitating cooperation (Gambeta 1988), creating social capital (Putnam 1993, 2000), reducing risks and incertitude (Luhmann 1988).

The dependent variable focuses on factors related directly to trust, as follows: features of the trustworthy person (Messik and Kramer 2001), reputation of the middleman (Coleman 1988), impact of closeness, egalitarianism, and organizational structure in the development of intra-organizational trust relationships (Ouchi 1981).

Seen as instrumental value, trust is the main ingredient for an effective therapeutic relationship. It has been showed to affect some of the most important behaviours and attitudes, including patients’ willingness to seek care, reveal very personal information, submit to treatment, participate in research, remain with a physician, and recommend the physician to other patients (Parsons 1951; Rhodes and Strain 2000). It was also shown to mediate clinical outcomes. Shapiro and Shapiro (1983) argue that trust is a key factor in the mind-body interactions that may underlie the effects of placebo, the efficiency of alternative medicine, and that may explain variations in outcomes from conventional therapies, from one patient to another.

Concerning trust relationship, Gray (1997) mentions the halo effect: an interpersonal trust relationship may influence a patient’s trust in a hospital or health plan, or the correlative may be true—institutional trust stimulates interpersonal trust (Buchanan 2000).

By using the concept of blind trust, Mechanic (1996) pinpoint that trust in the medical system influences positively trust in medical staff, in medical institutions, and in therapeutic procedures. Medical relationships are much more reciprocal than

any other type of relationships. The physicians' trust in the patient's abilities, especially in chronic disease, facilitates the success of the therapeutic relationship.

In most studies, patient's characteristics do not seem to be predictors of trust. In their investigations on patients with chronic disease, Thorne and Robinson (1988a, b) found that greater trust in the provider is entailed by the provider's attitude of trust in their patient's abilities of managing the disease. Special attention is paid to the importance of patient participating to decision making concerning treatment in constructing the trust relationship. Excluding age, studies proved inconsistent, weak, or inexistent correlations between trust and socio-demographic characteristics (Anderson and Dedrick 1999; Kao et al. 1998). Age may be a predictor of the trust relationship, because it involves long-term interaction of the person with the physician and the medical system. Some studies have found other demographic factors such as race or education to have a relationship with trust but other studies found that it depends on the type and quality of relationship rather than on any particular features of the patient (Thom et al. 1999; Tarrant et al. 2003; Calnan and Sanford 2004) or on relationship continuity (Caterinicchio 1979). Lack of continuity in the treatment was found to have much greater impact on trust relationship than do race, gender, education level, standard of living, or health status (Doescher 2000).

In their study, Mainous et al. (2001) reflect that the elderly and less educated people are more likely to trust both physicians and the system. Meyer et al. (2008) posit that trust increases when patients are treated with respect, seriousness, and when care providers share information with them.

By using the concept of blind trust, Kraetschner et al. (2004) show that some patients relate trust to the physician's professional status; therefore, they do not expect to play an active role, to participate in decision making with regard to the treatment plan. In chronic disease, characterized by high uncertainty and risk, increased dependence in the physician may entail increased level of trust (Calnan and Rowe 2006). Besides interpersonal skills, physicians' technical skills are acknowledged as a factor that determines high levels of trust (Goold and Klipp 2002), and keeping the same physician on a long-term basis may reflect a high level of trust (Kao et al. 1998; Baker et al. 2003). The physicians' behaviour and personality, interpersonal skills, and communication manners seem to be fundamental for building trust. As for situational factors, the frequency of visits to the doctor is not a predictor of trust. Studies found that trust in the physician is often correlated with adherence to treatment, with not changing the physician, not asking for a second opinion, recommended the physician to other patients, few disagreements with the physician, treatment effectiveness, and patient's self-management of health status.

From the perspective of medical personnel, a problem may be their ability of adapting communication and involvement depending on the style of each patient. For the care of patients with chronic disease, studies showed that an important factor—that provides the expected answer—is the trust relationship with the

physician and the medical system. This relationship can be explained by attachment theory, (Bowlby) which posits that a person is used, since childhood, to a certain type of receiving care. These experiences with the attachment person are incorporated within schemes and maps, depending on which the individual acts and understands the behaviour of others within interpersonal relationships, especially in vulnerable times, such as the experience of a chronic disease. By applying attachment theory to adults' behaviour in these situations, Bartholomew and Horowitz (1991) propose a model that identifies four categories or styles of adult attachment: secure, dismissive, preoccupied, and fearful. If the physician is able to identify the type of patient (thus of relationship suitable to the patient's needs), a relationship of trust may be constructed, which is so necessary within the therapeutic process.

4 Conclusions

Trust may be related to a host of health system objectives: access to the system, healthy behaviours, continuity and quality of care, improvement of lifestyle, and monitoring of health status. Trust is associated with increased access to healthcare services and to their effective use (Russel 2005), to satisfaction with and loyalty to the physician (Safran et al. 1988), to self-monitoring of the health status (Wang et al. 2007), to the patient's desire of recommending the physician, to other persons, and to adherence to treatment (Hall et al. 2002). The quality of interaction, the involvement in decision making regarding the treatment, the continuity of the treatment, and the implication in behavioural change are determined by the trust between patient and healthcare provider. Socio-demographic factors, access to the healthcare system, use of healthcare services, and negative experiences with the medical system influence the type of patient—medical system relationship (Schwei et al. 2014). Professional norms, the quality of relationships between the categories of personnel medical institutions, and the way in which they reflect upon the patient are factors that can influence the relationship trust (Gilbert 2005). A deep understanding of the factors that determine the creation of a relationship of trust in institutions will contribute to improving medical services provided by institutions; it could also reduce disparities within the medical system and increase the degree of individuals' responsibility for their own health status.

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