Trust in health care: theoretical perspectives and research needs

Lucy Gilson
Centre for Health Policy, University of Witwatersrand, Johannesburg, South Africa

Abstract

Purpose – This paper presents some key theoretical issues about trust, and seeks to demonstrate their relevance to understanding of, and research on, health systems. Although drawing particularly on empirical evidence from low- and middle-income countries (LMICs), the paper aims to stimulate thinking across country settings.

Design/methodology/approach – Drawing both on conceptual literature and relevant empirical research from LMICs, the paper presents an argument about the role of trust within key health system relationships and identifies future research needs.

Findings – Theoretical perspectives on four questions are first discussed: what is trust and can it be constructed? Why does it matter to health systems? On what is it based? What are the dangers of trust? The relevance of these theoretical perspectives is then considered in relation to: understanding the nature of health systems; issues of equity and justice in health care; and policy and managerial priorities. The identified research needs are investigation of: the role of trusting workplace relationships as a source of non-financial incentives; the influence of trust over the operation of different forms of citizen-health system engagement; approaches to training trustworthy public managers; and the institutional developments required to sustain trustworthy behaviour within health systems.

Practical implications – The policy and management actions needed to strengthen health systems within LMICs, and elsewhere, include: recruitment of health workers that have the attitudes and capacity for moral understanding and motivation; training curriculae that develop such motivation; and developing the institutions (e.g. communication and decision-making practices, payment mechanisms) that can sustain trusting relationships across a health system. It is also important to recognise that distrust in some relationships may act to guard against the abuse of power.

Originality/value – Although the notion of trust has become of increasing importance in health policy debates in high-income countries, it has received less attention in the context of LMICs. The papers adds to the very limited literature on trust in LMIC health systems and also opens new lines of thinking for those working in high income countries – particularly around the role of health systems in generating wider social value.

Keywords Trust, Motivation (psychology), Management accountability

Paper type General review

Introduction

The aim of this paper is to generate discussion about the critical theoretical perspectives that shape work on trust and health care, and related research needs. The paper is framed by two main perspectives.

First, a concern for the particular experience of low- and middle-income countries (LMICs). Although trust is relevant across contexts, the role of trusting relationships within LMIC health systems has, as yet, been little considered.

Second, an overarching concern for how health systems work and how to strengthen them in delivering good quality and respectful care, particularly to

Journal of Health Organization and Management
Vol. 20 No. 5, 2006
pp. 359-375

1477-7266
DOI 10.1108/14777260610701768

marginalised groups. The general relevance of trust to these issues is that when people talk about their experience of and within health systems they often think about trust. Too often, therefore, poor patients experience failures of trust in relation to health care, and these failures are part of their lived experience of poverty. This is reflected, for example, in patient and community interviews conducted in Tanzania (Tibandebage and Mackintosh, 2005):

> A patient relies on the nurse's love and trustworthiness. S/he puts him/herself in the nurse's hands for help.
>
> If you are not known [by staff in the health facility] you are treated with contempt.
>
> If you have no money, nobody cares for you and you may die.
>
> Some of the staff are not trustworthy. For example, they may inject a patient with water instead of chloroquine.

At the same time, health workers' own experiences of a break-down in trust between themselves, their managers and their employer, may lead them to project their frustrations onto their patients. As noted by a nurse in South Africa:

> It looks as if the work we do is not enough and the management does not appreciate whatever we do and thus the nurses become less motivated. I guess that is why many nurses are no longer caring anymore, as the public would love them to be. I think due to frustration of what the nurses go through with their work they express their anger by becoming nasty to the patients of which this is not something that is supposed to be happening (Gilson and Erasmus, 2004, p. 21).

The paper first outlines four sets of key theoretical starting points about trust, drawing on conceptual literature from various disciplines and contexts, and then considers their relevance to trust relations in the context of health care organisations, drawing on empirical work from LMICs wherever possible.

Theoretical starting points

What is trust and can it be constructed?

Trust is commonly understood as "the optimistic acceptance of a vulnerable situation in which the trustor believes the trustee will care for the trustor's interests" (Hall *et al.*, 2001, p. 615). This definition highlights four key features of trust. It is a relational notion, a voluntary response to a set of expectations about how the person being trusted will behave in relation to you in the future, it involves a degree of vulnerability and risk, and it is rooted in the expectation that the other will have concern for your interests.

This last point explains why trust definitions generally combine expectations about the ability or competence of the other with expectations about her value orientation, that is her ethics, integrity, and motives (Ammeter *et al.*, 2004). As Hall *et al.* (2001) note:

> Trusting attitudes are directed as much to motivations and intentions as to results (Hall *et al.*, 2001, p. 615).

It is this concern for whether the other is motivated to care for the trustor's interests that highlights the affective, rather than solely cognitive, judgements on which trust is

based. Giddens (1990), thus, suggests that trust is more like faith, an expression of commitment, than a cognitive understanding. In addition, trust is different from confidence because trust judgements are made in the face of uncertainty about the motivations of others. Confidence in others, in contrast, implies a situation of relative stability and security where judgements about others are based on what is predictable, involving little risk for the person making the judgement (Gambetta, 2000). As Harrison and Smith (2004, p. 376) note, compared to confidence:

> Trust clearly involves different motivational attitudes, areas of uncertainty, levels of negotiability and possibilities for role ambiguity.

Although the notion of trust is commonly discussed in the context of one-to-one relationships, it is also discussed at the level of complex social systems in which large numbers of transactions are made on a daily basis between people who do not know each other. In these settings, institutions, understood as rules, laws, norms and customs (Ben-Ner and Putterman, 1998), provide a vital basis for trusting the strangers involved in those transactions (Giddens, 1990). In this way they also act to establish the foundations for trust in social systems – such as organisations, the expert system of medical knowledge and society at large (Coulson, 1998; Giddens, 1990; Offe, 1999). Generalised trust in others, the notion that other citizens of a society will act in our collective interest, is therefore, partly, founded on institution-based trust in strangers. However, such trust is also rooted in the inter-personal relationships that regularly affirm its affective bases. In other words, the micro and the macro-levels of trust are interconnected (Giddens, 1990).

The role of institutions in establishing trust in strangers clearly reflects the understanding that human behaviour is socially constructed – in contrast, for example, to the neo-classical economic understanding that behaviour is driven by self-interest or self-regarding preferences (Alkire and Deneulin, 2002). This role also suggests that, even though the propensity to trust may differ between people and societies, trust can, if only to some extent, be constructed through deliberate action to develop the institutional bases of trustworthiness.

Why does trust matter to health systems?

As argued elsewhere, there are two theoretical answers to the question of why trust matters to health systems (Gilson, 2003).

First, it enables the co-operation required across the multiple relationships present within a health system to deliver health care and produce health. Some analysts specifically argue that trusting patient-provider relations have a direct therapeutic effect (Mechanic, 1996, 1998), although the social capital literature suggests that a direct association between trust and health outcomes is doubtful. There is broader agreement that trust in providers underpins patient behaviours important to effective treatment, e.g. disclosure, adherence to therapy, necessary behavioural change (Mechanic, 1996, 1998). As the basis for the exercise of legitimate state authority (Rothstein, 1998), trust in public health authorities can also facilitate the acceptance and use of new vaccines or drugs by patients.

Second, and perhaps more important, a health system founded in trusting relationships can contribute to generating wider social value. This argument is based on the understanding that health systems do not just produce health care and have the

goal of improving health. In addition, as with other social and political institutions, they establish the social norms that shape human behaviour and so act as a repository and producer of wider societal value (Kramer, 1999; Offe, 1999). To the extent that these norms help establish a moral community whom you can trust, they may provide the basis for generalised trust (Ulsaner, 2001). Some argue that in the guise of affective trust (see also later), this is an end in itself (Mansbridge, 1999). Others argue that generalised trust may also promote ethical outcomes such as broader re-distributive action (Rothstein, 1998), a vibrant social community (Ulsaner, 1999) and/or a sense of unity within society (Weinstock, 1999). For others, trust although itself value-neutral, fosters other ethical outcomes by enabling communication processes that generate consensus within society (Thiede, 2005). Whatever the mechanisms, the social capital literature also suggests that civic trust is influenced by social policy and systems (Muntaner and Davey-Smith, 2000).

This second point, in particular, raises two questions for later consideration:

(1) Does examining trust relationships offer new perspectives on how to understand health systems?

(2) Are particular trust-based relationships important to the role of health systems as a producer of social value?

On what is trust based?

Some argue that inter-personal trust is a strategic behaviour, a rational gamble that the personal gains from trusting will outweigh the risk and costs involved; and the value of trust in this form is largely instrumental (Creed and Miles, 1996; Gambetta, 2000). However, as noted, others argue that trust is altruistic, a morally worthy behaviour based on a belief in the goodwill of others that has intrinsic value (Mansbridge, 1999; Ulsaner, 2001).

Many argue, moreover, that inter-personal trust evolves over time. Trust based initially on calculation may change to become less fragile as a result of the repeated engagements and communication that allow each person to get to know and develop new expectations of each other. As noted, the inter-personal grounds for trust include not only competence but also, for example, sincerity, empathy, altruism, congeniality, fairness, and reliability (Wuthnow, 2004), and are reflected in specific behaviours and attitudes. Growing engagement with each other may, eventually, generate the common values and norms of obligation that lay the grounds for identity based or altruistic trust (Lewicki and Bunker, 1996). Indeed it is often said both that trust is constructed through use and wears out with disuse (Offe, 1999; Ostrom and Ahn, 2001; Mansbridge, 1999), and that, although resilient in the face of violation, is difficult to re-construct once broken (Offe, 1999; Weinstock, 1999). Finally, inter-personal trust is two-way, requiring both parties to demonstrate behaviours that allow each to trust the other.

As noted, people also trust strangers. And, although such trust may be rooted in some form of shared identity or experience, such as ethnicity or nationality (Putnam, 1993), it is commonly rooted in the institutions that the trustor expects will influence the trustee's behaviour, institutions that allow the trustor to judge whether the trustee will act in her interests or lack malice towards her (Warren, 1999). Such institutions include well-specified organisational roles and legal frameworks for monitoring and

discipline (Warren, 2001), as well as technical and professional knowledge, and the associated licensing procedures (Giddens, 1990). By providing some certainty about the behaviours of others, these institutions promote confidence in those people.

However, perhaps the more critical institutions for trust are those shaping communication and decision-making practices. These generate information about how people are treated by others (Brockner and Siegel, 1996) and create expectations about the values driving the behaviour of others, so influencing judgements about motivations and intentions. They also provide opportunities to construct perceptions of meaning about the other (Watson and Papamarcos, 2002). Unlike one-way communication, dialogue with others requires each involved party to listen and consider the interests of the others involved, encouraging development of the shared interests and mutual respect that provide bases for trust (Thiede, 2005; Warren, 1999). Offe (1999) specifically argues that to provide a foundation for trust, institutions must commit those influenced by them to the values of truth and justice, either passively (in the form of truth-telling and fairness) or actively (in the form of promise-keeping and solidarity).

Overall, therefore, "trust does not depend only on judgements one person makes about another, but also on assumptions that emerge from the context in which relationships take place, on expectations derived from previous relationships, and on criteria for making judgements that are deemed legitimate by the actors involved" (Wuthnow, 2004, p. 150). This is deemed relevant both to inter-personal relationships and to a person's trust in an organisation (Giddens, 1990; Harre, 1999).

However, in thinking about trust within organisations, it is also important to note that organisations encompass a chain of relationships. So, as trust is a two-way process, to demonstrate care for the client's interests and so be trustworthy, organisations have to provide an environment that enables the development of various sets of mutual trusting relationships (Tendler, 1997). The complexity gets greater at the level of a health care system that encompasses a range of organisations that must co-operate together as well as multiple sets of individuals working within different organisations.

These theoretical points raise the following questions for later consideration:

- Are different bases of trust appropriate to health care relationships?
- Are some relationships more or less important to the specific outcome of generating wider social value?
- What are the inter-personal and institutional foundations for trust in different health care relationships?
- Given the understanding that trust can be constructed, how can the relevant inter-personal and institutional foundations for it be developed?

What are the dangers of trust?

Various dangers of trusting relationships are identified in the theoretical literature. First, trust based purely on shared identity may allow the development of the particularised trust that enables co-operation in pursuit of morally unworthy acts. The example of the mafia is often used in this regard.

Second, the abuse of power on the basis of trust is a more widespread danger (Warren, 1999). Although trust may provide legitimacy for the exercise of power,

trusting too much, without caution, may also enable the abuse of power, in the form of exploitation, domination or conspiracy against others. This is a particular danger for health care given the vulnerability of all patients, but particularly those from disadvantaged backgrounds, in relation to health care providers.

Trust may also result from and then legitimate and reinforce the exercise of power rooted in wider social structures or relationships, such as social hierarchies within organisations (Fox, 1974). In such cases, power is exercised as much through the process of socialisation that generates acceptance of certain structures and ways of behaving, and so trust, as through direct action. When the social structures or relationships are deemed illegitimate, trust rooted in acceptance of them and acting to reinforce them, can also be argued to be illegitimate.

An associated and final danger of trust is that wider social structures may shape individuals' propensity to trust and judgements of their trustworthiness. Some argue that it is easier to trust if you are powerful and wealthy, because economic security generates optimism and facilitates the risk judgements involved in trusting, and harder to trust when you are poor and the consequences of misplaced trust can threaten livelihoods and lives (Coulson, 1998; Inglehart, 1999; Ulsaner, 1999). Poorer groups may also be deemed not trustworthy because they fail to meet expectations of them, as when they are unable to re-pay loans (Russell, 2001). In both cases, the poor may be further marginalised as a result of trust relations.

Given these dangers, in thinking about health care we need to ask:

- Whether and in what health care relationships or contexts some level of distrust may be necessary to guard against the potential for abuse of power?
- What other actions may help protect against the abuse of power, and so provide the basis for trust?

Considering the relevance of these perspectives to health care organisations/systems

These theoretical perspectives offer three main insights for research on health care, particularly in LMICs. First, they allow a deeper understanding of health systems than that which is common, enabling more nuanced reflection on how to bring about change within them. Second, they allow renewed and re-framed thinking about equity and justice in the context of health care (in turn providing further justification for work on trust). Third, they provide insights about the types of policy and managerial actions that might sustain trustworthy and just health care systems, identifying priorities for research and action.

Understanding health systems

The focus on relationships and values that theoretical perspectives on trust highlight is important in countering the tendency to see health systems as machines through which bio-medical interventions are delivered, rather than as complex social institutions that need careful nurturing (Blaauw *et al.*, 2003). In LMIC policy debates, policy change is, therefore, generally seen as something implemented at the apex of the health system, ignoring the chains of people, relationships and understandings through which any policy is implemented. Behaviour is also largely understood as something that can be controlled or tweaked by financial incentives or informational signals, denying the

power to resist that rests even with the street level bureaucrats at the end of the implementation chain (Gilson, 2005a; Walker and Gilson, 2004). Even in high income settings health system reforms have also commonly been envisaged as new sets of structural or financing arrangements rather than signals about values or a re-configuration of existing relationships (Scott *et al.*, 2003).

Seeing health systems as machines that can be re-engineered to serve the ends of the mechanic, these sorts of understandings and approaches provide a weak basis for thinking about how to strengthen health systems. Actions based on them are unlikely to achieve their desired goals, and may actively generate resistance to change. Indeed, in LMICs they may help to explain why so many clinical interventions that could improve health fail to deliver on their potential (Gilson, 2005a). Thinking about the role of trust in health systems points instead to the need to consider the institutions and behaviours that shape performance, the sets of relationships that must be managed to deliver outcomes and the importance of developing shared meanings to sustain delivery (Gilson, 2003). Such actions require different policy and managerial interventions from those commonly identified and great humility about the difficulties of managing change (Gilson and Erasmus, 2004).

Equity and justice

To the extent that trust is either itself intrinsically valued or enables the achievement of other ethical outcomes, the importance of relationships and interactions to justice is made clear by consideration of trust. This focus both justifies work on trust in itself, and allows renewed thinking about the notion of justice and how health systems contribute to social justice.

At one level, it provides justification for a focus on the relevance of procedural justice to equity in health care. The foundation for trust in any relationship, and the associated moral obligations, is based on an assessment of whether the interests of the trustor are considered and respected in the decisions made at an individual or organisational level, rather than on who gets what as a result of that decision-making. This reflects the broader understanding that social value is derived from being a member of a community, and from the quality of our relations with other members of that community (procedural justice). Mooney (1996) thus argues that social value is generated both directly, as individuals participate in decision-making by and for the community, and indirectly, as each individual benefits from the freedom to achieve or to participate that others have secured for him/her. This, in turn, mirrors the second of Brecher's (1997, p. 219) two principles guiding action towards equity:

> (a) that there be a reasonable degree of equity in respect of outcomes concerning the distribution of basic resources and (b) that people treat each other as ends, and not merely as means. The first … may be understood as a political and economic dimension of socialism, while the second constitutes a moral and social element.

At another level, thinking about the role of trust in health systems supports broad and renewed thinking about the ethical bases of such systems. Rather than seeing ethics primarily as a function of the patient-provider relationship, a focus on trust allows the ethical dimensions of other health system relationships to be explored. Goold (2001), thus, suggests that being a provider of care, in which health care organisations are entrusted with the health, well-being, treatment decisions and the private information

of individuals, is only one role for these organisations. Also important are the roles of insurer, protector of the clinician-patient relationship, employer and user of community resources. In each role the organisation is entrusted with valued goods (such as, individual financial well-being, the clinician-patient relationship, employee livelihood, use of community resources) and that trust brings moral obligations (beneficence towards the very ill and insured, safeguarding the trust within the clinician-patient relationship, protecting employees' livelihoods, and prudent use of individual and community resources).

Finally, in considering equity and justice, the dangers of trust point to the need to ensure that, in every health system relationship, the problematic consequences of, and constraints on, trusting experienced by marginalised groups are taken seriously. Such action might include ensuring that there are procedural rules to enable these groups to engage in the constructive dialogue on which trust is based (Mooney and Jan, 1997), and establishing the rights that reduce vulnerability to power and so provide a sheltered space in which trust can grow (Warren, 1999).

These insights about the ethical bases of health systems and how they contribute to social justice are particularly important given the types of pressures currently placed on health systems worldwide. Such pressures provide incentives that undermine trustworthy behaviour. They include the combination of economic recession and budget constraints (everywhere), the introduction of new public management principles (in high income countries) and the growing commercialisation of health care provision (globally, but particularly in low and middle income countries). Harrison and Smith (2004), for example, argue that, by replacing trust with confidence as the basis of health system relationships, the UK's health system modernisation agenda may contribute to "a loss of moral sensitivity and awareness in everyday thinking and action" (p. 380).

As providers worry more about their budgets and targets, patients are fearful that their interests are not being considered (Mechanic, 2001). As providers worry more about securing income than about caring for patients, patients receive poor quality care, are forced to pay bribes for care received even when supposedly protected by exemption arrangements, and may even be denied treatment (Segall, 2000; Tibandebage and Mackintosh, 2005). As managers focus on budget constraints and respond to the pressures to be cost-efficient, relationships with employees become more antagonistic and less trustful, possibly undermining employee commitment to core organisational values (Cunningham and Hyman, 1996; Hunter, 1996). And all of these pressures are exacerbated by wider societal factors, such as the trend towards distrust of societal institutions and professionalism in high income countries (O'Neill, 2002) or the pressures on health workers to serve preferentially high status patients in lower and middle income countries (Andersen, 2004). Combating these pressures requires renewed focus on how to bring about equity and justice within and through health systems.

Policy and managerial priorities

The first set of priorities can be identified by considering how the foundations for trust can be established. Although a stronger evidence base is needed, some common issues are raised in the limited research that has been conducted in LMICs.

At an inter-personal level, patient (dis-)trust in a health care provider is commonly influenced by patient judgements about provider attitudes as well as technical competence (Gilson, 2005b). The acts of being rude or courteous, demanding bribes or not, treating some people preferentially over others, listening to the patient's explanation of their complaint or giving the patient too little time, influence patient judgements of whether the provider cares for their interests, as does the assessment that the provider could not bother to do a full examination or did not prescribe relevant drugs.

The available evidence also suggests that patients often look at provider payment mechanisms as an indication of the trustworthiness of the provider. For some people in some contexts (e.g. higher income people in Thailand and Sri Lanka), payments may be seen as a way of buying more care for the patient's interests, that is greater personal attention, better attitudes and opportunities for repeated interaction with the same provider (Riewpaiboon *et al.*, 2005; Russell, 2005). It is also more generally argued that fee for service payment may align the interests of patients and doctors. However such trust is often fragile (Riewpaiboon *et al.*, 2005). The empirical evidence suggests that patients, and particularly lower income patients, are just as, if not more, likely to see fee systems as incentivising providers to act against the patient's interests, encouraging unnecessarily expensive prescriptions, abuse and neglect (Gilson *et al.*, 2005; Tibandebage and Mackintosh, 2005). In contrast, the long-standing provision of free hospital care in Sri Lanka sustains trust in the public health system by providing a valued safety net for poor and rich patients alike that protects them from the high costs of hospital care (Russell, 2005).

Across various countries (Gilson, 2005b), the other institutions identified as important to patient-provider trust include ethical commitment (Tanzania) and the quality of training (Sri Lanka), effective complaint and accountability/scrutiny mechanisms (South Africa, Tanzania), organisational arrangements that support the provision of good quality care by ensuring equipment and drug availability (Sri Lanka, South Africa), and cultural acceptance of western medicine (Sri Lanka).

Taken together, these experiences clearly complement theory and suggest that developing a trustworthy health system requires more than competent providers. More importantly, it needs health workers that have the attitudes and capacity for moral understanding and motivation (Harrison and Smith, 2004) and institutions that sustain ethical behaviours and so provide a basis for trust. It is also essential to consider how any new health sector reforms will impact on these institutions, rather than assuming a neutral impact.

A second set of policy and managerial priorities is, therefore, linked to the two relationships that theoretical perspectives appear to highlight as particularly important in developing trust in the health system, and allowing it to contribute to wider social value. They are that between manager and provider, and that between citizen and health system.

In organisational and human resource management theory the role of trusting relations in building organisational commitment is widely discussed (Nyhan, 2000; Zeffane and Connell, 2003). In any organisational setting, moreover, the relationship between manager and provider demonstrates the values and norms of behaviour that are the essence of the organisation. Responsible for implementing key decisions such

as those around promotion, reward and discipline, the manager or supervisor is the guide to the organisation and its values (Whitener, 1997), even though her own role and practices are influenced by the organisational context and culture (Willemyns *et al.*, 2003; Albrecht and Travaglione, 2003). There is also theoretical, and a little LMIC empirical, literature to justify the common sense understanding that how you are treated affects how you treat others. How providers are treated by their managers can, thus, affect the way they treat patients (Gilson *et al.*, 2005; Tendler, 1997). In effect, managerial behaviour and practices set the rules and norms that shape provider behaviour, and that, therefore, influence the nature of justice meted out by the health system in its interactions with patients.

It seems likely that the manager-provider relationship is particularly important to strengthen within low and middle income country health systems as the vital function of human resource management has essentially been ignored in such settings for many decades. In addition, rather than tackling the complex task of managing non-financial incentives governments and international organisations working in LMICs appear to be emphasising new financial incentives in the hope that they will generate performance gains (Gilson and Erasmus, 2005). Yet without careful design, the experience of high-income countries suggests that such incentives may reinforce self-interested rather than altruistic behaviour, further violating patient-provider trust (Frey and Jegen, 2001; Le Grand, 2003).

To support management action, research could investigate the role of trusting workplace relationships as a source of non-financial incentives, and the balance between financial and non-financial incentives over provider behaviour in different contexts. In particular, it could investigate the role of trust as an enabler and product of these workplace relationships, as well as how trust can be developed within different relationships. This would also allow consideration of the types of managerial actions required to generate workplace trust and the institutions needed to sustain those actions (Gilson *et al.*, 2005).

The importance of trust between the citizen and the health system lies particularly in the opportunity this relationship may provide to contribute to wider social value. Weinstock (1999) discusses how constructing trust in divided societies can build a morally worthy form of unity and Newman (1998) notes that public managers have an important role to play in generating trust in public institutions across different identity groups within society. Drawing on experience of developing micro health insurance (MHI) schemes in Rwanda, but without presenting conclusive evidence, Schneider (2005, p. 1437) suggests that "not only may trust in MHI and in the wider community foster MHI, but the creation of MHI may foster trust in the wider community". It has also been argued that, in post-conflict settings, the reconstruction of health facilities can contribute to re-establishing the political legitimacy of the state and provide a basis for conflict resolution between groups within the community (Macrae *et al.*, 1996). However, the broader social capital literature makes clear the context-dependent nature of civic trust (Cattrell, 2001).

Trusting citizen-health system relationships are likely also to be important to the exercise of accountability, increasingly recognised as a vital aspect of health system strengthening in LMICs (Brinkerhoff, 2004; World Bank, 2000). The relationships may be played out through mechanisms such as health facility committees or boards,

around statements of patients' rights such as patients' charters, or through citizens' juries. The face-to-face dialogue between citizens and health managers made possible through some of these engagements may allow citizens to exercise agency and provide opportunities to build common understandings around the health system as well as broader collective goals (Gilson, 2003). As Goold notes, organisations that aspire to "identification-based trust, based on shared values, … will need to go beyond minimum standards of openness and honesty and incorporate the voices of those whose trust they seek" (Goold, 2001, p. 32).

As the propensity to trust may be unequally distributed between social groups, these mechanisms of citizen-health system engagement need to provide opportunities to include otherwise marginalised groups – giving them voice in debates and providing spaces for mutual learning. In this case, proper design implies rules and procedures that recognise the constraints on trusting experienced by these groups, so demonstrating the equal moral value of all. Such procedures might include funding the participation of poorer groups, or establishing procedures that give everyone present an opportunity to speak (rather than leaving it to those who shout loudest).

However, to support management action, research needs to dig deeper into the experience of different forms of citizen-health system engagement, generating better understanding of the objects of trust relevant to such mechanisms, the role of trust as an enabler and product, whether particular forms of trust have to be in place initially to allow them to function, the types of procedures and processes that can produce at least some of the forms of trust required, and whether such mechanisms can build wider social outcomes.

Arising from the previous two sets of policy and managerial priorities, the third is the need to understand better what forms of management generate trust and what strategies are needed to sustain them.

Some human resource management literature highlights, for example, the importance of moral management, management based on ethical principles, in developing employee trust (Ruppel and Harrington, 2000). Reinke (2003) specifically talks of the manager as servant or steward and Gomez and Rosen (2001) identify the importance of trusting employees as a step to generating trust, in turn requiring managers to share power. Nyhan (2000), meanwhile, emphasises the manager's role in enabling participation in decision-making, giving and getting feedback and valuing employees. Similarly, in discussing managers' roles in engaging with citizens, Ruscio (1996) proposes that managers must facilitate public discussion of collective interests. In a South African context, meanwhile, Froestad (n.d.) suggests that to generate trust, managers must specifically take action to reduce uncertainty and vulnerability both through impression management and by demonstrating moral commitments. In other words, trusting relationships are the product of deliberate and reflexive strategies, such as education, mentoring and supervision (Gilbert, 1998), as well as of moral commitment.

Given these diverse roles it seems important, then, that management training for public managers should develop the values, and skills, particularly communication skills, that will support them to work in ways that produce trust. But what sort of training is required to develop such skills? How can the skills be sustained over time? Willemyns *et al.* (2003) talk specifically, for example, of the importance of mentoring,

whilst noting the importance of personal sincerity. In addition, what institutions must be developed to sustain such managerial action? More research is needed in all these areas to inform the recruitment and training of public managers, as well as the development of the stable organisational communication and decision-making practices that themselves develop and sustain trust.

The fourth and final policy and management priority is to acknowledge that caution should be exercised in developing trust.

Different forms of trust may be relevant in different relationships and different contexts. Given that affective commitment to organisational goals may be derived from an employee's relationship with their supervisor (Albrecht and Travaglione, 2003), and that trusting relationships with colleagues provide a basis for the teamwork essential to providing health care (Erdem and Ozen, 2003), stronger forms of trust (knowledge or identity-based) may be important to these relationships. However, a more calculative form of trust may be appropriate in relationships where those involved clearly have different motives (e.g. public and private) or where one legitimately seeks to control the other (as in a regulatory relationship); or a more calculative form of trust may be relevant where the context provides weak institutional signals for behaviour.

Critically, a degree of distrust might be important in some relationships, as a means of protecting the vulnerable against the abuse of power. Tibandebage and Mackintosh (2005), for example, specifically argue that patients in Tanzania should distrust some providers, given experiences of abuse and rudeness. In these cases, providers have failed to demonstrate their care for the patient. However, these authors also propose three sets of policy actions that may reinforce existing sources of trust as well as influence the capability of the poor to access decent care: supporting and engaging with those facilities that do treat patients with respect; constraining individual profit-seeking by establishing scrutiny mechanisms that involve community representatives; and publicly acknowledging and valuing actions that produce patient trust. Again, therefore, they emphasise the importance of developing institutions that provide the basis for trust – including the procedural rules or rights that, as already noted, may provide the space in which the powerless can develop trust.

Conclusions

Thinking about the role of trust offers important insights into the nature of health systems, the issues important to equity and justice within them and to the policy and management priorities for strengthening them. Such thinking encourages reflection on the complexity of these systems and, particularly, on the importance of everyday ethical practice to the justice of their operation.

Trust theory also contributes to, and may widen, understanding of the nature and types of institutions that shape ethical behaviour and so, health system performance. Management is always important in generating trust, particularly in terms of organisational relationships with health workers as employees and in terms of the relationship between citizens and the health system. Within these relationships, trust is likely to be influenced by communication and decision-making practices, as well as, for patient trust in providers, provider payment mechanisms. In some relationships, distrust may be an important way of guarding against the abuse of power.

Research can support the policy and management action required to generate trust within and through health systems. Research needs include investigation of: the role of trusting workplace relationships as a source of non-financial incentives; the influence of trust over the operation of different forms of citizen-health system engagement; approaches to training trustworthy public managers; and the institutional changes required to sustain trustworthy behaviour within health systems. In conducting such research it will be important to recognise that trust is in some way always an input to and a product of a relationship, and that the meaning and nature of trust may change over time. Careful specification of different trust objects is important, and also methodological approaches that allow for complex causality and longitudinal perspectives.

References

Albrecht, S. and Travaglione, A. (2003), "Trust in public-sector management", *The International Journal of Human Resource Management*, Vol. 14 No. 1, pp. 76-92.

Alkire, S. and Deneulin, S. (2002), "Individual motivation, its nature, determinants, and consequences for within-group behaviour", in Heyer, J., Stewart, F. and Thorp, R. (Eds), *Group Behaviour and Development: Is the Market Destroying Cooperation?*, Oxford University Press, Oxford, pp. 51-74.

Ammeter, A.P., Douglas, C., Ferris, G.R. and Goka, H. (2004), "A social relationship conceptualisation of trust and accountability in organisations", *Human Resource Management Review*, Vol. 14, pp. 47-65.

Andersen, H.M. (2004), "'Villagers': differential treatment in a Ghanaian hospital", *Social Science and Medicine*, Vol. 59 No. 10, pp. 2003-12.

Ben-Ner, A. and Putterman, L. (1998), "Values and institutions in economic analysis", in Ben-Ner, A. and Putterman, L. (Eds), *Economics, Values and Organisation*, Cambridge University Press, Cambridge, pp. 3-69.

Blaauw, D., Gilson, L., Penn-Kekana, L. and Schneider, H. (2003), "Organisational relationships and the 'software' of health sector reform", background paper prepared for the Disease Control Priorities Project, Capacity Strengthening and Management reform, available at: www.fic.nih.gov/dcpp

Brecher, B. (1997), "What would a socialist health service look like?", *Health Care Analysis*, Vol. 5 No. 3, pp. 217-26.

Brinkerhoff, D. (2004), "Accountability and health systems: towards conceptual clarity and policy relevance", *Health Policy and Planning*, Vol. 19 No. 6, pp. 371-9.

Brockner, J. and Siegel, P. (1996), "Understanding the interaction between procedural and distributive justice: the role of trust", in Kramer, R.M. and Tyler, T.R. (Eds), *Trust in Organisations: Frontiers of Theory and Research*, Sage, Thousand Oaks, CA, pp. 390-413.

Cattrell, V. (2001), "Poor people, poor places, and poor health: the mediating role of social networks and social capital", *Social Science and Medicine*, Vol. 52, pp. 1501-16.

Coulson, A. (1998), "Trust and contract in public sector management", in Coulson, A. (Ed.), *Trust and Contracts: Relationships in Local Government, Health and Public Services*, The Polity Press, Bristol, pp. 9-34.

Creed, W.E.D. and Miles, R.E. (1996), "Trust in organisations: a conceptual framework linking organisational forms, managerial philosophies, and the opportunity costs of controls", in

Kramer, R.M. and Tyler, T.R. (Eds), *Trust in Organisations: Frontiers of Theory and Research*, Sage, Thousand Oaks, CA, pp. 16-38.

Cunningham, I. and Hyman, J. (1996), "Empowerment: the right medicine for improving employee commitment and morale in the NHS?", *Health Manpower Management*, Vol. 22 No. 6, p. 14.

Erdem, E. and Ozen, J. (2003), "Cognitive and affective dimensions of trust in developing team performance", *Team Performance Management: An International Journal*, Vol. 9 Nos 5/6, pp. 131-5.

Fox, A. (1974), *Beyond Contract: Work, Power and Trust Relations*, Faber and Faber, London.

Frey, B.S. and Jegen, R. (2001), "Motivation crowding theory", *Journal of Economic Surveys*, Vol. 15 No. 5, pp. 589-611.

Froestad, J. (n.d.), "Trust as a problem of management: strategies for reducing uncertainty and vulnerability", unpublished paper.

Gambetta, D. (2000), "Can we trust trust?", in Gambetta, D. (Ed.), *Trust: Making and Breaking Cooperative Relations*, University of Oxford, Oxford, pp. 213-37, available at: www.sociology.ox.ac.uk/papers/gambetta213-237.pdf

Giddens, A. (1990), *The Consequences of Modernity*, Polity Press, Cambridge.

Gilbert, T. (1998), "Towards a politics of trust", *Journal of Advanced Nursing*, Vol. 27, pp. 1010-6.

Gilson, L. (2003), "Trust and health care as a social institution", *Social Science and Medicine*, Vol. 56 No. 67, pp. 1452-68.

Gilson, L. (2005a), "Applying policy analysis in tackling implementation gaps", paper presented to the 9th Global Forum for Health Research, Mumbai, India, September.

Gilson, L. (2005b), "Editorial: building trust and value in health systems in low and middle income countries", *Social Science and Medicine*, Vol. 61 No. 7, pp. 1381-4.

Gilson, L. and Erasmus, E. (2004), "Values in use and organisational culture: exploring the relevance to health systems development", paper prepared for the UN Millennium Project's Task Force on Child Health and Maternal Health, available at: www.wits.ac.za/chp

Gilson, L. and Erasmus, E. (2005), "Supporting the retention of HRH: SADC Policy Context", paper prepared for the EQUINET/Health Systems Trust workshop on Human Resources in Southern Africa, Johannesburg, August.

Gilson, L., Palmer, N. and Schneider, H. (2005), "Trust and health worker performance: exploring a conceptual framework using South African evidence", *Social Science and Medicine*, Vol. 61 No. 7, pp. 1418-29.

Gomez, C. and Rosen, B. (2001), "The leader-member exchange as a link between managerial trust and employee empowerment", *Group and Organisation Management*, Vol. 26 No. 1, pp. 53-69.

Goold, S.D. (2001), "Trust and the ethics of health care institutions", *Hastings Center Report*, Vol. 32 No. 6, pp. 26-33.

Hall, M.A., Dugan, E., Zheng, B. and Mishra, A. (2001), "Trust in physicians and medical institutions: what is it, can it be measured and does it matter?", *Milbank Quarterly*, Vol. 79 No. 4, pp. 613-39.

Harre, R. (1999), "Trust and its surrogates: psychological foundations of political process", in Warren, M.E. (Ed.), *Democracy and Trust*, Cambridge University Press, Cambridge, pp. 249-72.

Harrison, S. and Smith, C. (2004), "Trust and moral motivation: redundant resources in health and social care?", *Policy & Politics*, Vol. 32 No. 3, pp. 371-86.

Hunter, D.J. (1996), "The changing roles of health care personnel in health and health care management", *Social Science and Medicine*, Vol. 43 No. 5, pp. 799-808.

Inglehart, R. (1999), "Trust, well-being and democracy", in Warren, M.E. (Ed.), *Democracy and Trust*, Cambridge University Press, Cambridge, pp. 88-120.

Kramer, R.M. (1999), "Trust and distrust in organisations: emerging perspectives, enduring questions", *American Review of Psychology*, Vol. 50, pp. 569-98.

Le Grand, J. (2003), *Motivation, Agency, and Public Policy*, Oxford University Press, Oxford.

Lewicki, R.J. and Bunker, B.B. (1996), "Developing and maintaining trust in work relationships", in Kramer, R.M. and Tyler, T.R. (Eds), *Trust in Organisations: Frontiers of Theory and Research*, Sage, Thousand Oaks, CA, pp. 114-39.

Macrae, J., Zwi, A.B. and Gilson, L. (1996), "A triple burden for health sector reform: 'post'-conflict rehabilitation in Uganda", *Social Science Medicine*, Vol. 42 No. 7, pp. 1095-108.

Mansbridge, J. (1999), "Altruistic trust", in Warren, W.E. (Ed.), *Democracy and Trust*, Cambridge University Press, Cambridge, pp. 290-309.

Mechanic, D. (1996), "Changing medical organisation and the erosion of trust", *The Milbank Quarterly*, Vol. 74 No. 2, pp. 171-89.

Mechanic, D. (1998), "Public trust and initiatives for new health care partnerships", *The Milbank Quarterly*, Vol. 76 No. 2, pp. 281-302.

Mechanic, D. (2001), "The managed care backlash: perceptions and rhetoric in health care policy and the potential for health care reform", *The Milbank Quarterly*, Vol. 79 No. 1, pp. 35-54.

Mooney, G. (1996), "And now for vertical equity? Some concerns arising from Aboriginal health in Australia", *Health Economics*, Vol. 5, pp. 99-103.

Mooney, G. and Jan, S. (1997), "Vertical equity: weighting outcome or establishing procedures?", *Health Policy*, Vol. 39, pp. 79-87.

Muntaner, L. and Davey-Smith, D. (2000), "Social capital and the third way in public health", *Critical Public Health*, Vol. 10 No. 2, pp. 107-24.

Newman, J. (1998), "The dynamics of trust", in Coulson, A. (Ed.), *Trust and Contracts: Relationships in Local Government, Health and Public Services*, The Polity Press, Bristol, pp. 35-52.

Nyhan, R.C. (2000), "Changing the paradigm: trust and its role in public sector organisations", *American Review of Public Administration*, Vol. 30 No. 10, pp. 87-109.

O'Neill, O. (2002), *A Question of Trust: The BBC Reith Lectures 2002*, Cambridge University Press, Cambridge.

Offe, C. (1999), "How can we trust our fellow citizens?", in Warren, M.E. (Ed.), *Democracy and Trust*, Cambridge University Press, Cambridge, pp. 42-87.

Ostrom, E. and Ahn, T.K. (2001), "A social science perspective on social capital: social capital and collective action", paper prepared for the European Research Conference on "Social Capital: Interdisciplinary perspectives", Exeter, 15-20 September, available at: www.ex.ac.uk/shipss/politics/research/socialcapital

Putnam, R.D. (1993), *Making Democracy Work: Civic Traditions in Modern Italy*, Princeton University Press, Princeton, NJ.

Reinke, S. (2003), "Does the form really matter? Leadership, trust, and acceptance of the performance appraisal process", *Review of Public Administration*, Vol. 23 No. 1, pp. 23-7.

Riewpaiboon, W., Chuengsatiansup, K., Gilson, L. and Tangcharoensathien, V. (2005), "Private obstetric practice in a public hospital: mythical trust in obstetric care", *Social Science and Medicine*, Vol. 61 No. 7, pp. 1408-17.

Rothstein, B. (1998), *Just Institutions Matter: The Moral and Political Logic of the Universal Welfare State*, Cambridge University Press, Cambridge.

Ruppel, C.P. and Harrington, S.J. (2000), "The relationship of communication, ethical work climate, and trust to innovation", *Journal of Business Ethics*, Vol. 25 No. 4, pp. 313-28.

Ruscio, K.P. (1996), "Trust, democracy and public management: a theoretical argument", *Journal of Public Administration Research and Theory*, Vol. 6 No. 3, pp. 461-77.

Russell, S. (2001), "Can households afford to be ill? The role of the health system, material resources and social networks in Sri Lanka", PhD thesis, London School of Hygiene and Tropical Medicine, University of London.

Russell, S. (2005), "Treatment-seeking behaviour in urban Sri Lanka: trusting the state, trusting private doctors", *Social Science and Medicine*, Vol. 61 No. 7, pp. 1396-407.

Schneider, P. (2005), "Trust in micro health insurance: an exploratory study in Rwanda", *Social Science and Medicine*, Vol. 61 No. 7, pp. 1430-8.

Scott, T., Mannion, R., Marshall, M. and Davies, H. (2003), "Does organisational culture influence health care performance? A review of the evidence", *Journal of Health Services Research and Policy*, Vol. 8 No. 2, pp. 105-17.

Segall, M. (2000), "From cooperation to competition in national health systems – and back? Impact on professional ethics and quality of care", *International Journal of Health Planning and Management*, Vol. 15, pp. 61-79.

Tendler, J. (1997), *Good Government in the Tropics*, The Johns Hopkins Press, Baltimore, MD.

Thiede, M. (2005), "Information and access to health care: is there a role for trust?", *Social Science and Medicine*, Vol. 61 No. 7, pp. 1452-62.

Tibandebage, P. and Mackintosh, M. (2005), "The market shaping of capabilities: charging, trust and abuse in health care transactions in Tanzania", *Social Science and Medicine*, Vol. 61 No. 7, pp. 1385-95.

Ulsaner, E.M. (1999), "Democracy and social capital", in Warren, M.E. (Ed.), *Democracy and Trust*, Cambridge University Press, Cambridge, pp. 121-50.

Ulsaner, E.M. (2001), "Trust as a moral value", paper prepared for the European Research Conference on "Social Capital: Interdisciplinary perspectives", Exeter, 15-20 September, available at: www.ex.ac.uk/shipss/politics/research/socialcapital

Walker, L. and Gilson, L. (2004), "We are bitter but we are satisfied: nurses as street level bureaucrats in South Africa", *Social Science and Medicine*, Vol. 59 No. 6, pp. 1251-61.

Warren, M.E. (1999), "Democratic theory and trust", in Warren, M.E. (Ed.), *Democracy and Trust*, Cambridge University Press, Cambridge, pp. 310-45.

Warren, M.E. (2001), "Trust in democratic institutions", paper prepared for European Research Conference on Social Capital: Interdisciplinary perspectives, Exeter, 15-20 September, available at: www.ex.ac.uk/shipss/politics/research/socialcapital

Watson, G.W. and Papamarcos, S.D. (2002), "Social capital and organisational commitment", *Journal of Business and Psychology*, Vol. 16 No. 4, pp. 537-52.

Weinstock, D. (1999), "Building trust in divided societies", *The Journal of Political Philosophy*, Vol. 7 No. 3, pp. 287-307.

Whitener, E.M. (1997), "The impact of human resource activities on employee trust", *Human Resource Management Review*, Vol. 7 No. 4, pp. 389-404.

Willemyns, M., Gallois, C. and Callan, V.J. (2003), "Trust me, I'm your boss: trust and power in supervisor-supervisee communications", *The International Journal of Human Resource Management*, Vol. 14 No. 1, pp. 117-27.

World Bank (2000), *World Development Report: Making Services Work for the Poor*, World Bank, Washington, DC.

Wuthnow, R. (2004), "Trust as an aspect of social structure", in Alexander, J.C., Marx, G.T. and Williams, C.L. (Eds), *Self, Social Structure and Beliefs: Explorations in Sociology*, University of California Press, Berkeley, CA, pp. 145-66.

Zeffane, E. and Connell, J. (2003), "Trust and HRM in the new millennium", *The International Journal of Human Resource Management*, Vol. 14 No. 1, pp. 3-11.

About the author

Lucy Gilson conducts health policy and systems research in South Africa as well as other low and middle-income countries. Her particular areas of research interest are health system equity and the management of policy change. Lucy Gilson can be contacted at: lucy.gilson@nhls.ac.za

This article has been cited by:

1. Dickson R O Okello, Lucy Gilson. 2015. Exploring the influence of trust relationships on motivation in the health sector: a systematic review. *Human Resources for Health* **13**. . [CrossRef]
2. Paul R. Ward, Philippa Rokkas, Clinton Cenko, Mariastella Pulvirenti, Nicola Dean, Simon Carney, Patrick Brown, Michael Calnan, Samantha Meyer. 2015. A qualitative study of patient (dis)trust in public and private hospitals: the importance of choice and pragmatic acceptance for trust considerations in South Australia. *BMC Health Services Research* **15**. . [CrossRef]
3. Alison R. Hernández, Anna-Karin Hurtig, Kjerstin Dahlblom, Miguel San Sebastián. 2015. Integrating views on support for mid-level health worker performance: a concept mapping study with regional health system actors in rural Guatemala. *International Journal for Equity in Health* **14**. . [CrossRef]
4. Lise Rosendal Østergaard. 2015. Trust matters: A narrative literature review of the role of trust in health care systems in sub-Saharan Africa. *Global Public Health* **10**, 1046-1059. [CrossRef]
5. Stephanie Tierney, Maria Blackhurst, Rachael Scahill, Peter Callery. 2015. Loss and rebuilding: A qualitative study of late diagnosis of cleft palate. *Journal for Specialists in Pediatric Nursing* **20**:10.1111/jspn.2015.20.issue-4, 280-289. [CrossRef]
6. Joseph D Tucker, Yu Cheng, Bonnie Wong, Ni Gong, Jing-Bao Nie, Wei Zhu, Megan M McLaughlin, Ruishi Xie, Yinghui Deng, Meijin Huang, William C W Wong, Ping Lan, Huanliang Liu, Wei Miao, Arthur Kleinman. 2015. Patient–physician mistrust and violence against physicians in Guangdong Province, China: a qualitative study. *BMJ Open* **5**, e008221. [CrossRef]
7. Michael P. Leiter, Arla Day, Lisa Price. 2015. Attachment styles at work: Measurement, collegial relationships, and burnout. *Burnout Research* . [CrossRef]
8. Jill Pattison, Theresa Kline. 2015. Facilitating a just and trusting culture. *International Journal of Health Care Quality Assurance* **28**:1, 11-26. [Abstract] [Full Text] [PDF]
9. Tuba Bozaykut, F. Gulruh Gurbuz. 2015. Power and trust in organizational relations: an empirical study in Turkish public hospitals. *The International Journal of Health Planning and Management* **30**:10.1002/hpm.v30.1, E1-E15. [CrossRef]
10. Kristine Rørtveit, Britt Sætre Hansen, Ingrid Leiknes, Inge Joa, Ingelin Testad, Elisabeth Severinsson. 2015. Patients' Experiences of Trust in the Patient-Nurse Relationship—A Systematic Review of Qualitative Studies. *Open Journal of Nursing* **05**, 195-209. [CrossRef]
11. Aku Kwamie, Irene Akua Agyepong, Han van Dijk. 2015. What Governs District Manager Decision Making? A Case Study of Complex Leadership in Dangme West District, Ghana. *Health Systems & Reform* **1**:2, 167. [CrossRef]
12. John Eyles, Bronwyn Harris, Jana Fried, Veloshnee Govender, Loveday Penn-Kekana. 2015. Suspicious Minds: Apportioning and Avoiding Blame for Distrustful Relationships and Deferring Medical Treatment in South Africa. *Sociology Mind* **05**, 188-199. [CrossRef]
13. Daniel Lopes Ibanez-Gonzalez, Emily Mendenhall, Shane A Norris. 2014. A mixed methods exploration of patterns of healthcare utilization of urban women with non-communicable disease in South Africa. *BMC Health Services Research* **14**. . [CrossRef]
14. T.J. McCabe, Sally Sambrook. 2014. The antecedents, attributes and consequences of trust among nurses and nurse managers: A concept analysis. *International Journal of Nursing Studies* **51**, 815-827. [CrossRef]

15. Christine J. Fenenga, Kwasi Boahene, Daniel Arhinful, Tobias Rinke de Wit, Inge Hutter. 2014. Do prevailing theories sufficiently explain perceptions and health-seeking behavior of Ghanaians?. *The International Journal of Health Planning and Management* **29**:10.1002/hpm.v29.1, 26-42. [CrossRef]
16. Khaled Seddiq, Donald A Enarson, Karam Shah, Zaeem Haq, Wasiq M Khan. 2014. Implementing a successful tuberculosis programme within primary care services in a conflict area using the stop TB strategy: Afghanistan case study. *Conflict and Health* **8**, 3. [CrossRef]
17. Baltica Cabieses, Philippa Bird. 2014. Glossary of Access to Health Care and Related Concepts for Low- and Middle-Income Countries (LMICs): A Critical Review of International Literature. *International Journal of Health Services* **44**, 845-861. [CrossRef]
18. Alison R Hernández, Anna-Karin Hurtig, Kjerstin Dahlblom, Miguel San Sebastián. 2014. More than a checklist: a realist evaluation of supervision of mid-level health workers in rural Guatemala. *BMC Health Services Research* **14**, 112. [CrossRef]
19. Lisa M. Cook. 2013. Can nurses trust nurses in recovery reentering the workplace?. *Nursing Critical Care* **8**, 14-17. [CrossRef]
20. Florina Spânu, Adriana Băban, Mara Bria, Dan L. Dumitrascu. 2013. What happens to health professionals when the ill patient is the health care system? Understanding the experience of practising medicine in the Romanian socio-cultural context. *British Journal of Health Psychology* **18**:10.1111/bjhp.2013.18.issue-3, 663-679. [CrossRef]
21. David K. Leonard, Gerald Bloom, Kara Hanson, Juan O'Farrell, Neil Spicer. 2013. Institutional Solutions to the Asymmetric Information Problem in Health and Development Services for the Poor. *World Development* **48**, 71-87. [CrossRef]
22. Samantha B. Meyer, Paul R. Ward. 2013. Differentiating between trust and dependence of patients with coronary heart disease: furthering the sociology of trust. *Health, Risk & Society* **15**, 279-293. [CrossRef]
23. Lisa M. Cook. 2013. Can nurses trust nurses in recovery reentering the workplace?. *Nursing* **43**, 21-24. [CrossRef]
24. Patrick R Brown. 2011. The dark side of hope and trust: Constructed expectations and the value-for-money regulation of new medicines. *Health Sociology Review* **20**, 410-422. [CrossRef]
25. Patrick R Brown. 2011. The dark side of hope and trust: Constructed expectations and the value-for-money regulation of new medicines. *Health Sociology Review* 421-433. [CrossRef]
26. Majella Mullarkey, Anita Duffy, Fiona Timmins. 2011. Trust between nursing management and staff in critical care: a literature review. *Nursing in Critical Care* **16**:10.1111/ncr.2011.16.issue-2, 85-91. [CrossRef]
27. Petra Brhlikova, Ian Harper, Roger Jeffery, Nabin Rawal, Madhusudhan Subedi, MR Santhosh. 2011. Trust and the regulation of pharmaceuticals: South Asia in a globalised world. *Globalization and Health* **7**, 10. [CrossRef]
28. Margaret E. Kruk, Peter C. Rockers, Godfrey Mbaruku, Magdalena M. Paczkowski, Sandro Galea. 2010. Community and health system factors associated with facility delivery in rural Tanzania: A multilevel analysis. *Health Policy* **97**, 209-216. [CrossRef]
29. Valery Ridde, Slim Haddad, Moussa Yacoubou, Ismaelou Yacoubou. 2010. Exploratory study of the impacts of Mutual Health Organizations on social dynamics in Benin. *Social Science & Medicine* **71**, 467-474. [CrossRef]
30. H. N. Plomp, N. Ballast. 2010. Trust and vulnerability in doctor-patient relations in occupational health. *Occupational Medicine* **60**, 261-269. [CrossRef]

31. ANNE LYBERG, ELISABETH SEVERINSSON. 2010. Midwives' supervisory styles and leadership role as experienced by Norwegian mothers in the context of a fear of childbirth. *Journal of Nursing Management* **18**, 391-399. [CrossRef]
32. Margaret E. Kruk, Lynn P. Freedman, Grace A. Anglin, Ronald J. Waldman. 2010. Rebuilding health systems to improve health and promote statebuilding in post-conflict countries: A theoretical framework and research agenda. *Social Science & Medicine* **70**, 89-97. [CrossRef]
33. Patrick Brown, Michael Calnan. 2010. The Risks of Managing Uncertainty: The Limitations of Governance and Choice, and the Potential for Trust. *Social Policy and Society* **9**, 13. [CrossRef]
34. Cornelius B. Pratt, E. Lincoln James. 2009. Mobilizing and Empowering War-Torn African Communities to Improve Public Health. *Howard Journal of Communications* **20**, 370-393. [CrossRef]
35. Julia Abelson, Fiona A. Miller, Mita Giacomini. 2009. What does it mean to trust a health system?. *Health Policy* **91**, 63-70. [CrossRef]
36. Sachiko Ozawa, Damian G. WalkerTrust in the context of community-based health insurance schemes in Cambodia: Villagers' trust in health insurers 107-132. [Abstract] [Full Text] [PDF] [PDF]
37. Nina Hallowell. 2008. Encounters with medical professionals: a crisis of trust or matter of respect?. *Medicine, Health Care and Philosophy* **11**, 427-437. [CrossRef]
38. Katrina Armstrong, Suzanne McMurphy, Lorraine T. Dean, Ellyn Micco, Mary Putt, Chanita Hughes Halbert, J. Sanford Schwartz, Pamela Sankar, Reed E. Pyeritz, Barbara Bernhardt, Judy A. Shea. 2008. Differences in the Patterns of Health Care System Distrust Between Blacks and Whites. *Journal of General Internal Medicine* **23**, 827-833. [CrossRef]
39. Michael Calnan, Rosemary Rowe. 2007. Trust and Health Care. *Sociology Compass* **1**:10.1111/soco.2007.1.issue-1, 283-308. [CrossRef]