Investigations of trust in public and private healthcare in Australia: A qualitative study of patients with heart disease

Samantha B. Meyer
University of Waterloo, Canada

Abstract
The Australian healthcare system is complex, comprised of public services (universal access via Medicare) and private health insurance options (fee-for-service). This article presents data from a qualitative study investigating patients’ trust in Medicare and private healthcare in Adelaide, Australia. Interviews were conducted with 37 patients with coronary heart disease between October 2008 and September 2009. The findings suggest that private health insurance holders are fearful and distrusting of public healthcare. Additionally, the findings indicate that both public and private healthcare users are concerned about, and many are distrustful of, the role of government in public healthcare services. These findings are discussed in relation to Niklas Luhmann’s social theories of trust, which provide an analytic framework for understanding private health insurance subscribers’ distrust in Medicare.

Keywords
health, insurance, Luhmann, Medicare, private healthcare, trust

There is a wealth of literature highlighting declining levels of trust in healthcare (Birungi, 1998; Davies and Rundall, 2000; Gilson, 2003, 2006; Goudge and Gilson, 2005; Mechanic, 1996; Mechanic and Meyer, 2000; Welsh and Pringle, 2001). However, Calnan and Sanford (2004: 92) suggest that ‘the empirical evidence about the extent of the decline in trust in healthcare appears to be limited and inconsistent’ and have argued that trust in healthcare as a system is declining, but that trust in medical professionals remains strong (Calnan and Sanford, 2004; Dew et al., 2007). The Australian healthcare system provides near-universal public health services through Medicare. However, about
50% of the population have private coverage (Harley, Willis et al., 2011). There has been a large amount of theoretical and empirical research on patient trust in healthcare in Australia (Apps et al., 2004; Lupton and Tulloch, 2002; Meyer and Ward, 2008; Meyer et al., 2008b, Ward and Meyer, 2009), and internationally (Brown, 2008; Brownlie and Howson, 2005b; Calnan and Sanford, 2004; Casiday et al., 2006; De Costa et al., 2008; Hall et al., 2002; Mainous III et al., 2001). Extending previous research through the application of Luhmann’s social theories of trust, this article presents original data that explores the nature and extent of trust in public and private healthcare systems in Australia.

Medical sociologies recognize and conceptualize two forms of trust: institutional and interpersonal (Lewis and Weigert, 1985). Interpersonal trust is regarded as being negotiated between individuals (a decision to trust someone or not) and as a learned personal trait, whereas institutional trust is that which is placed in an abstract system or institution. It is beyond the scope of this article to provide an exhaustive analysis of the theoretical literature on trust, and this has been done admirably in recent sociological literature (Allsop, 2006; Barbalet, 2009; Brown, 2009; Brown and Calnan, 2012; Gilson, 2003; Kuhlmann, 2006; Natalier and Willis, 2008). For the purpose of this research, trust is defined as the optimistic acceptance of a vulnerable situation that is based on positive expectations of the intentions of the trusted individual or institution (Dugan et al., 2005; Gilson, 2003; Hall et al., 2001).

Luhmann addresses the concept of trust in terms of its function in society (Luhmann, 1988), which fits with his overarching structural functionalist theory. He argues that trust is the ‘glue’ that holds everything together in social life because it reduces the complexity of how individuals think about the world around them, providing them with the capability to act and make decisions (Pearson et al., 2005). The decision to place trust or distrust reduces complexity in society because both decisions function as ways to pursue actions rationally (Luhmann, 1979).

Central to understanding Luhmann’s theories of trust is his influential Social Systems Theory. Luhmann’s work has been described as being divided into two parts (Seidl and Becker, 2006). Herein reference is made to his earlier writings on Social Systems Theory (Luhmann, 1990) and subsequent works that focus on autopoiesis (Luhmann, 1995).

Social Systems Theory studies the complex systems that exist in nature, society and science. The basic characteristics of Social Systems Theory are social differentiation and system formation; the differentiation of society and formation of internal and external systems. Society, via communication, is differentiated into social systems based on the function of the systems, which has led to the development of social systems such as the economic, healthcare and political systems. Systems are self-referential and are differentiated by the form and semantics of communication within and outside of them.

While Luhmann’s theorizing may be partly captured by the term ‘self-referential society’, one also needs to keep in mind the centrality of ‘autopoiesis’, which comes from biological systems theory (Luhmann, 1995). Autopoiesis is a process whereby systems (in this case, social systems) strive to develop themselves as self-managing or self-organizing systems that can develop and maintain their boundaries with the outside
world (in this case, other social systems) (Borch, 2005; Mingers, 2004; Van Assche and Verschraegen, 2008). Autopoietic systems are operatively closed, whereby all operations are produced by the system itself in the process of self-reproduction. The system maintains contact with the environment; however, no operations can enter or leave the system (Seidl and Becker, 2006). For example, in Australia the operations within state healthcare (e.g. the way in which funding is managed) are maintained and remain within the system itself, although the system maintains contact with the environment (e.g. the federal government provides the state healthcare budget). For Luhmann, all systems’ boundaries depend on the self-organization of subsystems (Luhmann, 1997). If society is understood as a global system, then all systems within society depend and mutually interact with all other systems and subsystems. All the while, systems and subsystems continue the process of deconstruction and reconstruction, requiring self-distinguishing capacity.

Central to Luhmann’s works is complexity reduction. He argues that the objective world outside of an internal system is more complex because the modern world consists of more possibilities than the system itself can realize. Consequently, internal systems exhibit greater order because they have fewer possibilities (less variation in understanding) than the outside world (Luhmann, 1990). The system has a subjective representation of the world and reduces the world’s complexity to an amount that it can meaningfully orient itself with, by structuring the possibilities of its own experiences and actions through the agreement of the system’s members. Additionally, systems can form subsystems to further reduce complexity (Luhmann, 1997). The functionally differentiated partial systems are themselves autopoietically organized (Muller and Powell, 1994). The inner order of a system helps to stabilize an extremely complex environment by organizing a less complex system-order that is better suited to human capacities for action (Luhmann, 1988). However, he also argues that within its boundaries a system can grow in complexity, ‘for only within its boundaries, can a system operate, build up, change, or forget’ (Luhmann, 1997: 71).

The focus of this research is Luhmann’s social theories of trust; however, the above engagement with Social Systems Theory and Luhmann’s work on the organization of society is important to the investigation of trust in healthcare systems. Luhmann viewed trust as a major component in the reduction of complexity within and between social systems and subsystems. In this way, trust becomes the core functional element that maintains social order and functioning. In application to this research, the interaction between systems is of central importance. Despite being closed, systems maintain contact with the environment. They are simultaneously autonomous and dependent. Muller and Powell (1994: 46) write:

The scientific system could never get by without the political system, but the latter is also dependent on knowledge made available by science and scholarship. The art system is dependent on, for example, the legal system or on the political system; here, too, dependencies can easily be inverted.

Of central importance here is the acknowledgement that systems are dependent on one another. For Luhmann, the interactions between social systems and individuals (psychic
systems) are not conceptualized in a one-way, unidimensional manner. Rather, trust is best understood in a multidimensional sense (Brown, 2008), with trust in one social system being highly dependent on trust both in other social systems and individuals (Luhmann, 1979). Of interest in this article is the extent to which system interaction influences the nature and extent of patient trust in healthcare. The corollary is obviously also the case, whereby trust in one system (public or private healthcare) is highly contingent on trust in a variety of social systems within which it mutually interacts (e.g. government, private health insurers, financial systems) (Meyer et al., 2008).

Australia is of particular interest when researching trust in healthcare because of its dynamic two-tiered healthcare arrangement. Healthcare in Australia is universal in that all Australians receive the same access to healthcare services through Medicare (Australian Government, 2006). However, healthcare is also available for private purchase, which reduces waiting times and hospital measures, and provides access to specific doctors and additional services not covered by Medicare (Willis et al., 2009).

Luhmann’s Social Systems Theory is pertinent to investigating trust in public and private healthcare because both systems ultimately interact with medical education, government and economics. The structure of the current healthcare system has been shaped by wider political influences over the past few decades. Since the late 1970s the tone of Australian welfare has largely been towards a greater uptake of neoliberal social policies. Some writers call the current Australian form of the welfare state ‘neo-liberal’ (Paul, 2012) and identify it as one that is explicitly modelled on market values and practices (i.e. privatization) (Clarke, 2004; Ward et al., 2011). In reference to healthcare, this has been implemented in the form of, for example, government rebates to facilitate purchase of private health insurance (PHI), additional Medicare charges for high income earners who do not take out PHI and the Private Health Insurance Incentives Scheme. As a result, rates of PHI have increased in Australia with 44.5% of the population having hospital coverage and 51.2% ancillary coverage in 2009 (see Harley et al., 2011: 308). Thus, consumer trust in private health insurers and government may be considered to be prominent influences on consumer trust in healthcare systems. The aim of this article is to explore the nature and extent of trust in public and private healthcare in Australia.

Methodological approach and research design

A qualitative theory-driven methodology was employed (Layder, 1998). The design of the research followed Danermark et al. (1997) who outline a six-stage model for explanatory research. Following a critical analysis of Luhmann’s social theories of trust (Meyer et al., 2008), research was designed to investigate patient trust in a variety of social systems in order to understand the nature and extent of trust in public and private healthcare. An intrinsic case study (Stake, 2003) with patients with coronary heart disease (CHD) was employed as a means of conducting the research. CHD patients were selected as a case study because they have had a wide range of experiences with the Australian healthcare system, as inpatients and/or outpatients in public and/or private healthcare. In line with theory-driven research, the sampling structure was theoretically informed by an initial critical analysis of social theories of trust (see Meyer et al., 2008). A range of factors understood to influence trust were investigated as part of the research project.
(e.g. risk, familiarity) and CHD provided a case study where these potential influences are evident (e.g. there are varying levels of risk in CHD; CHD patients engage with their GP [likely someone they are familiar with] and cardiologists/surgeons [likely a low level of familiarity]). These influential factors are not discussed within this article but data are published elsewhere (see Meyer and Lunnay, 2013; Meyer et al., 2012; Meyer and Ward, 2013).

A non-probabilistic, purposeful sampling approach was used because participants had to meet two basic criteria: they had to be over the age of 18 in order to give informed consent, and they needed to have been diagnosed with CHD. Participants were sampled from 33 different postcodes in Adelaide, South Australia, and recruitment continued until saturation of data was reached, giving a total of 37 participants.

Participants were recruited through South Australian cardiac rehabilitation programmes, GP surgeries, and snowballing. Potential participants were given an information sheet, a letter of introduction, consent form and a demographic questionnaire. No financial incentives were offered for participation in the study. This research project was given ethics approval in June 2008 prior to data collection by Flinders University Social and Behavioural Research Ethics Committee. Participants were requested to sign a consent form before participation in this research.

The participants consisted of 22 males and 15 females with ages ranging from 32 to 80 years. Seventeen of them held PHI and 20 did not and hence relied solely on the public system. Interviews were conducted between October 2008 and September 2009, in the participants’ homes or at locations of their choice. Two interviews took place at a shopping mall, one at a café and another over a picnic.

The main purpose of the interviews was to explore patient (dis)trust in doctors and the public and private healthcare system arrangements in Australia. This article reports on findings regarding the systems but additional publications regarding trust in doctors are available elsewhere (see Meyer and Lunnay, 2013a; Meyer and Ward, 2013; Meyer et al., 2012). Guided by theory, interview questions were specifically framed to explore participants’ trust in the public and private healthcare systems, and in other social systems understood as interdependent with the healthcare system. The interviews explored participants’ views on the arrangement of the healthcare system, and a discussion of their experiences and reasoning behind their (dis)trust. The real benefit of a qualitative approach is that it is not restrictive and allows participants to determine and explore the themes that are important to them, in the context of their lives. All respondents were asked identical questions in the same sequence but the interviewer’s probes were based on responses (Guest et al., 2006). For example, when a participant discussed a medical experience, the researcher would specifically ask about whether he or she was in public or private care at the time.

After ensuring that each of the questions served the purpose of investigating aspects of the theory, the interview guide was piloted and subsequently the sequence of the questions and the wording were altered slightly.

A central critique of theory-driven research is that, given the structured nature of the research, a researcher does not logically identify the unintended artefacts of empirical data but, instead, the experiences of participants are filtered through the theoretical lens (Coryn et al., 2010). Additionally, theory-driven researchers have been accused of conducting empirical research for the sole purpose of testing theory, rather than for the
empirical outcomes (Stufflebeam and Shinkfield, 2007). Luhmann’s social theories of trust were used to frame the design of the research, rather than solely to explain findings. As such, in addition to deductive logic, two additional forms of reasoning were employed to allow for analysis outside of the theoretical frame: abductive and retroductive inference (see Meyer and Ward, 2013). Deduction was used to identify data that were consistent with the initial theoretical frame. However, abductive and retroductive inference were employed via an iterative process of coding. The coding system was initially derived from a priori theoretical critiques and knowledge of the literature on patient trust (Meyer et al., 2008) and evolved throughout the analysis using abduction and retroduction. The analysis was conducted using pre-coding (or provisional coding) and memo-writing (Layder, 1998).

Pre-coding is an iterative process that involved highlighting or pulling out words or sections of the text that appeared significant, despite the fact that some segments of data did not trigger an association with theory. Pre-coding employed both deductive and abductive inference. The transcripts were read for associations with theory and were coded accordingly, which required deductive inference. However, in order to avoid the aforementioned criticisms of theory-driven research, abductive inference was used as a means of identifying findings that fell outside of the theoretical framework.

Memo-writing extends the analysis by adding another layer of analysis to the coding process. The researcher used memo-writing to write notes, ask questions and identify theoretical problems in the data. The process of memo-writing required the researcher to reflect on and question their interpretation of the data, identifying how concepts emerged in a practical setting. For example, following deduction, codes within the initial theoretical framework were further analysed using retroduction to further understand how theory is operationalized in the real world in order to extend theory.

The data presented in this article are the result of deductive inference. Findings pertinent to understanding trust within and between systems were in line with, or conflicted with, the original theoretical premise. However, as discussed later in this article, theory only goes so far in explaining the nature of trust in healthcare. The critical analysis presented and subsequent extension of Luhmann’s theory demonstrates the utility of memo-writing. More comprehensive demonstrations of the use of abductive and retroductive inference in analysing empirical research regarding trust in healthcare are published elsewhere (Meyer and Lunnay, 2013).

**Patient experiences, assumptions and (dis)trust in Medicare**

The following presents key findings as they relate to participants’ trust in the Australian healthcare systems. The responses of the interviewees are used to reflect upon Luhmann’s insights about trust in one system (government) influencing trust in interdependent systems (Medicare and private healthcare). As such, the following results are organized to first demonstrate participants’ identification of the role of government in Medicare and, next, the extent to which the role of the government impacts their trust in Medicare.
The role of government in Medicare

All participants acknowledged the role of government in Medicare, drawing primarily on their knowledge of, or assumptions about the way in which the effectiveness of public healthcare is contingent on the role of government. Participants with and those without PHI both identified problems with the current public healthcare system that they related directly to a lack of government funding. However, participant concerns about the system differed according to whether they had PHI or primarily used the public system. Public healthcare users were concerned with waiting times caused by a shortage of funding and subsequent under-staffing. Conversely, PHI holders did not agree with the way in which the government overfunds or mis-funds the public system.

Public healthcare users M10, F11 and M11 stated that they had had positive experiences in public care and were happy with the system. However, they had friends who had been required to wait for emergency treatment or elective surgery. Consequently, they were concerned about healthcare in the future, stating that waiting times were only going to get longer as the population ages.

Public healthcare user M16 was concerned with the role of government in funding healthcare and said that the government’s control lies in the fact that they ‘hold the purse strings’. M16 also believed that the government had made some poor choices with regard to spending the healthcare budget. He said that he was happy with his access to healthcare but that ‘I still think they, government, should be spending more money.’ When asked if he trusted the government, he said ‘Well I, I, I think this government [Labor] is better than the previous one [Liberal] but I would not entirely trust a politician nor would I trust a lawyer.’

Public healthcare user M8 also talked about how unhappy he was with the role of government in public healthcare. He said that the government has control over the finances and therefore: ‘although it’s nice to say “you need this, you need that, this is what’s going to happen”, it doesn’t always happen because Big Brother says “no, it’s not going to happen”.’

Consistent with public healthcare users, PHI holder M9 also believed that the government plays a large role in the public healthcare system and that they needed to ‘pour more money in to the hospitals’. When asked how she felt about the role of government in healthcare, PHI holder F7 said that ‘as far as governments go with hospital and mainly public hospitals, I think the government should be putting more resources into making sure that whoever needs care gets that care as quickly as they possibly can’. Similarly, PHI holder F14 was unhappy with the way the state government was spending the healthcare budget. When asked if she trusted her government, she said: ‘um 50/50. I am a bit undecided. I find that they make a lot of rash decisions.’ Conversely, other PHI holders were concerned with the misuse or overuse of government funding. As a PHI holder, F7 was concerned with where the money the government put into public healthcare was spent: ‘it doesn’t matter what government’s in – you know, I just wonder where all the money for hospitals goes’. PHI holder M17 was concerned that too much of the money the government put into public healthcare was wasted. He believed that the way the government controlled the healthcare system was ‘teaching people to be social welfare cripples. We give people too much for free. I’m one of the one-third of Australians that
supports the other two-thirds.’ When asked if he trusted the healthcare system, M17 said: ‘Yeah I do trust the system but their hands are tied, they’re linked very much to the government policy aren’t they?’ He said that he trusted the individuals within the system but realized that ultimately they are controlled by government. M6 (PHI holder) also had concerns about the role of government in healthcare because the government is ‘always controlled by vested interests, to varying degrees. The better governments stand out against them.’

Participant responses identified their concerns regarding the role of government in public healthcare. Although the notion of trust was not always specifically noted by all participants, it was essential to the presentation of their statements illustrating the role of government in shaping public opinion regarding healthcare. However, discussion with participants extended beyond their concerns with the current healthcare system and government, and they specifically discussed their trust, or lack thereof, in the public system. More specifically, participants’ discussions indicated that the way in which the government has structured the two-tier healthcare system has divided public opinion regarding public healthcare. The findings indicated that PHI holders did not trust the public healthcare system and were fearful of being without private coverage. For example, F4 said she trusted the system ‘in my case yes [she trusts the healthcare system she uses] because I have private health but I’ll never give up my private health cover.’ Conversely, public healthcare users said they were happy with their level of care, and that they trusted the public system. One participant, M22, went as far as to say that he did not see the point of having PHI.

(Dis)trust in the public healthcare system

Participants were asked to discuss their (dis)trust in the healthcare system. As noted, the Australian healthcare system is two-tiered, a combination of public and private healthcare. Consequently, when asked about the healthcare system, participants discussed the system under which they sought care (public and/or private).

Common responses from PHI holders when asked if they trusted the healthcare system in Australia were exemplified by M2 and his wife F3: ‘I don’t think we’d ever be, we’d ever be willing to put ourselves in a situation where we only had access to the public system. I really don’t.’ Similarly, F5 said that, in general, her experiences with the Australian healthcare system had been positive because she had private cover. F5 considered herself lucky so far, because ‘I’ve had really good attention whenever I’ve needed it but then I’m under the private health cover as well and I think that does make a difference.’ She said that she would be concerned if she did not have private cover. M9 also trusted the system because he and his wife have PHI. In the interview with M9, his wife discussed the reason why they chose to be privately insured: ‘[We’re] at that age of our life now that we can’t afford not to have it [PHI].’ F14 said that the Australian healthcare system was ‘good in comparison to a lot of others’, but, similar to other participants, she ‘wouldn’t be without’ PHI.

The finding that patients did not trust the public system did not necessarily mean that they agreed with the privatization of care, but rather that in the current state of the public system, they would not go without private care. For example, private insurance holder M6 said: ‘We still have a major problem between the private system and the public
system.’ He had private cover for his wife who was very ill, and said: ‘I sometimes wonder if it wasn’t for [my wife], I wouldn’t have had private cover. Philosophically I probably I don’t agree with it.’ Similarly, F7 was concerned about the structure of the two-tiered health system and the negative portrayals of the public system. She said that it was after her heart attack that she began to question whether private care is indeed superior to public. Prior to the heart attack she was ‘very anti public hospitals’ but since being in the public system’s emergency department ‘I just feel very confident with public hospitals and the people working in public hospitals and the doctors and the nurses in there.’ However, she still held PHI because it gave her the autonomy to choose her own doctor and have access to a private hospital if she wished.

In contrast to the majority of PHI holders, participants without it were satisfied with the public healthcare system and did not feel a need for private services. For example, regarding trust in the system, F15 said:

“I am more than happy. I am very happy with it. I am a public patient and the care and help that has been given to Clive and I, we are very very happy with it. I get a little bit cross with some of these people that, you know, knock and something shocking and I think of other countries that don’t have near the health that we get. I really think, people, everybody should go overseas in their life to see what the other side of the world is like because we are very lucky – we really are. No I, I am very happy with the system.

Similarly, when asked if he trusted the system, public healthcare user M18 said that he did. He went on to discuss his feelings about the system:

“I mean we can’t have perfection and there will always be mistakes and there will always be people that abuse it and think it’s terrible but I reckon it’s the best in the world.

M22 said he trusted the system because it was always available for him ‘every time that I’ve needed help’. He used to have private cover but said that one day he decided he and his family did not need it because in emergency situations, patients are taken to public hospital emergency departments before being transferred to private hospitals: ‘So for that sort of emergency, you’re in a public system and it works fine.’ When questioned about his trust in the system, M22 responded, ‘I’m afraid I’ve got a lot of trust in the medical system, yeah.’

Understanding distrust in Medicare

This article began by providing a theoretical model for investigating trust in public and private healthcare systems in Australia. This model assumed that (dis)trust in one social system (e.g. government) would influence an individual’s trust in interdependent systems (e.g. healthcare). Contrary to these assumptions, the findings suggest that despite distrust in government or concerns about the role of government in healthcare, participants still trust the healthcare arrangements to which they belong. However, it was identified that PHI subscribers do not trust the public system.

Consistent across the majority of participant responses was an apparent distrust or concern regarding the role of government in healthcare. The findings regarding distrust...
in the government are unsurprising given that previous research suggests that concerns regarding healthcare systems often stem from financial concerns regarding cost cutting and waiting lists (Calnan and Sanford, 2004). Indeed, a lack of government provision has a negative impact on trust in government. In an Australian national survey, over 40% of respondents distrusted local, state and federal governments (Meyer et al., 2012). The lowest levels of trust were identified in populations that had the poorest access to government services. However, with regard to the findings of this research, despite their distrust in government, participants continued to trust the healthcare systems they used.

Public patients’ trust in Medicare may be explained by previous research, which suggests that non-profit healthcare arrangements provide services that are more trustworthy (Schlesinger et al., 2005). This occurs for two reasons. The first is that doctors in public hospitals are less motivated than those working privately to pursue practices that generate surplus return because they cannot profit personally. The second reason is that non-profit health systems have more open governance and are more open to the influence of community members (e.g. via voting) (Schlesinger et al., 2005). Our findings challenge Luhmann’s theory that trust in one social system will influence trust in an interdependent system. Rather, the findings may be explained by further engagement with empirical literature on trust in healthcare. For example, Calnan and Rowe (2005: 2) argue that trust consists both of cognitive elements (grounded on rational and instrumental judgements) and affective dimensions (grounded on relationships and affective bonds generated through interaction, empathy and identification with others). Patient trust may instead be the result of the level and nature of their experiences in the public system, which have been demonstrated to influence patient perceptions of healthcare (Calnan et al., 1993).

Public concerns about funding and waiting times are not surprising. Professor Andrew Wilson, Director of the Menzies Centre for Health Policy at the University of Sydney was recently cited as saying that despite roughly 50% of hospital care and 70% of other healthcare being provided in the private sector in Australia, to an overwhelming extent discussion about healthcare in Australia is around the performance of public sector hospitals. He went on to state that while it is evident that Australians favour the mixed public private model (supported empirically by Hardie et al., 2008), ‘there is little discussion about what this means about the expectations of the private sector and on its performance’ (Sweet, 2013). As the result of the constant attention paid to public services, attitudes about the public system may be understood as ‘factoids’ (2013: 436); that is, ‘assumptions or speculations reported and repeated so often that they are popularly considered true; they are simulated or imagined facts’ (Cummins and Macintyre, 2002). However, patients’ experiences within the public system may allow them to challenge or reject these assumptions. This is supported by F7’s statement; she was ‘very anti public hospitals’ before her experiences with public care and she now feels confident in the people, the doctors and nurses, working there. This may also explain private patients’ fear of, and distrust in, the public healthcare system. Their lack of experience within the public healthcare system prohibits them from challenging common assumptions about the system. The findings suggest that Luhmann’s premise (that distrust in government influences distrust in public healthcare) may be an initial tendency of patients; however, this tendency may be superseded by affective dimensions stimulated by experience in the system.
One means of understanding PHI subscribers’ lack of trust in the public system is by applying Luhmann’s framework. PHI subscribers’ distrust in Medicare can be understood as the result of their reported distrust in government. The governance of Medicare is controlled and maintained by government and, as suggested above, a lack of trust in government contributes to distrust in government-run systems. Participant concerns about the healthcare system seem to stem from their concerns about the role of the government in healthcare. Indeed, the fears of waiting for access to services and funding cuts to services were of most concern to participants. However, this framework fails to explain PHI subscribers’ trust in the private healthcare system despite it being partially funded by government, which actively encourages PHI purchase through policy and regulation (Harley et al., 2011). This may be explained by a lack of public awareness of the regulatory and financial role of government in shaping private provision of healthcare. However, it may also identify that, despite the awareness of the role in government in the funding of private care, other aspects of the private system that are reasoned to be trustworthy supersede PHI subscribers’ concerns about the role of government. This finding is in need of further investigation.

Another approach to understanding private patients’ distrust in the public healthcare system is to apply Luhmann’s framework to the diffusion of health information. Just as healthcare is understood to interact with government, the media plays a significant role in the dissemination of health information and public perceptions of the healthcare system. Health information can be understood as being provided in a broadcast sense (Hardey, 1999). It is conveyed by family members, peers, through educational sources, by health professionals and by sources of information outside of the health system (Thiede, 2005), including influential media sources and celebrities. The ‘utilization of health services is generally subsequent to the consumption of information’ (Thiede, 2005: 1454), often regardless of whether it is from potentially unreliable sources (Meyer and Ward, 2008). Media coverage on health matters is typically analysed in terms of risk amplification (Brownlie and Howson, 2005). It is evident within Australia that media stories have fuelled fears that healthcare is not trustworthy for those without health insurance. For example, participants’ fears about waiting times for elective surgeries and overcrowded and underfunded hospitals echoed media accounts of public healthcare (ABC News, 2011; Duke, 2011; Sikora, 2011). Mechanic (1998: 666) suggests that ‘because of the intense interest of the public and media in such events [in this case, medical negligence], even rare but dramatic events receive wide publicity and may disproportionately color how the public views medical competence’. Certainly, media reports typically depend on human interest stories (despite their rarity) that focus on negative issues such as abuse and public anxieties over healthcare. Although Mechanic’s work was published over ten years ago, his concerns about media accounts of healthcare are still applicable because of the on-going political debates on the state of public healthcare in Australia:

[media reports] are especially salient because many people are experiencing changes in their health insurance arrangements, their health plan choices and their personal doctors. This environment contributes to increasing insecurity and distrust. (1998: 682–3)

Evidently, the findings demonstrate that government, media and healthcare interact and are interdependent on one another. The findings of this article identify the extent to which
these interactions may influence patient trust in Medicare. Indeed, Jones (2004) suggests that a lack of trust in government and the media are related, a view echoed by (Bennett et al., 1999: 17): ‘as [the media and government officials] attack and criticize each other, they pull down evaluations of themselves and related societal institutions’. We suggest that the media play an influential role in shaping public opinion of both government and healthcare; a role that may be detrimental to the way in which Medicare is regarded.

The aim of this article was to explore the nature and extent of trust in public and private healthcare in Australia. However, the empirical results also provide a foundation for theoretical development. The findings identify that engagement with Luhmann’s theories when explaining empirical research requires critical analysis beyond the initial theoretical frame. Luhmann never tested his theories empirically but provides the theoretical tools that have been employed in this research (Bluhdorn, 2000). Consequently, this research provides empirical data that demonstrate Luhmann’s theory in action, while at the same time calling into question whether such rigid theory can be used for the interpretation of such a complex social system (Bluhdorn, 2000). Kuhn (1996: 10) argues that theories are not falsified but become the subject of continuous research. Evidence that does not support a theory should be regarded as only a temporary problem towards which future research should be directed. The author and colleagues are currently collecting data which extends this research to additional clinical areas in order to further explore this theoretical framework.

Acknowledgements
The author would like to acknowledge Professor Paul R. Ward, Professor John Coveney and Professor John McMillan for their contribution to this work. The author would also like to thank the anonymous reviewers for their critical insights which strengthened this manuscript.

Funding
This research received no specific grant from any funding agency in the public, commercial, or not-for-profit sectors.

References


**Author biography**

Samantha B. Meyer is an Assistant Professor in the School of Public Health and Health Systems at the University of Waterloo, Canada. Her research interests include social theories of trust and risk and, in particular, the practical application of social theory to social health research.