

TRUST, PARTICIPATION, AND PERFORMANCE IN PUBLIC ADMINISTRATION

An Empirical Examination of Health Services in Israel

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ABSTRACT: *This paper suggests a framework for measuring trust in health care at the institutional level and for explaining the impact of structural variables on trust. The empirical study was conducted in Israel using a national survey. Trust in health care is found to be positively related with performance and satisfaction much more than with participation in decision-making processes and other structural variables such as accessibility, equality, and autonomy. Participation is positively related with performance. The paper also provides an explanation based on political culture for the weak relations between participation in decision making and trust in health-care organizations.*

KEYWORDS: *health services, Israel, participation in decision making, performance, trust*

This paper explores the relation between citizen participation in decision making and trust in health-care systems and empirically examines the theoretical arguments by reference to the Israeli health-care system. Participation theories usually praise the involvement of citizens in decision-making processes at various levels as a central instrument for increasing performance and satisfaction with administrative agencies (Barner & Rosenwein, 1985; Box, 1999; Frederickson, 1982, 1997; King, Feltey, & Susel, 1998). Despite some criticism about the nature of citizens' participation in the managerial era of governance, most of the literature supports higher levels of citizenry involvement in both administrative and political processes

(e.g., Rimmerman, 1997; Vigoda, 2002). The main argument of these works is that citizen participation and involvement, both on the organizational/bureaucratic level and on the communal/political level, may increase trust in governance and potentially in administrative agencies because they enhance the information citizens have about various processes and their identification with policies and outcomes (Rose, 1999; Yankelovich, 1991). Trust theories usually point to the central role of trust for ensuring stability in administrative and political systems while attempting to explain the necessary conditions for trust (Anderson, 1995; Borre, 2000; Bouckaert & Van de Walle, 2003; Glaser & Hildreth, 1999).

However, most of the theoretical and empirical research in the area of citizen participation emphasizes that such mechanisms are most effective at the local level and in small groups (Irvin & Stanbury, 2004; King et. al, 1998). Fung and Wright (2001) attempted to make several generalizations based on comparative case studies regarding the conditions shared by successful participation mechanisms. They concluded that such success is more likely to be achieved when participation is applied at the local level to relatively simple policy areas. Studying the relation among trust, participation, and performance in health-care systems, which operate nationally and deal with complex issues related to the welfare of society, poses an important challenge to the generalizing of participation mechanisms. Due to these characteristics of health-care organizations, we measure the subjective feelings of respondents regarding the level of client participation in decision making in the health system as a whole, rather than referring to a specific participatory mechanism. Furthermore, trust in health-care systems may be a very complex and ambivalent concept (Calnan & Rowe, 2006; Mishra, 1996), which makes the relation between citizen participation and trust in health-care systems extremely interesting.

This challenge should be understood in the broader context of the New Public Management (NPM) approach, which has motivated numerous public sector reforms, although some scholars now suggest that NPM has peaked (Hughes, 2003) or is even dead (Dunleavy, Margetts, Bastow, & Tinkler, 2005, 2006). The NPM approach, which emerged in the 1980s and 1990s as part of a reform movement in the public sector, treats bureaucrats as managers and citizens as customers. NPM strategies include contracting out or the privatization of services, adopting a customer-oriented approach, measuring performance and efficiency, and changing the incentive structure of workers from life-long employment to personal contracts (Ferlie, Ashburner, Fitzgerald, & Pettigrew, 1996; Hood, 1991; Lane, 2000, pp. 147–178). The rationale suggested by the NPM doctrine expects a positive relation between citizen participation in decision making on one hand and perceived performance and trust on the other (Yang & Holzer, 2006). Such a relation has been observed in several types of organizations (Van Ryzin, Muzzio, Immerwahr, Gulick, & Martinez, 2004; Vigoda-Gadot & Mizrahi, 2008; Wang, 2001). We

question whether this relation is also applicable to the Israeli health system as an exemplar of other health systems.

Israeli society provides an interesting field in which to study trust relations, and its health-care system may be a good exemplar of other health systems. Israeli society has been significantly transformed in recent decades from a highly centralized society, where most social, economic, and administrative systems were dominated by a strong Labor Party in the 1950s and 1960s, into a fragmented society with several power centers and a growing private sector in the 1980s through the present (Arian, 1998; Horowitz & Lissak, 1989; Mizrahi & Meydani, 2003). Yet, many of its administrative systems, including its health-care system, have remained highly centralized and controlled to a large extent by the Ministry of Finance (Horev & Babad, 2005; Maman, 2002). These processes catalyzed the emergence of mass social movements during the 1970s and 1980s but later, when the instability of the political system grew, citizens felt increased disappointment with public policy in general and with reform programs in particular (Arian, 1998; Mizrahi & Meydani, 2003). Such disappointment with governmental services is not unique to Israel but, rather, has been observed worldwide (Borre, 2000; Bouckaert & Van de Walle, 2003; Glaser & Hildreth, 1999). Furthermore, like many other health systems, the Israeli health-care system has gone through a significant reform, beginning in 1995, which, as explained in more detail in the following discussion, makes it a good exemplar for studying the relations between citizen participation and trust.

As in other societies, where dissatisfaction with services led to a decline in trust, in Israel, fragmentation processes and dissatisfaction with services also affected trust in administrative agencies. A five-year study conducted during 2001–05 shows a relatively stable low level of trust in administrative agencies and political organizations as well as little trust in politicians and public administrators (Vigoda-Gadot & Mizrahi, 2008). The health-care system is not exceptional in that respect, yet respondents in that general survey were more trusting of their own health fund (health provider organization similar to an American HMO) and physicians compared to the general level of trust.

Defining trust as the belief of an individual in the good faith of others and their future intentions (Hosmer, 1995), trust relations in general, and in health care in particular, exist at three levels: interpersonal, organizational, and institutional (Calnan & Rowe, 2006). At the micro level, we can identify the level of interpersonal trust between an individual patient and a clinician and the level of organizational trust between one clinician and another and between a clinician and a manager. At the macro level, we can identify the level of institutional trust as the trust of the patient and the public in clinicians and managers in general, in a particular health-care organization, and in the national health-care system. A review of the relevant literature shows that most empirical research has addressed threats to

patient–provider relationships, whereas the organizational and institutional levels are relatively less studied (Calnan & Rowe, 2004).

We suggest a framework for measuring trust in health care at the institutional level and for explaining the impact of structural variables on this type of trust. The measurement tool is based on questionnaires developed for measuring trust relations in the public sector (Vigoda-Gadot & Mizrahi, 2008), and the explanatory framework examines the relations between citizen participation in decision-making processes, perceived health-care performance, and trust.

The empirical analysis is based on a questionnaire distributed among 656 Israeli citizens. The findings show that Israeli citizens do not have a high level of trust in health-care providers. In addition, Israeli citizens do not feel that they are part of the decision-making process. Trust in health care is found to be positively related with performance and satisfaction much more than with participation in decision-making processes. Participation is positively related with performance. Therefore, the past and present experience of the population with health-care organizations and services, on which performance and satisfaction evaluations are constructed, influences trust in the future behavior and intentions of health-care organizations more than structural variables such as participation, accessibility, equality, and autonomy. We suggest an explanation based on political culture for the weak relation between participation in decision making and trust, arguing that Israeli citizens, who face a highly centralized, bureaucratic system, have developed do-it-yourself mechanisms and alternative politics to influence policy making in general and health policy in particular.

Participation, Trust, and Performance of Health-Care Organizations

Health-care organizations play a significant role in the mechanism of the modern welfare state. As such, they are also significantly influenced by the transformation of the welfare state (i.e., its retrenchment, budget cuts, and the privatization of services). Welfare state reforms are often directed toward these organizations as part of the attempt to weaken the welfare state and the social security network (Hacker, 2002, 2004; Pierson, 1995). The question of organizational independence is especially important in this respect. In many cases, clients do not distinguish between policymakers and service providers, thus blaming health-care organizations for poor-quality services even though the decline in these services is also the result of government decisions (Rowe & Calnan, 2006).

Thus, health-care organizations face both significant external pressures due to budget cuts, the rise of private market competitors, and political intervention in the management process and internal pressures, especially from clients, to improve and modernize services. These pressures are often expressed in demands to adopt NPM strategies.

The NPM approach emerged in the 1980s and 1990s as part of a reform movement in the public sector (Lane, 2000, pp. 1–10). The basic argument suggests that central processes in traditional bureaucratic organizations are not efficient, are politically biased, and are poorly managed, thus leading to an inefficient supply of public services as well as to citizen dissatisfaction. The NPM approach suggests solving most of these problems by applying a managerial, rather than an administrative, approach and adopting managerial strategies developed in the private sector (Hood, 1995). This idea clearly expresses a change of belief in many countries where private ownership and management is preferred to public ownership and bureaucratic control (Esping-Andersen, 1999; Hood, 1991, 1995). Thus, the NPM approach treats bureaucrats as managers and citizens as clients, and NPM strategies include contracting out or the privatization of services, adopting a client-oriented approach, measuring performance and efficiency, and changing the incentive structure of workers from life-long employment to personal contracts (Lane, 2000, pp. 147–178). All these changes are expected to increase efficiency as well as the quality of services provided to the public.

This approach was very popular in the 1990s, yet it was also criticized by leading scholars for its inadequacy in handling public services such as health, education, security, and welfare (Hood, 1991). It has also been argued that the NPM approach is likely to lead to deterioration in the living conditions of the poor and increase socioeconomic gaps. Yet, there is no doubt that the NPM approach is still very popular in many countries and guides central public administration reforms (Lane, 2000, pp. 76–100). The approach pays special attention to the internalization of performance indicators and their potential for increasing trust. In a recent paper, Yang and Holzer (2006) explored the performance-trust link, arguing that the difficulty of empirically demonstrating this link is rooted in the difficulty of defining and measuring government performance meaningfully. They suggested that performance measurement can improve trust in government directly through citizen participation in the evaluation process or indirectly by improving citizens' perceptions of government performance. Yang and Holzer's account of the performance–trust link calls for an exploration of the mutual relation among trust, performance, and citizen participation in decision-making procedures. This paper attempts to conduct such an examination by focusing on the attitudes of Israeli citizens toward the Israeli health system.

CITIZEN PARTICIPATION IN DECISION-MAKING PROCESSES

The involvement of citizens in public administration decision making, as well as possible reforms in that direction, has recently been the focus of public administration research (Ebdon, 2002; King, Feltey, & Susel, 1998; Weeks, 2000). For example, public hearings are one of the most frequently used methods of participation, yet such public participation often proves inefficient in several ways

(Berner, 2003). Arnstein (1969) and Church et al. (2002) suggested viewing community input as a spectrum or "ladder" of participation. The lower rungs of the participation ladder comprise processes in which power holders seek to educate the public about particular issues. Higher up on the ladder are processes through which power holders consult individuals or groups who could potentially be affected by a proposed or current policy. Still higher up on the ladder, power holders and interested parties agree to share responsibilities for decision making. On the top rungs of the ladder, lay individuals dominate decision making. This level of participation requires a transfer of decision-making power from traditional decision makers to lay individuals. In accordance with this framework, Cooper, Bryer, and Meek (2006) developed a conceptual model of approaches to civic engagement that can range from adversarial to deliberative and citizen-centered, collaborative public management. Basically, we can hypothesize that high levels of participation are more likely to produce trust, yet Cooper and Bryer (2007) showed that strategies further down the ladder, such as manipulation, can be used effectively to increase trust and satisfaction. However, their account emphasizes the local level as a central scene for citizen participation where interpersonal relations and trust have an important impact.

Irvin and Stansbury (2004) weighed the advantages and disadvantages of citizen participation and concluded that the ideal conditions for citizens' participation are based on strong community ties, small groups organized locally, willingness to volunteer, and the urgency of the issues at stake. A more radical approach characterizes the work of King et al. (1998), who, based on interviews and focus group discussions, developed the concept of authentic participation (i.e., deep and continuous involvement in administrative processes with the potential for all involved to have an effect on the situation).

Thus, participation theory finds the application of participatory mechanisms at the local level the most effective for increasing performance and trust while attempting to identify the proper mechanism for achieving certain goals (Fung, 2006; Fung & Wright, 2001). In the current research, we did not measure a specific rung in the participation ladder but, rather, adopted a holistic approach, measuring the subjective feelings of respondents regarding the level of client participation in decision making in health-care organizations. Such an approach is especially relevant for health-care organizations that operate nationwide and may use various modes of participation.

Democratic participatory theory suggests that participation in decision-making processes increases the players' responsibility for the outcomes, so the players tend to accept and cooperate with the system (Dahl, 1971; Pateman, 1970; Putnam, 1993). Moreover, participation in decision-making processes may strengthen the sense of group identity and, correspondingly, loyalty to the group/organization (Bouckaert, Van de Walle, Maddens, & Kampen, 2002; Lincoln & Kalleberg,

1990; Osterman, 1999; Rose, 1999). In this manner, widespread participation of citizens in decision-making processes helps increase the performance of public agencies and the trust in them. Fornell, Anderson, Cha, and Bryant (1996) showed, for example, that monopolist companies receive lower client satisfaction ratings than nonmonopolists because the use of the latter companies depends on free choice. Therefore, the monopolistic nature of many government services alone could explain part of the dissatisfaction.

An engaged citizenry might become more sympathetic evaluators of the tough decisions that government administrators have to make, and the improved support from the public might create a less divisive, combative populace to govern and regulate (King et al., 1998; King & Stivers, 1998; Putnam, 1993). Most studies focus on the role of the public and better management of their involvement in the administrative process (e.g., Box, 1998, 1999; Rimmerman, 1997). Indeed, some studies employ theories of skill and resource transaction between social institutions to argue that the tradition of citizens' involvement is acquired through a process of political learning (e.g., Pateman, 1970; Peterson, 1990; Sigel, 1989; Sobel, 1993; Soss, 1999; Verba, Schlozman, & Brady, 1995). While these studies relate institutional actions or culture to individual political participation, they rarely consider the mutual relations among democratic participatory behavior, citizens' involvement in decision-making processes, and trust in public agencies. Citizens who participate in decision making feel responsible for the outcomes. Therefore, participating citizens are more likely to evaluate managerial quality and the performance of public agencies positively and thus have greater trust in administrative agencies. In turn, this increased trust motivates citizens to participate more intensively in decision-making processes.

People's experiences with participatory mechanisms are very subjective. For example, individuals may feel that they are not part of the decision-making process even when formal participatory mechanisms do exist. Conversely, individuals may feel that they can make their opinions heard even when such mechanisms do not exist. Therefore, we should measure participation in decision making as it is experienced by the public. Indeed, the relation between participation in decision making as it is perceived by the public and trust is at the core of the model proposed in this paper.

TRUST RELATIONS IN HEALTH CARE

Trust relations are central for the analysis of performance and management in health-care systems, which are often characterized by uncertainty and risk (Calnan & Rowe, 2006). Due to processes of budget cuts and privatization in health systems, individuals seeking health treatment cannot be certain about the motives, intentions, and future actions of others on whom they must rely (Calnan & Rowe, 2006; Mishra, 1996). Defining trust as the belief of an individual in the good

faith of others and their future intentions (Hosmer, 1995), trust can lead people who face uncertainty and risk to cooperate with the organization, thus increasing performance and satisfaction.

As mentioned previously, the majority of empirical research has addressed threats to patient–provider relationships. It has been argued that interpersonal trust between patient–practitioner may have therapeutic effects (Mechanic, 1998) as well as an indirect influence on health outcomes through its impact on patient satisfaction (Calnan & Rowe, 2004). The literature also shows that trust can be regarded as a quality indicator because patients suggest that high-quality doctor–patient interactions are characterized by high levels of trust (Safran et al., 1998). Trust is also a more sensitive indicator of performance than patient satisfaction (Thom, Hall, & Pawlson, 2004) and might be used as a potential marker of how patients evaluate the quality of health care. From an organizational perspective, trust is believed to be important for the provision of effective health care and has been described as a collective good. Specific organizational benefits that might be derived from trust as a form of social capital include a reduction in transaction costs (Gilson, 2003).

However, studies that focus on the organizational and institutional level tend to assess levels of trust rather than explain trust relations (Calnan & Rowe, 2004). In the United Kingdom, for example, patients have high levels of trust in individual clinicians but lower levels of trust in health-care institutions (Calnan & Sanford, 2004; Calnan & Williams, 1992; Tarrant, Stokes, & Baker, 2003). A survey conducted by Calnan and Sanford (2004) shows that patients in the United Kingdom have a high level of confidence in individual physicians (about 85 percent) but very little confidence in health service managers (about 30 percent). Yet, in their attempt to explain the determinants of the general public’s assessments of confidence in today’s national health-care system, the best predictors were aspects of patient-centered care, while the weakest predictors were aspects of macro-level performance such as waiting lists, waiting times, and cost cutting. In other words, the low level of confidence in managers does not necessarily reduce the confidence in the system and the organizations as long as patients trust their own doctor.

The institutional aspects of the British health-care system are at the center of Rowe and Calnan’s analysis (2006, p. 378) in which they adopted a sociological approach “in order to understand how the meaning and enactment of trust is influenced by wider social structures and in particular how changes in the organization and delivery of health care as well as broader social changes may have affected trust relations in the UK NHS.” More specifically, they argued that key policy initiatives, such as the introduction of clinical governance, the use of performance management, the increase in patient choice, and involvement in decision making regarding care changed the context for trust relations within the national health-care system. Viewing changes in trust as driven by the dialectical relation

between trust, power, governance, and accountability, it follows that changes to governance mechanisms that seek to increase accountability will produce shifts in the extent and distribution of power and trust relations between patients, health-care professionals, and the state. Rowe and Calnan then developed a theoretical framework for analyzing trust relations in the U.K.'s national health-care system, suggesting that the market model and the NPM model are likely to produce low levels of trust while the bureaucratic model and the professional model are likely to produce high levels of trust. In this paper, we basically accept Rowe and Calnan's institutional approach, yet we question their criticism of the NPM model and especially the possible contribution of participation in decision making to increased levels of trust.

A similar approach is adopted by Schee, Groenewegen, and Friele (2006), who attempted to evaluate the impact of the decline in the performance of the Dutch health-care system on trust. They found that trust appears to be relatively stable between 1997 and 2004 although performance objectively changed, meaning that public trust cannot be a reliable measure of the performance of a health-care system. They, therefore, questioned whether the measure of public trust is sensitive enough to provide information on the performance of the health-care system. We present a measurement tool that has proven to be sensitive to performance. This tool can also strengthen the reliability and validity of the measures used by Calnan and Sanford (2004).

THE ISRAELI HEALTH-CARE SYSTEM AND TRUST

The Israeli health-care system is composed of four health-care organizations operating under governmental regulations. Until the mid-1990s the system was dominated by Kupat Holim Clalit (henceforth: Clalit), which was established during the 1920s by the national labor union (Histadrut). Clalit was the major supplier of health-care services, operating hospitals and clinics at all levels and in all geographical areas. Health insurance was paid via the labor union taxes, and hence, by the 1980s the Israeli health-care system faced a major economic crisis (Chernichovsky & Chinitz, 1995). After a very complex political process, the Israeli Parliament voted on June 15, 1994, to enact the National Health Insurance Law (NHIL). The law included national health insurance, granting a basic package of care to each citizen and thereby bringing most of the system's finances under public auspices. While the financing of the system was actually nationalized and done through governmental channels, the provision of health-care services remained in the hands of the four health-care organizations, which were financed based on a capitation formula. These changes weakened the dominance of Clalit and triggered the privatization of those services that were not included in the basic package.

Following the enactment of the NHIL, the government tightened its control of

the health-care system by pushing through various legislative amendments of the law that regulated the powers, management, and supervision of the health funds, even though this was not part of the underlying rationale of the law (Horev, 2004; Horev & Babad, 2005). All these measures have enabled the Ministry of Finance to gradually reduce the public share in the funding of health-care services as part of its general and ongoing policy, yet not necessarily planned for the long term, of retrenching the welfare state.

Thus, latent privatization processes in the Israeli health-care system have occurred via incremental policy making, with the Ministry of Finance adopting an approach of “muddling through” in budget management and resource allocation (Lindblom, 1959; Wildavsky, 1984). The fact that this behavior is facilitated by centralization processes, however, increases the potential for inefficiency. Practically speaking, it does not allow market forces to take part in the health-care system even as the government cuts back on funding (Horev & Babad, 2005). Consequently, residents are increasingly required to find their own solutions to the resulting shortage in health-care services. They seek immediate solutions in semi-legal or “black” markets, which, in turn, are institutionalized by the government, thus exacerbating the lack of long-term planning in the system (Mizrahi & Meydani, 2003). Such processes place significant pressures on health organizations, as clients demand a wide variety of high quality services while the government blocks many initiatives in that direction.

Thus, client participation in the Israeli health-care system is effectively manifested through a do-it yourself strategy and unilateral initiatives that ultimately force institutional changes in the system (Horev & Babad, 2005; Mizrahi & Meydani, 2003). It follows that in the Israeli health system there are relatively few formal mechanisms for client participation in decision making. According to the model posited in this paper, we expect to find a relation between this low level of participation and a low level of trust in the health-care system.

Indeed, studies have shown that more than 10 years of implementation have not achieved the goals of the NHIL, largely due to significant budget cuts and the retrenchment of the welfare state. Chernichovsky, Elkana, Anson, and Shemesh (2005) showed that there is a correlation between the relative health of the population and socio-demographic characteristics. The impact is clearly expressed in the declining quality of services in peripheral geographic areas and the weaker sectors of society (Gross & Barmeli-Grinberg, 2001; Heler, 2002; Nirel & Rosen, 2004; Swirski, 1999). Shoval and Anson (2000) also showed that the new law did not significantly improve the situation of the weaker sectors.

We attempt to assess the current level of trust in the institutions responsible for health-care provision in Israel and explore the possible determinants that can explain trust relations in the Israeli health-care system. While client satisfaction is measured by internal surveys conducted by the health-care organizations as well

as by academic research (Gross, Barmeli-Grinberg, & Mazliach, 2007), there are relatively few studies of trust in the Israeli health-care system. Furthermore, they do not explore the wide range of aspects of trust in the system, nor do they explain the variables influencing the level of trust (Chinitz, 2004; Chinitz, Galili, Alster, & Israeli, 2001). Indeed, Chinitz (2000) suggested studying the impact of trust on policy aspects but did not treat trust as a dependent variable. In this paper, we suggest a comprehensive analysis of trust.

Participation, Trust, and Performance in Health Care: The Israeli Case

The relations between participation in decision making, performance, and trust in Israel have been modeled and empirically examined in a five-year longitudinal study (Vigoda-Gadot & Mizrahi, 2008). In this section, we rely on this framework, suggesting a modified model that takes into consideration the special characteristics of health-care organizations.

RESEARCH MODEL AND HYPOTHESES

The research model examines the effect of perceived citizen participation in decision making on the perceived performance of health-care organizations and on trust. To isolate this impact and establish the relations between these variables, we also examine the possible impact of alternative variables on trust, that is, the effect of perceived performance and client satisfaction on trust in health care as well as the impact of citizen perceptions about the structural characteristics of the health-care system on trust.

Specifically, the model includes three structural variables that were tested as independent variables: autonomy, accessibility to services, and equality in service provision. Autonomy refers to the level of managerial independence of the organization as perceived by clients. Accessibility to services refers to clients' perceptions regarding the degree to which they can actually access health services. Equality in service provision refers to the degree to which clients believe that health services are provided equally.

The relations between all the variables are presented in Figure 1, which is based on the theoretical development we have presented so far. We should emphasize that all paths in the model represent correlative relations and no causal relations should be inferred. We start by suggesting that perceived citizens' involvement and participation in decision making at the administrative level is positively related with the performance of the organization as perceived by citizens. As explained previously, this hypothesis is based on the idea of authentic participation and the works by Irvin and Stansbury (2004) and King et al. (1998). We argue that when people are heavily involved in practical administrative processes of any kind, they

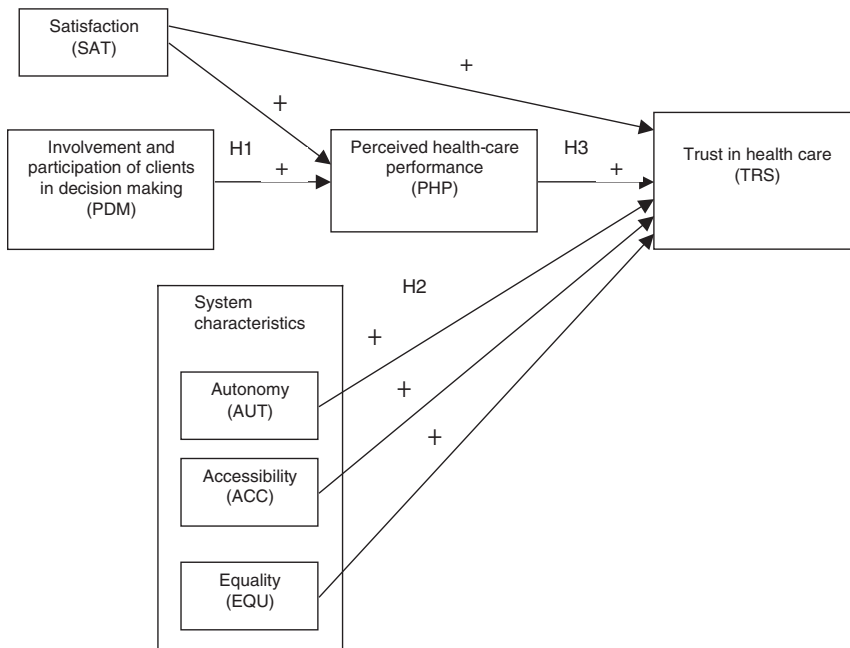


Figure 1. Research Model

Note: All paths represent correlative relation; no causal relation should be inferred.

acquire a better understanding and more realistic perspective of specific processes, difficulties, and dilemmas that the public sector and its officials face in daily activities. As a result, these citizens will tend to have more positive perceptions about the quality of services and goods with which they are provided by the organization. In line with these arguments, we suggest the first hypothesis.

H1: *Perceived health-care performance is positively related to satisfaction with health-care organizations and with perceived citizen participation in decision making in health-care organizations.*

Health-care organizations are often subjected to strict governmental regulations regarding their budget and the amount of services they ought to provide (Chernichovsky, 2005). Yet citizens usually regard the organizations themselves, rather than the government, as responsible and accountable for the services they receive. The variable of autonomy indicates the extent to which health-care organizations are regarded as independent in their activity and accountable for outcomes and is likely to affect the level of trust in the organization. Accessibility to services and equality in service provision are two system characteristics that indicate the degree to which clients believe that the organization is willing to pro-

mote egalitarian values rather than solely economic values. Given the definition of trust as citizens' beliefs in the good intentions of the organization toward its clients, citizen perceptions regarding these system characteristics are likely to be positively related with trust. Therefore, we expect positive relations between these system characteristics and trust because a high level of autonomy, accessibility, and equality can guarantee that client interests will be positively considered. Thus, we suggest the second hypothesis.

H2: *Trust in health-care organizations is positively related with autonomy, accessibility to services, and equality in service provision.*

Modern public administration and NPM emphasize market-oriented parameters such as organizational performance and client satisfaction. These variables are most likely to influence trust, as demonstrated by Vigoda-Gadot and Mizrahi (2008). The third hypothesis follows.

H3: *Trust in health-care organizations is positively related with perceived health-care performance and satisfaction.*

METHOD: SAMPLE AND MEASURES

The model is examined with data gathered in Israel during the spring of 2007. The data were collected using questionnaires distributed to citizens nationwide. The questionnaire was designed to examine citizens' perceptions of health-care organizations—especially the four health-care organizations operating in Israel—and different aspects of the services they provide. Altogether, 656 individuals participated in the study. Data were collected by a random sampling method. We sampled various cities and other communities based on geographic location and the size and structure of the population. In addition, we sampled the four health-care organizations to guarantee that each health-care organization was represented in the sample relative to its market share in the population. Interviewers met the participants in public venues, governmental institutions, and private homes, and, as explained in the following discussion, we made sure that the sample was representative post hoc. Citizens were approached by one of the research assistants and asked if they would be willing to take part in the study. The ratio between those who were asked to participate and those who finally participated in the survey constitutes the response rate, which was 65 percent.

Of the total sample, 45 percent were men and 55 percent women, and 50 percent were married. Average age was 38 years (*S.D.* = 14.6) and average years of education was 13 (*S.D.* = 2.56). With regard to socioeconomic level, 87 percent were Jews, and a breakdown by income showed that 30.8 percent had a low monthly net income (up to NIS 4,000; \$900), 39.5 percent had an average income (NIS 4,000–7,000; \$900–1,600), and 28.5 percent had a high income (above NIS

7,000; \$1,600). Note that the research sample was highly representative of the overall Israeli population. The demographic characteristics of the sample were quite similar to those of the total population in Israel as reported in the Statistical Yearbook. The average level of health of the participants (ranging from 1 to 4, where 4 represents *very good health*) was 3.3 (*S.D.* = 0.66). The average number of visits to clinics was 3.6 visits per year (*S.D.* = 1.18).

The variables were measured in this study by groups of questions that were verified and tested in previous research on trust in the public sector (Vigoda-Gadot & Yuval, 2003, 2004; Vigoda-Gadot & Mizrahi, 2008). Evaluations were provided on a scale of 1 to 5.

To determine how much voice individuals felt they had in the decision-making process, respondents were asked to evaluate: (a) the degree to which their health organization considers client participation important, (b) the degree to which they feel that they take part in decisions, (c) the degree to which they are asked to take part in decisions and processes regarding improving efficiency and services, (d) the degree to which they receive information from and provide information to their health organization, (e) the degree to which their health organization consults them, and (f) the degree to which they are asked to evaluate performance. The average score of these evaluations comprises the subjective evaluation of respondents regarding the level of client participation in decision making in the health system. In other words, we did not measure specific participatory mechanisms but, rather, measured the subjective feelings of the respondents about their opportunity to participate in their health-care provider's decision-making process. Such an approach is especially relevant for health-care organizations that operate nationwide and may use various modes of participation.

To measure the perceived performance of health-care organizations, respondents were asked to evaluate (a) the efficiency of the health-care organization, (b) the professionalism of workers, and (c) the degree to which their health-care organization (a) sets and achieves its goals, (b) provides high quality and fast service; (c) uses advanced technologies, (d) initiates new ideas, and (e) allocates resources in a manner that serves the public. The average score of the answers to these questions comprises the perceived performance of health-care organizations.

To measure the level of satisfaction, respondents were asked to rate their satisfaction with (a) the services they receive from their health-care organization, (b) the quality of the medical treatment, (c) the quality of administrative services, (d) the quality of management, (e) the operation of their health-care organization, and (f) the outcomes. The average score of the answers to these questions comprises the level of satisfaction with health-care organizations.

To measure trust in health-care organizations, respondents were asked to evaluate their trust in their health-care organization as well as the level to which

they trust managers of their health-care organization, the general management, physicians, and workers in their health-care organization. The relevant measure for our purposes is trust in the organization, although trust in the various functions of the organization may provide some interesting insights into the nature of trust in health care.

In addition, the model includes three additional variables that were tested as independent variables: autonomy, accessibility to services, and equality in service provision. Sample questions that measure autonomy are: “My health-care organization is the only one that decides which health-care services I will get, at what level of quality, and for how long a period of time” and “There are people and organizations that can obtain services which I cannot because I am not part of these organizations.”

Accessibility was measured by questions such as “I feel that I can approach my health-care organization’s workers and managers anytime in order to clarify things important to me” and “My health-care organization always explains my rights as a client to me and maintains good and efficient communication channels with its clients.”

Equality in service provision was measured by questions such as “My health-care organization provides equal services for all clients, without regard to race, religion, or gender” and “My health-care organization will employ any capable worker, without regard to race, religion, or gender.”

FINDINGS

The psychometric characteristics of the research variables and the correlations between them are presented in Table 1. Trust in health-care organizations is modest (3.15). While Israeli citizens are relatively satisfied with the health services they receive (3.34), health-care performance (3.2) is regarded with less satisfaction. Israeli citizens do not feel that they participate in decision-making processes in the health-care system in general (2.5) or in any of the health-care organizations in particular. In a similar vein, the level of accessibility to services is considered low (2.75). However, the two other structural variables—autonomy in operation and equality in services—are evaluated at a medium to high level (3.43 and 3.37, respectively).

Table 1 also presents zero-order correlations for the research variables. As can be seen, most of the inter-correlations hold in the expected directions. Perceived health-care performance demonstrates positive and quite strong relation with citizens’ involvement and participation in decision making and satisfaction ($r = .55, p < 0.001$ and $r = .76, p < 0.001$, respectively). Trust in health care is positively related with perceived health-care performance, participation in decision-making, and satisfaction ($r = .74, p < 0.001$; $r = .49, p < 0.001$; and $r = .72, p < 0.001$, respectively).

Table 1. Correlation Matrix

	Means	S.D.	N	1	2	3	4	5	6	7	8
1. Participation	2.50	0.73	650								
2. Satisfaction	3.34	0.79	650	.53***							
3. Accessibility	2.75	0.88	649	.41***	.31***						
4. Autonomy	3.43	1.24	645	<i>ns</i>	.13***	<i>ns</i>					
5. Performance	3.20	0.78	646	.55***	.76***	.37***	.16***				
6. Trust	3.15	0.87	645	.49***	.72***	.40***	.08**	.74***			
7. Political participation	2.21	0.49	649	<i>ns</i>	<i>ns</i>	<i>ns</i>	.15***	<i>ns</i>	<i>ns</i>		
8. Point of view	2.73	0.67	649	.13***	<i>ns</i>	.09*	<i>ns</i>	.09*	.09*	.09*	
9. Equality	3.37	0.79	642	.25***	.37***	.15***	<i>ns</i>	.35***	.41***	<i>ns</i>	.09*

*p ≤ .05. **p ≤ .01. ***p ≤ .001.

Trust is also positively related with two of the structural variables—accessibility and equality ($r = .40$, $p < 0.001$ and $r = .41$, $p < 0.001$, respectively)—while it has a relatively weak relation with autonomy ($r = .08$, $p < 0.01$). Two additional control variables—political participation and attitudes towards democracy—were found to be weakly or insignificantly related with the research variables. These findings provide initial support for hypotheses H1, H2, and H3. The strong correlation between perceived performance and satisfaction indicates that, as often observed, satisfaction reflects perceived performance (Kelly & Swindell, 2002). The strong correlation among trust, satisfaction, and performance is not unusual and is acknowledged in the literature (Van Ryzin, 2004, 2005; Van Ryzin & Freeman, 1997; Van Ryzin, Muzzio, & Immerwahr, 2004; Van Ryzin, Muzzio, Immerwahr, Gulick, & Martinez, 2004; Vigoda-Gadot, Mizrahi, Miller-Mor, & Tevet, 2008). Indeed, it may indicate that there is a significant overlap among the concepts, yet the literature also clearly distinguishes between trust and satisfaction, as well as between satisfaction and performance. Trust is considered more of a psychological state of counting on someone to do the right thing, whereas satisfaction is an output reaction to the quality of goods or services. Furthermore, satisfaction is only a part of overall performance, which can also be measured by other means such as hard economic data, financial figures, or goal setting and goal attainment. This methodological limitation is discussed later. However, these relations still need to be tested with multivariate analysis to determine their stability.

Table 2 presents the results of three multiple regression analyses in which trust is first regressed on all the independent variables and then on part of them, and perceived health-care performance is regressed on participation in decision-making and satisfaction. The impact of sociodemographic characters such as gender, age, and education was not found significant. According to Table 2 (column 3), perceived health-care performance is positively related with participation in decision making and satisfaction ($\beta = .21$; $p < 0.001$ and $\beta = .65$; $p < 0.001$, respectively). These findings support H1. The first column in Table 2 shows that the dependent variables are generally related with trust to a large extent ($R^2 = 0.62$). Trust was positively related with satisfaction and perceived health-care performance ($\beta = .35$; $p < 0.001$ and $\beta = .37$; $p < 0.001$, respectively). However, trust is not directly related with participation in decision making. These results also remain stable when trust is regressed solely on participation in decision making, satisfaction, and perceived health-care performance (second column in Table 2). These findings support H2. The combination of H1 and H2 means that the model is generally supported without any direct test of mediation. Finally, trust has no relation with autonomy and relatively weak relations with accessibility and equality ($\beta = .12$; $p < .001$ and $\beta = .13$; $p < .001$, respectively). Hence, H3 is only partially supported, meaning that these structural variables are not good candidates for predicting or explaining trust. We now discuss the implications of the study.

Table 2. Multiple Regression Analysis (Standardized Coefficients) for the Effect of Independent Variables on Trust and Performance

	Trust			Trust			Performance		
	β	<i>t</i>	SE	β	<i>t</i>	SE	β	<i>t</i>	SE
Constant		-1.71	.13		1.12	.10		5.5	.09***
Participation	.03	.83	.04	.06	2.08	.04*	.21	7.18	.03***
Satisfaction	.35	8.9	.04***	.36	9.22	.04***	.65	22.2	.03***
Accessibility	.12	4.28	.03***						
Autonomy	-.03	-1.06	.02						
Performance	.37	9.15	.04***	.43	10.83	.04***			
Equality	.13	4.8	.03***						
<i>R</i> ²	.63			.60			.61		
<i>N</i>	631			644			646		
<i>F</i>	175.63***			322.67***			494.9***		

p* < .05. *p* < .01. ****p* < .001.

Trust in Health Care and Political Culture: A Discussion

Trust relations are central for the analysis of performance and management in health-care systems, which are often characterized by uncertainty and risk. Defining trust as the belief of an individual in the good faith of others and their future intentions, trust can lead people who face uncertainty and risk to cooperate with the organization, thus increasing performance and satisfaction.

The paper contributes to the study of trust, participation, and performance in several important aspects. First, most of the theoretical and empirical research in the area of citizen participation emphasizes that such mechanisms are most effective at the local level and in small groups (Fung & Wright, 2001; Irvin & Stansbury, 2004; King et al., 1998). Studying the relation among trust, participation, and performance in health-care systems, which operate nationally and deal with complex issues related to the welfare of society, poses an important challenge to the generalizing of participation mechanisms.

Second, trust in health-care systems may be a very complex and ambivalent concept (Calnan & Rowe, 2006; Mishra, 1996), which makes the relation between citizen participation and trust in health-care systems extremely interesting.

Third, our model studies trust, participation, and performance in relation to other variables such as autonomy, accessibility, equality, and participation in decision making. The literature on such relations is quite limited.

Fourth, the study explores these relations in the Israeli social and cultural context, which is different from the conventional North American or European one. Israeli society provides an interesting field in which to study trust relations, and its health-care system may be a good exemplar of other health systems. The Israeli health-care system has many unique features, including the fact that its entire population is enrolled in "managed care" plans, the extent to which those plans are regulated by the government, and the extent to which needs-based capitation is central to financing health care. This is not to say that the Israeli system has been successful, but rather to note that Israel provides an important, real-world test case of a much talked-about model (Rosen, 2003, p. 137).

The findings show that Israeli citizens do not have a high level of trust in health-care providers, nor do they feel that they participate in decision making. Trust in health care is positively related with performance and satisfaction much more than with participation in decision-making processes. Participation is positively related with performance.

The fact that participation in decision making is not related with trust either directly or even strongly indirectly may imply that citizen participation cannot be regarded as a good mechanism for increasing trust in health-care organizations. This conclusion sets certain boundaries for participation theories, as it implies that in complex organizations, which deal with multidimensional and complex

issues, participatory mechanisms may fail to increase trust. Alternatively, integrating participatory mechanisms into health-care organizations may require a decentralization of decision-making processes in a way that opens the doors for citizen participation (Fung & Wright, 2001). However, we would like to offer another possible explanation that concentrates on political culture.

As demonstrated by Mantzavinos (2001) and Mantzavinos, North, and Shariq (2004), any human activity involves problem solving, in which the individual is constantly engaged in learning ways to solve problems—either existing ones or new ones. In a similar vein, Peterson (1990) and Sobel (1993) described the relation between work and politics as a spillover effect. This notion arose from early research on the work/nonwork relation (Blauner, 1964; Goldthorpe, Lockwood, Bechhofer, and Platt, 1971). The spillover model states that the nature of one's work experiences will carry over into the nonwork domain and affect attitudes and behaviors there. It posits transference of beliefs, attitudes, and values learned in one setting to another. The degree of involvement at work will be directly related to the degree of involvement in social roles outside the workplace (Champoux, 1981; Randall, 1988). Moreover, influences also flow from family and religion to the community or to the political system (Crouter, 1984; Price, 1985). Sobel (1993) suggested a spillover effect in the opposite direction in which intense participation in politics might influence work participation, participation in decision making, and one's attitudes toward the organizational environment.

We may thus infer that public sector performance and trust are related with participation in decision making either positively or negatively depending on the nature of the political culture. A participatory political culture motivates positive relations between participation in decision making and performance, whereas a nonparticipatory culture encourages negative or no relations between participation in decision making and performance. Research on Israeli society shows that Israeli society has gone through learning processes at the national/political level that have led to the internalization of a problem-solving approach characterized by unilateral solutions (Ben-Porat & Mizrahi, 2005; Mizrahi & Meydani, 2003). As a result, participation by the public in the political arena has focused on the use of alternative politics. This mode of behavior differs significantly from democratic participatory behavior, and therefore the necessary condition for successful implementation of participation in decision making has not been fulfilled.

Israeli political culture can best be described by what we term the alternative provision of public services or alternative politics. Specifically, during the 1980s and 1990s, many groups and individuals in Israeli society employed noninstitutionalized initiatives to create alternatives, often illegal or semi-legal, to governmental services. The 1980s were characterized by a significant growth in the "black-market economy"—particularly the illegal trade in foreign currency, "gray-market medicine" (expressed in the semi-legal, private supply of health services

use of public facilities), “gray-market education” (expressed in the employment of privately paid teachers and the evolution of independent private schools), and pirate cable networks—all of which were alternatives to inadequate governmental services (Lehman-Wilzig, 1992). In the 1990s, this mode of behavior spread to other policy areas such as civil marriage (Lehman-Wilzig, 1992), internal security (Zinger, 2004), social welfare (Gidron, Bar, & Katz, 2003), and even the policy toward the Arab–Israeli conflict (Ben-Porat & Mizrahi, 2005). Indeed, during the 1990s, it became clear that, for the most part, only initiatives of this kind could help people obtain the services they needed (Mizrahi & Meydani, 2003). Furthermore, the Israeli government responded positively to those initiatives by changing its policies in the direction signaled by these groups (Bruno, 1993; Chernichovsky, 1991; Yogev, 1999). To a large extent, the policymaking process has transformed from a top–down orientation into a bottom–up orientation.

This transformed political culture has little to do with conventional democratic participatory behavior, meaning that there are no solid grounds for participation in decision-making reforms. Therefore, contrary to the assumptions made by the studies presented previously, the Israeli public is also unlikely to believe that mechanisms for participating in decision making will result in better public sector performance and increased trust in government. It follows directly that the structural and cultural conditions in Israel significantly differ from those in the United States, meaning that most of the participation in decision-making literature developed in the American context should be applied carefully.

As discussed previously, the Israeli health-care system is not exceptional in this regard. For many years, it was characterized by mechanisms of alternative politics, and since the passage of the NHIL in 1995, the financing of the system has been highly centralized. Under these circumstances, Israeli citizens do not feel that they have a real say in decision-making processes and do not relate such participation with trust. On the other hand, they utilize a direct, do-it-yourself approach in the form of gray-market medicine very effectively (Lachman & Noy, 1998). This twofold process calls for careful planning about the possible ways of integrating existing do-it-yourself initiatives into health-care reforms in a positive manner that will also increase levels of trust. Further research will elaborate on such integration.

Finally, several limitations of the study should also be mentioned. First, there is a strong correlation among three major variables. However, as explained previously, the strong correlation among trust, satisfaction, and performance is not unusual and is acknowledged in the literature. Second, we do not compare our model to other alternative models. Thus, we can comment only on the quality of the relations proposed here, not on alternative relations that might have given rise to other models. We believe this problem can be resolved with structural equation modeling, if and when the model is applied in future studies. In this study, we do

not challenge the basic model with other alternatives. Doing so would have called for broader theory building and rationalization and a more complicated analysis. Our hypotheses point to elementary relations among variables that were not examined that far in the context of our model. These relations undoubtedly deserve future consideration, especially given that autonomy, accessibility, equality, and participation in decision making are related to satisfaction, trust, and performance. We encourage future researchers to use our model as a starting point for comparison with other models that involve the same variables but that rely on a more specific and perhaps also causal theory.

Third, the results of our study cannot and should not be interpreted in a causal way but, rather, at the level of correlative relations. Fourth, our findings are based on self-reported data. This technique may result in source bias (e.g., the social desirability effect) or common method error. Nevertheless, the study demonstrates sound psychometric properties in terms of the reliabilities of the research variables, which testifies to the solid structure of our measures and their construct validity. Finally, we must note that our data and model apply to only one culture, the Israeli one. Future studies that use data and settings other than the Israeli one can extend our knowledge about the validity of the theoretical model and its implications for health services worldwide. Nonetheless, these limitations should not minimize the benefits of our model and findings. Further studies are needed to support them in other sociopolitical environments.

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