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Social Science & Medicine 56 (2003) 1453–1468

SOCIAL SCIENCE & MEDICINE

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Trust and the development of health care as a social institution

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Abstract

Health systems are inherently relational and so many of the most critical challenges for health systems are relationship and behaviour problems. Yet the disciplinary perspectives that underlie traditional health policy analysis offer only limited and partial insights into human behaviour and relationships. The health sector, therefore, has much to learn from the wider literature on behaviour and the factors that influence it. A central feature of recent debates, particularly, but not only, in relation to social capital, is trust and its role in facilitating collective action, that is co-operation among people to achieve common goals. The particular significance of trust is that it offers an alternative approach to the economic individualism that has driven public policy analysis in recent decades. This paper considers what the debates on trust have to offer health policy analysis by exploring the meaning, bases and outcomes of trust, and its relevance to health systems. It, first, presents a synthesis of theoretical perspectives on the notion of trust. Second, it argues both that trust underpins the co-operation within health systems that is necessary to health production, and that a trust-based health system can make an important contribution to building value in society. Finally, five conclusions are drawn for an approach to health policy analysis that takes trust seriously.
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Keywords: Trust; Social capital; Health policy; Equity

Introduction

Health systems are inherently relational and so many of the most critical challenges for health systems are relationship problems. Poor staff attitudes towards patients can cause dissatisfaction with services, which even good technical care may not offset. Such attitudes may, in turn, result from de-motivating management practices and behaviours. International concern with the weak responsiveness of health systems towards its users, particularly in low income countries, reflects these sorts of problems (World Health Organisation, 2001). At the same time, concern about the broader relationship between health care and society is reflected in discussions about the decline of popular trust in health systems (Birungi, 1998; Davies, 1999; Mechanic, 2001; Segall, 2000; Tendler & Freedheim, 1994; Welsh & Pringle, 2001).

The dominant perspectives applied within health policy analysis, however, offer few insights into the nature and value of health system relationships. Epidemiological and biomedical frameworks are of limited assistance in understanding the internal dynamics of health systems, whilst the core behavioural assumption of traditional economic analysis, that human behaviour is primarily rational and calculative, is flawed. Critics suggest that this economic understanding of human behaviour and how it is shaped is inadequate (Kiser, 1999; Gregory, 1999) and, by inhibiting the expression of social solidarity, may have dangers for re-distribution and equity (Mackintosh, 1997; Melhado, 1998).

Yet outside the health sector, and across a range of disciplines, there has been an explosion of interest, conceptual discussion and policy debate concerning relationships, behaviour, and the factors that influence

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PII: S0277-9536(02)00142-9

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them. A central feature of these debates, particularly, but not only, in relation to social capital (Coleman, 1990; Putnam, 1993), is trust and its role in facilitating collective action, that is co-operation among people to achieve common goals. Economists, both within and outside the health sector, have also been reviewing their traditional behavioural assumptions and have re-emphasised the influence of values and institutions,[1] including trust, over behaviour (e.g. Ben-Ner & Putterman, 1998; Le Grand, 1997; Sen, 1977; Wiseman, 1998).

Table 1 provides details of five different bodies of literature in which trust has recently been emphasised. Although they draw on a range of disciplinary perspectives, discussion of social capital is linked to four of these five sets of literature. The table also indicates the varying range of policy implications that have been derived from consideration of trust. As Misztal (1996, p. 95) suggests, trust "can be a silent background, sustaining the unproblematic, smooth running of cooperative relations. It can be a solution to the free-rider problem. It can help people to reconcile their own interests with those of others. It can provide political leaders with the necessary time to carry out reforms. It can provide friends or lovers a platform from which to negotiate their relations. But above all, trust, by keeping our mind open to all evidence, secures communication and dialogue". Moreover, as an underlying concern of current public policy debates is that the existing bases of social cohesion have been eroded, the particular potency of trust comes from its role as "a symbolic carrier of lost values, acting as a counter to economic individualism in the market place, to hierarchy within organisations, and to the effects of fragmentation across contractualised relationships" (Newman, 1998, p. 51).

What do the debates on trust have to offer health policy analysis? This paper considers the question by considering the meaning, bases and outcomes of trust, and its relevance to health systems. Through an eclectic use of theoretical perspectives drawn from various disciplinary traditions and lines of policy debate, the paper seeks both to establish a conceptual basis for considering the relevance of trust to health systems and to demonstrate the diverse intellectual roots of its argument.

There are two main sections to the paper. The first presents a synthesis of theoretical perspectives on the notion of trust. Drawing on this discussion, the second then argues both that trust underpins the co-operation within health systems that is necessary to health production, and that a trust-based health system can make an important contribution to building value in society. Finally, five conclusions are drawn for an approach to health policy analysis that takes trust seriously.

What is trust and why does it matter?

Trust is a relational notion: it generally lies between—people, people and organisations, people and events. It may also be considered as self-trust, but this notion is not considered further in this paper.

Voluntary trust and dependency

The search for an understanding of trust is most easily initiated by considering a relationship between two individuals known to each other. Trust is essentially a psychological state. In common understanding, to trust someone else is a *voluntary* action based on expectations of how others will behave in relation to yourself in the future. These expectations may be disappointed and, if so, will generate negative outcomes (Brockner & Siegel, 1996; Luhmann, 2000). Trust, therefore, involves an element of risk derived from one individual's uncertainty regarding the motives, intentions and future actions of another on whom they depend (Coulson, 1998b; Lewicki & Bunker, 1996; Kramer, 1999).[2] The types of expected behaviours that generally underlie trust include technical competence, openness, concern, and reliability (Coulson, 1998b). A health care provider is specifically expected to demonstrate impartial concern for the patient's well-being (Davies, 1999; Mechanic, 1996).

In relationships that result from lack of choice or occur in a context of inequality, such as that between health care provider and patient, a form of involuntary trust may appear to exist. However, as trust cannot be coerced into existence (Misztal, 1996), the involuntary trust seen in these relationships is more correctly seen as a form of dependency. Nonetheless, where institutions, such as ethical codes, are established by the state to protect the dependent partner they may also provide the basis for the emergence of voluntary trust within the relationship (see Section Impersonal trust).

Forms of voluntary trust

There are two contrasting perspectives about why one person voluntarily trusts another. At one end of the

[1] The term institution is understood here to refer to rules, laws, norms and customs, as distinct from the term organisations which refers to social settings within which activities such as production, learning, and consumption take place (Ben-Ner & Putterman (1998, p. 37), see also North (1990) (economist), Douglas (1987) (anthropologist) for similar perspectives).

[2] The context of risk specifically distinguishes trust from something like confidence which can generate apparently similar behaviour—but on the basis of an expectation of little or no risk (Levi, 1998; Luhmann, 2000).

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Table 1
Intellectual contributions to trust debates

Body of literature	Economic development[a]	Meaning of democracy[a]	Management in the public sector[a]	Organisational management[a]	Social sector contracting
Disciplinary roots	Development economics Sociology Political Science	Political science	Public administration Political science Sociology	Social psychology Sociology	Economics (agency theory)
Main problem/ issue of focus	Varying levels of economic and social development and variable success in public policy implementation between countries and geographical areas	Growing alienation of citizens from political systems, as evidenced in poor voter turn-out rates in elections, and loss of trust in government; disillusion with state structures and governments in transitional societies	Declining probity and trust in public organizations undermines their legitimacy and so capacity to fulfil tasks	Poor morale and motivation amongst workforces, poor levels of productivity	Costly to implement and monitor formal contracts, especially in sectors where outcomes difficult to measure
Role of trust	Builds relationships that underlie economic development	Builds legitimacy of governance institutions, may promote ethical outcomes in society	Builds legitimacy and so capacity of public systems	Employee trust in employer enhances morale and motivation, and so organisational performance	Reduces the need to monitor and so reduces transactions costs and enhances ability to manage complexity
Policy implications	Develop role of civil society as key support for households and source of economic dynamism Public policy must both complement the actions of civil society and households, and work with these agents, requiring new approaches to managing public organisations	Develop new governance practices—that is: forms of, and structures for, engagement with citizens	Need to: recognise the peculiar nature and tasks of public management; develop new approaches to structuring, managing and delivering services; build sense of mission in civil servants	Human resource management practices and approaches need to build trust within workplace	Develop relational contracts that involve transactional inter-dependence, backed up by effective sanctions

[a] Indicates linked to social capital debates.

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spectrum, as described above, trust is a *strategic* behaviour rooted in risk and expectations about how another person will behave. Strategic trust can vary between a state of complete trust and complete dis-trust, depending on the level of uncertainty calculated to surround the relationship (Gambetta, 2000). In this form, to trust means "that you are prepared to make yourself vulnerable, to run a risk that the other partner will exploit you, and to build up credit by doing more than the minimum necessary in the hope that, if you have problems yourself, your partner will help you in return" (Coulson, 1998a, p. 4). The value of trust is, therefore, largely instrumental.

At the other end of the spectrum, trust is a *moralistic* or *altruistic* behaviour rooted in expectations about how people should behave (Mansbridge, 1999; Ulsaner, 2001). Based on a belief in the goodwill of others, in this form of trust "one trusts the other more than is warranted, as a gift, for the good of both the other and the community" (Mansbridge, 1999, p. 290). Such trust cannot be conceptualised as a variable level; there can only be trust or dis-trust (Ulsaner, 2001). The value of this form of trust is, moreover, both intrinsic and instrumental as "altruistic trust expresses respect for others, catalyses cooperation, and creates even more altruistic trust through modelling behaviour to others" (Mansbridge, 1999, p. 295).

There are a further two contrasting views concerning the basis of strategic trust. Rooted in traditional economic and rational choice theory, one perspective sees trust essentially as a *calculation* that the other person's future actions will be beneficial rather than harmful, and that the benefits of the cooperation resulting from trusting will outweigh the risks and costs involved (Creed & Miles, 1996; Hindmoor, 1998; Warren, 1999a). Such behaviour is rooted in the rational gamble that, given the circumstances facing the other, she will serve my interests rather than her own and will refrain from harming me despite the vulnerability I expose as a result of trusting (Jacobsen, 1999; Moore, 1999; Offe, 1999; Zaheer, McEvily, & Perrone, 1998). As Hardin (1999, p. 26) explains, "…to say that I trust you means I have reason to expect you to act, for your own reasons, as my agent with respect to the relevant matter". In this conception, trust is, therefore, a *cognitive* phenomenon, rooted in judgements about the circumstances surrounding the trust relation (Warren, 1999b).

Williamson (1993, 1996; see also Coulson, 1998b; Lane, 1998), an economist, even argues that as most of what is called trust is based on calculation, it is a form of risk analysis. However, our common experiences of trusting indicate that it involves more than calculation. Giddens (1990), for example, suggests that trust is more a form of faith, an expression of a commitment to something that goes beyond cognitive understanding. Sociologists and psychologists point, therefore, to the *affective* basis of strategic trust. Rather than calculation, the grounds of affective trust include the emotional bonds and obligations generated through repeated interaction, empathy and identification with the other's desires or intentions, or the desire to treat the other as I would wish to be treated myself (Lewicki & Bunker, 1996; Kramer, Brewer, & Hanna, 1996; Newman, 1998; Misztal, 1996; Warren, 1999b).

Altruistic trust, similarly, has emotional rather than calculative roots, derived from the belief that most people share your fundamental moral values (Mansbridge, 1999; Ulsaner, 2001). The altruistic notion also deems trusting behaviour as morally worthy behaviour. In contrast, although the rational choice perspective allows that the decision to trust may be an altruistic or moral choice, it does not judge that trust itself has any moral worth (Hardin, 1999). Some analysts (e.g. Levi, 1998) even argue that it is incorrect to consider trust as a moral virtue because it can produce harmful outcomes for the beneficiary or society (see Section The benefits and dangers of trusting behaviour). Others emphasise that altruistic trust is only morally praiseworthy when it is used for morally praiseworthy ends (Mansbridge, 1999).

Yet despite the diversity of views on trust, there is widespread agreement that, in practice, different forms of trust exist side by side. Our common experiences suggest that the motivations for trust generally include some combination of strong personal bonds and the belief that it enhances our own interests. The extent of calculation involved in trusting also varies with our expectations of others as well as with the nature of our relationship and the types of obligations inherent in them (Lane, 1998). Some people are just more calculative in their approach to relationships; other people are more likely to trust almost instinctively. The extent of calculation may, finally, vary between stages in a relationship, as learning is important to the development of trust. Lewicki and Bunker (1996), for example, suggest that trust can evolve through three levels: *calculus-based* trust; *knowledge-based* trust and *identification-based* trust (see Table 2). Even where trust was initially extended through a rational gamble, common values and norms of obligation may develop over time. These generate affective trust and allow identification with the other, in turn laying the grounds for altruistic trust to emerge (Lane, 1998). Trust is "a rational gamble that cooperation with others will ultimately pay off, as well as a commitment to 'prosocial behaviour' even if others do not always reciprocate" (Ulsaner, 1999b, p. 123).

Impersonal trust

Beyond the bounds of a relationship between two individuals known to each other, there are two main

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Table 2
Key dimensions of trust debates

	Forms of trust		
	Calculus-based	Knowledge-based	Identification-based
1. Inter-personal trust	*Cognitive trust*	⟨⟨⟨ ⟩⟩⟩	*Affective/altruistic trust*
Meaning	Calculation that the other will act in your interests (rational gamble)	Judgement/prediction that the other will act in your interest	Instinctive behaviour involving belief the other will act in your interests or at least not harm you
Bases	Assessment that the other's interests are best-served by co-operating with you and that deterrents exist to prevent them abusing your vulnerability in trusting	Past experience of each other and of interaction with each other generates expectation of trusting behaviour or knowledge that trustor will use available deterrents if trust abused	Emotional ties; shared values and identity; altruism
2. Impersonal trust	*Strangers*	⟨⟨⟨ ⟩⟩⟩	*System and generalised trust*
Bases	Information, mediator, reputation, shared norms, institutions		Institutions, societal norms provide context of shared values and basis for shared identity; altruism
3. Dangers	*Exploitation; corruption*	⟨⟨⟨ ⟩⟩⟩	*Particularised trust*
Bases	Abuse of power		Belonging to group that sets itself in opposition to other groups

forms of impersonal trust: trust in strangers and trust in social systems. What are the bases of these forms of trust?

Cognitive trust can be extended to strangers when you, as the trustor, have adequate information with which to judge that the trustee is likely to take account of your interests (Warren, 1999b, 2001). Such information may come from those known to you, who vouch for the stranger, or from the stranger's reputation, or from the shared norms that come from your both belonging to the same group or community (such as a church, ethnic group or nationality). Trust in strangers may, finally, be rooted in institutions that lower the risks you face in trusting them, and so allow *delegated* (Patterson, 1999) or *fiduciary* (Thomas, 1998) trust to develop. These institutions provide the basis for judging whether the agents associated with them share your interests or at least lack malice towards you (Warren, 1999b). They include monitoring and disciplinary procedures that promote consistent behaviour among trustees (Warren, 2001), as well as the faceless commitments (Giddens, 1990) embodied in expert systems (such as technical and professional knowledge, backed by relevant institutional arrangements including licensing those receiving the training and ethical codes). Such institutions enable us to trust the employees of organisations even when we have never had contact with them or share no relevant communal allegiance (Newman, 1998; Offe, 1999; Patterson, 1999). As patients, they provide the basis for our judgement that health care providers will act in our best interests.

Institution-based trust is a specific response to the complexity of modern societies, involving a large number of interdependent transactions between social groups and across large space and time distances (Giddens, 1990; Zucker, 1986). Institutions, therefore, act not only as a guarantor of inter-personal trust but also as the foundation of trust as a property of the overall social system, playing a critical role in the preservation of social order (Coulson, 1998b; Misztal, 1996; Offe, 1999).

At a personal level, affective or altruistic trust may be extended to strangers where shared norms provide the basis for a sense of shared identity between people and a belief in the goodwill of others. Where the social norms underlying these forms of trust are built into the institutions supporting societal exchange, these institutions may, moreover, promote *generalised trust* in other citizens of that society based on the belief that they will act in our collective interests (Hall, 1999; Offe, 1999; Patterson, 1999; Thomas, 1998; Ulsaner, 1999a, b). The relevant norms reflect the expectations of individual behaviour that underpin inter-personal trust (Section Voluntary trust and dependency). They include

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truthfulness, attitudes of solidarity, a belief in fairness and spontaneous altruism (Offe, 1999; Mansbridge, 1999; Ulsaner, 2001; Uphoff & Wijayaratna, 2000; Warren, 2001). Social and political institutions embodying these norms promote affective trust in societies by committing and enforcing upon all those involved in them a specific set of values (Kramer, 1999; Offe, 1999), establishing a moral community whom you can trust (Ulsaner, 2001). However, to achieve these ends the norms must have sufficient persuasive power and recognised moral value to motivate all to act accordingly, and must be backed up by the capacity to enforce them when they are ignored (Offe, 1999). Institutions, therefore, have different levels of trustworthiness (Levi, 1998; Offe, 1999) and levels of trust vary between societies (Rothstein, 2000). Nonetheless, "trust cannot be fully understood and studied without the examination of institutions as repositories of values and without addressing a practical issue of how far human beings' concepts of duties and obligations are influenced by the societal institutions which organise the ways in which people are bound together" (Misztal, 1996, p. 25).

Giddens (1990), however, emphasises that the micro- and macro-levels of trust are inter-connected. Facework commitments, that is, the trust relations built through inter-personal interactions, are critical in sustaining system-level trust rooted in faceless commitments (see also Harre, 1999; Newman, 1998; Offe, 1999). Individuals act as the access points of social expert systems representing and constantly reaffirming the systems' trustworthiness (Bachmann, 1998). Therefore, whilst the institutions inherent within health systems underpin our trust in individual health care providers, positive interactions with these providers re-inforce our trust in the expert system of medical knowledge (Misztal, 1996).

The benefits and dangers of trusting behaviour

Trust offers both micro-level benefits for the parties involved in a relationship, and macro-level benefits for the wider society. Both are rooted in the cooperation between people (known to each other and/or between strangers) that is catalysed, facilitated and sustained by trust. Trust breaks down the barriers that prevent or constrain cooperative behaviour.

At a micro-level, trust benefits people by establishing stable relationships; indeed, without trust successful relationships are almost impossible (Coulson, 1998b). From the calculative perspective, for example, it allows cooperation to develop by reducing the need to monitor performance (Coulson, 1998b; Goddard & Mannion, 1998; Kramer, 1999; Gregory, 1999; Moore, 1999; Taylor-Gooby, 1999; Offe, 1999); and so also reduces the transaction costs associated with relationships in conditions of uncertainty (Coulson, 1998b; Offe, 1999; Moore, 1999; Taylor-Gooby, 1999).

The macro-level benefits of calculative trust, therefore, include the overall efficiency gains resulting from reduced monitoring of transactions. In addition, at a macro-level, generalised (affective) trust may promote broader re-distributive action and solidarity (Rothstein, 1998), spontaneous sociability (Kramer, 1999), a tolerant society and vibrant social community (Ulsaner, 1999b), and even a morally worthy unity within society (Weinstock, 1999). In effect, by institutionalising trust towards fellow citizens within social and political structures, such as health systems, generalised trust becomes the basis for a well-ordered society (Misztal, 1996).

Incorporating institutions that promote trust within the public organisations that act as the state's implementing agents has the further benefit of providing the basis for the legitimate exercise of state authority (Levi, 1998; Newman, 1998; Rothstein, 1998; Offe, 1999). Such authority is, in turn, required to maintain social order in contexts of complexity and uncertainty (Misztal, 1996). The notion of legitimacy refers to whether or not governments are seen by their citizens as entitled to be obeyed (Robertson, 1985). The effective implementation of any public policy requires that state action be seen as legitimate—and so, be accepted and acceptable. Such legitimacy is reflected in the extent to which citizens tolerate the interventions of public organisations, accept these organisations' decisions when they are aimed at influencing citizen behaviour and co-operate with the organisations to achieve their goals (Rothstein, 1998). The peculiar nature of health care, as a set of interventions requiring behavioural change but often rooted in uncertain knowledge about what works, means that legitimacy is particularly important to health policy implementation. Public organisations build their legitimacy when they demonstrate through organisational and managerial practices values and norms that underlie or are associated with trust (Gregory, 1995; Levi, 1998).

However, trusting behaviour may also have dangers. At the micro-level, trust may allow corrupt behaviour when the parties involved in the relationship gain at the expense of those outside it (Warren, 2001). In addition, because every trusting relation sets up a potential power relation between the trusted, the trustor and a valued good (Warren, 1999b), trust may allow exploitation. The trustor may be forced to act in the interests of the trustee (and against their own interests) because the trustee holds some resources that the trustor wants. Trust rooted in affective origins, specifically shared identities, may allow the trustor to become prey to these dangers by encouraging her to trust too easily (Kramer et al., 1996).

Where impersonal trust is rooted in the shared social norms of a group that defines itself as in opposition to other groups, there are also likely to be macro-level

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dangers (Warren, 2001). The *particularised trust* of these groups is trust only of your own kind (Patterson, 1999). It may allow subcultures to be formed, such as criminal gangs, with goals that are opposed to the broader public interest, or provide the grounds for corruption or promote conflictual action between groups (Warren, 2001). Such trust clearly brings limited benefits to the wider community and may even initiate a vicious cycle of dis-trust leading people to withdraw from civil life (Ulsaner, 1999b).

A final danger of trust is that as it is unequally distributed within societies, its benefits are likely also to be unequally distributed. It is easier for those who already have power (Coulson, 1998b; Offe, 1999), and who are the beneficiaries of the existing social, economic and political system (Evans, 1996; Foley & Edwards, 1999; Hall, 1999; Patterson, 1999), to trust, than those who have fewer resources. This may be because prosperity makes people optimistic and breeds trust, whilst poorer and less powerful groups have a less positive world view (Ulsaner, 1999b, 2001). Poorer people are also less likely to gamble on inter-personal trust because the consequences of mis-placed trust under conditions of extreme poverty may be fatal (Inglehart, 1999). The policy challenge, however, is to enable the poor and more vulnerable groups to trust—because without trust they are likely to perpetuate their own poverty by investing in other forms of social control (Offe, 1999).

What is the importance of trust to health systems?

The role of trust in key health system relationships

The production of health and health care requires co-production (Alford, 1993; Cahn, 1997) between patient and provider and co-operation among health system agents. Can trust facilitate these different levels of co-operation? To answer this question it is important to think through the role that inter-personal trust plays within any health system, as well as the way that inter-personal trust is shaped by the broader institutional setting. In both cases the expectations that underpin trusting behaviour are critical considerations.

At the heart of health care provision is the patient/provider interaction. The effective delivery of health care requires not only the supply of care but also the acceptance and use of services by the patient. The patient plays a critical role in effective medical therapy and in the behavioural change necessary to prevent health problems and promote healthful behaviour (Mechanic, 1998; Perry et al., 1999). A trusting relationship between provider and patient can have a direct therapeutic effect (Mechanic, 1998). It also heightens the quality of their interaction, facilitates disclosure by the patient, enables the provider to encourage necessary behavioural changes and may permit the patient greater autonomy in decision-making about treatment (Mechanic, 1996, 1998). A trusting patient/provider relationship is rooted in specific expectations and personal behaviours (Sections Voluntary trust and dependency and Forms of voluntary trust). However, the importance of trust within this relationship will vary in relation to the perceived risks associated with the illness, the degree of patient discretion in utilisation and differences in patient circumstances such as their education, sophistication and access to information (Mechanic, 1998; Mechanic & Meyer, 2000). Trust in providers may matter less to patients with lower risks, such as those with acute illnesses requiring only primary care who can shop around for services, and more educated and assertive patients. It may matter more to vulnerable patients with higher risks—be they less educated or having chronic or catastrophic illnesses. Nevertheless, some form of trust is always important in providing a context in which providers and patients can work co-operatively to establish care objectives and seek reasonable ways of achieving them (Mechanic, 1996; Perry et al., 1999).

The patient/provider relationship is, however, also shaped by the institutions embedded within the health system. Where these are seen to support provider behaviour that takes the patient's interests into account they are likely to underpin trust in the provider (Section Impersonal trust). Professional and ethical codes are, therefore, clearly important, together with training systems and procedures for licensing the graduates of these systems.

Funding arrangements within the health system also influence trust between patient and provider. At one level, funding mechanisms introduce incentives that directly support or undermine the fiduciary relationship between provider and patient. The non-exploitative ethos of the UK's National Health Service resulting from the lack of overt financial incentives affecting provider behaviour was one of the founding bases of its perceived fairness and so of trust in the providers working within it (Whitehead, 1993). In contrast, Mechanic (1996) has argued that managed health care initiatives in the USA generate dis-trust because they are perceived to create financial incentives for the doctor to act against the patient's interest (e.g. reducing time spent with patients or discouraging certain forms of treatment, although empirical evidence suggests otherwise: Mechanic, 2001). At a second level, funding and resource allocation mechanisms may also demonstrate norms or values, such as solidarity, fairness and procedural justice (Brockner & Siegel, 1996; Levi, 1998; Offe, 1999; Rothstein, 1998), that promote trust in the system within which providers are located, with positive spin-offs for trust in the providers themselves. Such

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mechanisms include risk-pooling, selection on the basis of need rather than ability to pay, and resource allocation mechanisms that weight need differentially in response to community-based preferences (Gilson, 2000; Mooney, 1996; Whitehead, 1993).

Birungi (1998) provides a detailed analysis of the mutually reinforcing breakdown of inter-personal and system level trust within the Ugandan health system over the 1970s and 1980s. Political and economic crises undermined the government health system. Under-funding and societal change led to unprofessional practices, falling health worker morale, and a proliferation of formal and informal private health facilities. The resulting dis-trust of immunisation services provided through government facilities was rooted in patients' concern for their own safety. It led people to own their own syringes; then they could either opt to be given an injection by a friend or relative, or insist on their own equipment being used when attending a government health facility. Popular dis-trust in the systems of health care provision and funding, thus, influenced trust in individual providers as well as personal health practices.

Another aspect of the organisational environment that influences trust between patient and provider is the set of relationships between the networks of organisations that comprise the health system. One network is the range of public organisations that together support the delivery of government services (including both different health care facilities and organisations in different sectors of government). A second network spans the public and private health care sectors, comprising all providers as well as financing intermediaries and other resource generators. Trust is linked to these relationships in two ways. At one level, trust may enable these networks to function effectively. Experience of using contracts to manage network relationships has highlighted the significant ex ante and ex post transactions costs they entail and the resulting capacity needs (Bennett, McPake, & Mills, 1997; Mills, Bennett, & Russell, 2001). In contrast, trust can encourage communication and information flows (Jacobsen, 1999; Mechanic, 1998; Tyler & Kramer, 1996; Veenstra & Lomas, 1999), reduce the complexities associated with managing multiple agents (Coulson, 1998b; Gregory, 1999; Goddard & Mannion, 1998; Kramer, 1999; Mechanic, 1996; Moore, 1999; Offe, 1999; Taylor-Gooby, 1999) and so, as already noted, reduce the transaction costs associated with contracting (Newman, 1998; Moore, 1999). The trust established between organisations with shared values, such as public and not-for-profit health providers, may, therefore, provide the basis for their co-operation to achieve common goals (Gilson et al., 1997). At a second level, the effectiveness of these networks can directly influence patient trust in providers by shaping the technical competence and fairness of providers (key patient expectations of providers). The way the networks function determines not only whether individual providers have the range of resources necessary to provide care, such as drugs, equipment and access to referral services, but also the way they provide care, the range of services they offer and the people they seek to serve.

Provider attitudes and practices towards patients are, moreover, strongly shaped by their own relationships with their managers and by the management practices of their organisations. The application of new public management (NPM) approaches to welfare and health systems has, therefore, been criticised for endangering the trust and long-term co-operation between client/patient and provider critical to the effective delivery of health and welfare services, by replacing high trust relationships between employees and managers with low trust ones (Gregory, 1999; Le Grand, 1999, 2000; Mackintosh, 1997; Segall, 2000). Low-trust management practices are rooted in measurement and performance monitoring and leave little room for professional discretion (Hunter, 1996). In contrast, high-trust management practices permit the client-centred and problem-solving approaches to service delivery (Tendler, 1997; Perry et al., 1999) that support the development of a trusting relationship between patient and provider. High-trust management practices are participatory, demonstrate procedural fairness and encourage employees to share the goals of the organisation and co-operate in achieving them (Brockner & Siegel, 1996; Tendler, 1997; Rothstein, 1998).

In any system, providers may also demonstrate different levels of trust towards different groups of patients through their behaviours and practices. In the UK particular groups of welfare service users (such as single parents, promiscuous teenagers, welfare scroungers, etc.) have often been singled out as undeserving (Newman, 1998; Taylor, 1998; Williams, 1999). Although rarely investigated in low and middle income countries, similar views have also been identified within the attitudes of South African health care providers. A range of studies have confirmed that many public health care providers state that they do not trust their patients because they believe that patients use services inappropriately and incorrectly, and that some patient groups are particularly undeserving, such as teenage mothers, teenage girls using family planning services or foreigners (Jewkes, Abrahams, & Mvo, 1998; Oskowitz, Schneider, & Hlatshwayo, 1997). The stated lack of trust leads providers to adopt harsh and uncaring attitudes towards particular patient groups that are demeaning and undermine the quality of patient interactions with the health system. Such attitudes may only be strengthened when they are translated into the formal practices of welfare systems. For example, where targeted programmes allocate resources to particular groups because they are seen as needy, this may stamp the groups as

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socially inferior and result in stigmatisation (Cox, 1998; Rothstein, 1998).

The assumptions underlying attitudes and practices within any welfare system can be seen to reflect the settlement on which it was founded, that is the macro-level relationship established between it and broader societal values through the incorporation of these values into the arrangements and practices of the system. This settlement sets "…the limits within which compromises over what and how, and by whom and for whom, welfare services and benefits are delivered … Some groups either have their welfare needs ignored by state-organised institutions or have them met to some extent but in a stigmatised or residual way. There is thus a hierarchy of inclusions in the welfare state" (Hughes, 1998, p. 4; see also Mackintosh, 2000). Although the settlement literature speaks particularly to the experience of the UK welfare state, it reflects how state–society relations are expressed through any health and welfare system. The general lack of entitlement to state social protection in African societies has, for example, been traced back to the colonial period when white colonial rulers had rights of citizenship and Africans were simply subjects. This has been translated in current times to the division between the citizens employed in the formal sector and receiving social protection, and the (often rural) subjects who largely have only informal livelihoods and limited access to social provisioning (Mamdani 1996, cited in Norton, Conway, & Foster, 2001; see also Macpherson, 1997).

The prevailing settlement underlying a welfare system, however, interacts with, and is shaped by, the changing value base of society. The deliberate efforts made to expand the rural health care networks after independence in Mozambique and Tanzania, for example, reflected the new understandings of social justice and re-distribution applied to health system design by new political leaders (Mackintosh, 2000). Similarly, in South Africa, the post-apartheid moves towards establishing a human rights culture are embodied not only in a Bill of Rights but also in health policies such as building clinics in rural areas, the removal of fees for primary health care services and the provision of abortion services (Gilson et al., 1999). Changing societal values are reflected in health system changes that, in turn, shape the patient/provider relationship by encouraging different expectations of, and attitudes, towards each other.

Health systems as part of the social fabric

At one level, therefore, trust is important to health systems because it underpins the co-operation throughout the system that is required for health production. But trust-based health systems also offer more to society. Rather than simply being shaped by the changing basis of societal values, a trusting and trusted health system can contribute to building wider social value and social order.

This argument is based in the understanding that health systems are part of the social fabric of every country. They are not only producers of health or health care but they are also the purveyors of a wider set of societal values and norms (Alford, 1993; Loewy, 1998; Mooney, 1998). Although patients may be primarily concerned with getting well by getting good heath care for themselves, citizens may be equally or more interested in the role of health systems in allowing the attainment of other goals. At an individual level, these might include sharing information, allowing autonomy in patient decision-making and/or being treated respectfully (Mooney, 1998). At a societal level, they might include a decent society (Bevan in Foot, 1975) or altruism (Titmuss, 1970). As Rothstein (1998, 2000) suggests, people value health and welfare systems both because they satisfy their own interests through them and because such systems allow them to contribute to the social good.

The health system's contribution to the construction of broader social value and, specifically, trust, flows directly from the interaction between citizen (not patient) and health system. Four bodies of conceptual thinking together suggest that (i) the design of any decision-making situation itself shapes patterns of behaviour towards others: it can promote trusting or self-interested behaviour; (ii) the extent to which individuals are actively involved in decision-making influences the degree to which their need for self-esteem is met; and (iii) greater self-esteem is empowering and so provides opportunities to build trust by enabling participation in decision-making and developing a sense of personal moral worth.

First, the philosopher Jurgen Habermas suggests that when people engage in face–face dialogue as they argue the case for particular courses of action, they are more likely to take the interests of others into account and so to generate collective solutions, than when decisions are made in isolation from other citizens (Ranson & Stewart, 1998; Warren, 1999b; see also Rothstein, 1998). If undertaken freely and openly, the process of communication and dialogue with others requires us to confront the mis-matches between our own beliefs and those of others, enabling self-reflection and learning. Such discourse can not only encourage mutual respect, but also generate the mechanisms, such as shared understandings, persuasion, promises, that align self-interest with the collective interest and so build trust (Kaufman, 1997; Ranson & Stewart, 1998; Warren, 1999b). "Our active participation in creating projects which are to shape our selves as well as the communities in which we live provides the sense of purpose to work together with others and to secure trusting relations with them" (Ranson & Stewart, 1998, p. 250).

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Second, using wide-ranging empirical and experimental data concerning the motivations, rules and institutions underlying collective action within groups, the political scientist Elinor Ostrom has provided evidence that some people are natural co-operators, driven by norms of reciprocity, fairness, and trustworthiness (intrinsic motivations), rather than acting only as selfish agents (e.g. Ostrom, 1990, 1997). Like Habermas, Ostrom argues that the design of decision-making situations itself influences how people conceive their self-interest, and so shapes their behaviour towards others (Rothstein, 1998). External interventions in communities, such as the establishment of new health facilities, can therefore, support or undermine behaviour governed by intrinsic motivations by the way they influence the design and manner of decision-making. Intrinsic motivations are particularly diminished when individuals feel that external interventions undermine their own self-determination or self-esteem. But such interventions can build intrinsic motivations such as trust when they are perceived to be supportive, fostering self-esteem and enlarging self-determination by giving individuals freedom to act (Ostrom, 2000).

The third body of work looks specifically at the ways in which individuals' interactions with welfare systems, such as health care, allows needs for self-esteem to be met (or prevents them from being met). Writers of the UK's new politics of welfare (NPW) school argue that welfare systems and practices must recognise individual autonomy and agency by allowing individuals to play an active role in their care and to be held responsible for their own choices (Deacon & Mann, 1999; Hughes & Lewis, 1998; Williams, 1999). They stress that it is through the exercise of such agency that individuals develop a sense of their own identity and moral worth. Welfare systems must be understood "not only as the institutionalisation of social rights but as part of the 'networks and communities of value' which we inhabit, through which some of our needs for 'due recognition' might be met" (Williams, 1999, p. 675; see also Taylor, 1998). They suggest, therefore, that the democratisation of the user/provider relationship is critical in enabling the experience of welfare users and their own definition of their needs to become central to the organisation of welfare services. Because of the different needs of different identity groups (such as those characterised by their race, gender or disability), such a process would have to allow for diversity and could incorporate the reflective debate between groups seen by Habermas and Ostrom as a foundation for building trust.

Although the concerns of the NPW literature may seem of little relevance to countries with fundamentally unequal economic structures, they have clear echoes in the fourth set of (development) literature about the multi-faceted nature of well-being and social exclusion. Sen (1992), for example, suggests that well-being consists of a set of valuable functionings that include being adequately fed and sheltered, as well as social achievements such as taking part in the life of the community. More recent thinking moves beyond Sen in emphasising the role of social institutions within well-being and the importance of agency in making and unmaking institutions (Jackson, 1999; Macpherson, 1997). These analyses suggest that "disadvantage results in social exclusion when the various institutional mechanisms through which resources are allocated and value is assigned operate in such a way as to systematically deny particular groups of people the resources and recognition which would allow them to participate fully in society" (Kabeer, 2000, p. 86). Emerging understandings of rural livelihoods, therefore, include cultural capital, that is cultural practices valued for their meaningfulness, that foster "certain forms of identity maintenance and patterns of interaction", and so "enable, inspire and indeed empower" (Bebbington, 1999, p. 2034). Overall, this literature suggests that both the relational and the distributional aspects of exclusion are important to countries at all levels of economic development (Bhalla & Lapeyre, 1997). There is, therefore, renewed interest in developing mechanisms for participation in social and health policy that allow 'users and choosers' to become 'makers and shapers' (Cornwall & Gaventa, 2000; Hyde, 1999).

Together these arguments point to the ways in which, throughout any health system, the design of key decision-making processes (such as the patient/provider interaction, resource allocation mechanism and the mechanisms for dialogue and consultation with citizens) influences the extent to which the system provides the basis for trust-building. "The design given to political institutions such as health systems governs the notions of morality and justice prevailing in society" (Rothstein, 1998, p. 160; see also Mackintosh, 2000).

Where decision-making approaches allow engagement and dialogue with citizens they are more likely to build trust. However, decision-making mechanisms will only build trust among all groups of the population if they are developed in recognition of the particular constraints on trusting experienced by poor and vulnerable groups. They also need to incorporate the values and institutions that themselves promote trust—such as openness, solidarity, fairness, truth-telling (Section Impersonal trust). For example, one such value, procedural justice, is reflected in decision-making situations characterised both by specific interpersonal behaviours (reasons for decision clearly and adequately explained; implementers treat those affected by decisions with dignity and respect), and by the structure of the decision process (procedures implemented on a consistent basis) (Brockner & Siegel, 1996). Birungi (1998), therefore, suggests that the first step in re-building trust in the provision of injections by the Ugandan public health system would

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be to sterilise immunisation equipment in the presence of community representatives. This would not only both prove that the equipment was safe but would demonstrate a commitment to the values underlying trust—such as telling the truth about whether or not sterilisation has occurred.

Conclusions

Overall, this paper argues that trust matters to health systems and trust-based health systems matter to society. People value health systems not only for the care they themselves receive in times of sickness but also for the contribution the systems make to the broader well-being of society. From this argument the paper also offers five specific pointers for health systems and policy analysis.

First, health systems comprise a complex web of relationships whose overall functioning and performance is influenced by the institutions, particularly trust, that govern human behaviour. Yet many recent health reforms are apparently underpinned by an understanding of the health system that "… seems oddly 'transparent': a set of rules and formal organisations that can be re-written, reorganised, and redirected, given the political will" (Mackintosh, 2000, p. 176). Future analysis and policy development must recognise that health systems are complex socio-political institutions and not merely delivery points for bio-medical interventions.

Second, because of this complexity it is particularly important to develop the legitimacy of state action within health systems. The state plays the central role in all health systems regardless of funding arrangements or configuration of provider networks (Frenk, 1994), but it can only function effectively if its actions are seen as legitimate. At one level, such legitimacy is important in persuading patients to co-operate with providers in co-producing health—for example, accepting new health care interventions (drugs, vaccinations) delivered through the health system. At another level, such legitimacy provides the foundation for the co-ordination among relatively autonomous (public and private) health care providers and regulation of their dealings with citizens that is necessary to benefit and protect citizens (Offe, 1999; Rothstein, 1998).

Third, to establish the legitimacy of state action it is necessary to build trust in the state and its agencies. Recognising that trust cannot be taken for granted but has to be actively produced and negotiated (Benington, 1998; Giddens, 1990; Taylor-Gooby, 1999), the analysis of this paper, summarised in Fig. 1, suggests that building trust within health systems requires:

- personal behaviours, particularly between patients and providers but also between employer and employees, among managers and between public and private sector agents, that build inter-personal trust;
- managerial and organisational practices that, by providing spaces for caring, engagement and open dialogue, provide opportunities for inter-personal interactions that support the building of trust;
- political processes that support the development of these managerial and organisational practices, protecting the poorest and least powerful groups and managing the relationship of the health system to prevailing and changing social norms.

Fourth, building legitimacy also requires consideration of the interactions between fairness, trust and legitimacy. Rothstein (1998) suggests that the legitimacy of a public policy or intervention rests on its being seen as generally fair, funded through a fair level of contribution levied on everyone and implemented in a fair manner. But what sort of fairness builds legitimacy? Levi (1998) argues that impartiality is central to the belief in government fairness: in other words, the process of decision-making must be understood as fair. Brockner and Siegel (1996), moreover, specifically suggest that the degree of trust engendered by procedural fairness influences the extent to which needs for self-esteem are satisfied, and so determines people's reaction to decisions. Where trust and fairness are found, people judge that their future relationship with the decision-making authority will be self-enhancing and so accept its decisions with little consideration of the distributional outcome. But both Levi and Brockner and Siegel argue that when procedures are seen as unfair, people's reactions to a decision are more linked to its distributive outcomes.

Fifth, as trust and legitimacy are, therefore, likely to be rooted as much in fair processes as in material redistribution, equity goals for health systems must take procedural justice seriously (Gilson, 2000; Mooney, 1996; Mooney & Jan, 1997). For example, although such goals generally emphasise equal geographical and financial access for all, more consideration needs to be given to ensuring equal cultural access for all groups. Williams specifically suggests that universalism should be seen not solely as a matter of re-distributive strategies which seek to bring about equality in material resources between social groups, but also as "the commitment to the equal moral value of all and inclusion of all" (Williams, 1999, p.684). Similarly, Fraser (1997) proposes a distinction between affirmative and transformative remedies for injustice. Affirmative remedies aim to correct the inequitable outcomes of existing social arrangements without disturbing the unequal structures of power and resources that generate them. In contrast, transformative remedies aim to shake up those structures by challenging existing group identities and

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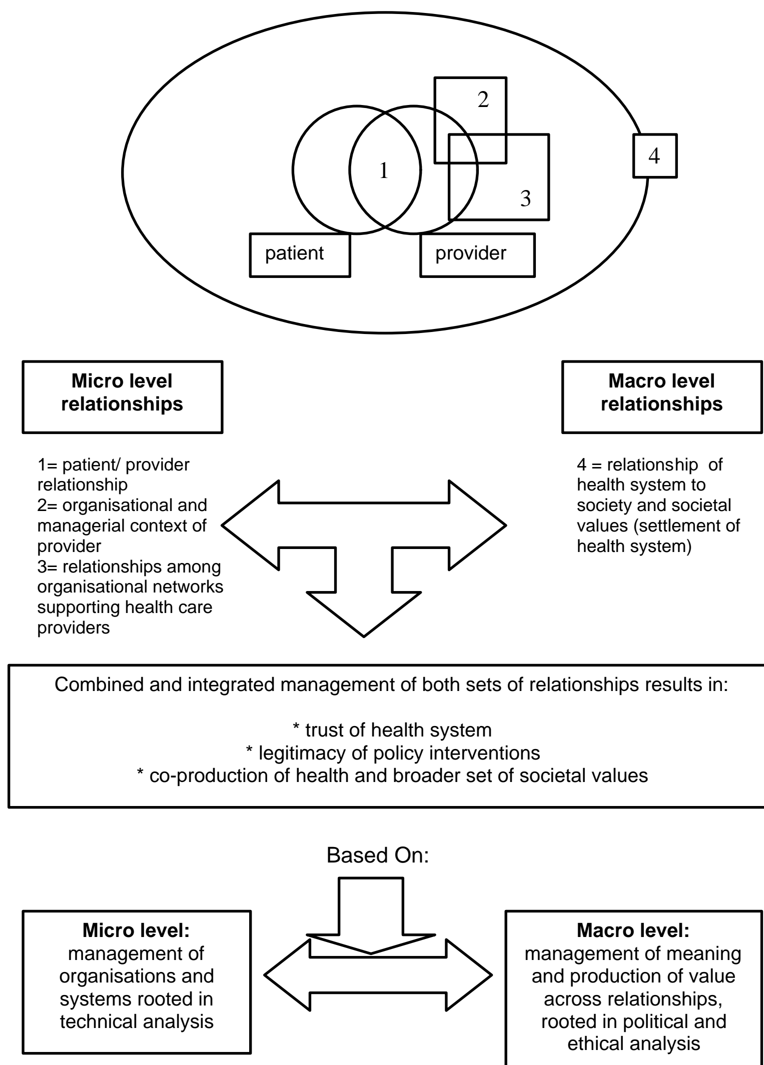

Fig. 1. Managing health system relationships to build trust.

differences in order to raise the self-esteem of currently devalued groups and change everyone's sense of self. Mechanisms of dialogue, consultation and participation are critical to the implementation of transformative remedies.

Such remedies must, nonetheless, be built in recognition of wider societal inequalities. As these inequalities often limit the ability of the poor and vulnerable to trust, exercise agency or manage to desire, specific consideration must be given to how to support this group to engage in newly established decision-making mechanisms (Section The benefits and dangers of trusting behaviour; Hoggett, 2001; Mooney & Jan, 1997). Some argue, for example, that ensuring state funding for even a minimum package of essential health services, and widely publicising this commitment, might provide the basis for transformational engagement with the health system by, and on behalf, of poorer groups (Bloom, 2001; Loewenson, 1999; Mackintosh, 2000). Basic distributional commitments may, therefore, provide the basis for the political action necessary to secure wider participation in decision-making, which may in turn enable wider re-distributive action.

Ultimately, this paper suggests that the state should not, as is common in health policy discussions, be seen as just a provider, funder, manager or regulator of health services. Rather, in relation to health care, its central role is to manage the processes through which the meaning of the health system to society, and so its contribution to broader societal value, is established (Fig. 1). The paper also suggests that a central challenge for health systems, as with the wider public domain, is

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"to renew the purposes and institutions of democracy which allow citizens to participate in the creation of a society, enabling each to develop as a person but also to contribute to the good of the community as a whole" (Ranson & Stewart, 1998, p. 257; see also Evans, 1996; Ulsaner, 2001). The demands of transformational justice specifically require that this renewal provides opportunities for all groups, especially the poor and vulnerable, to build self-esteem, and so challenges existing inequalities.

Acknowledgements

I am most grateful for the support of a group of friends and colleagues who have thought with me about trust, as well as read and commented on this paper. They cannot, however, be held responsible for the final product. Thanks to Duane Blaauw, Annabel Bowden, Jane Goudge, Anne Mills, Gavin Mooney, Helen Schneider, Liz Walker, and Gill Walt. Lucy Gilson is a part-time member of the Health Economics and Financing Programme at the London School of Hygiene and Tropical Medicine, which receives funding from the UK's Department for International Development.

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