Author's response to reviews

Title: A qualitative study of patient (dis)trust in public and private hospitals: the importance of choice and pragmatic acceptance for trust considerations in South Australia.

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Author's response to reviews: see over
We sincerely thank the Editor and two reviewers for extremely insightful and useful comments – we now think the paper is much stronger. We have made the changes in Track Changes in the Word document, but we also respond below to where our changes can be found.

**Reviewer – David Pilgrim**

First, there is no mention of what happened to the more fundamental critiques of trust in modern medicine (for example put forward by Illich in the 1970s). His arguments about clinical, cultural and social iatrogenesis are still pertinent to recall in our new world concerned with the link between risk and trust.

We have greatly expanded the section of the paper related to fundamental ideas on trust, risk and choice, and have included Illich within this.

Second, this is an Anglo-Australian collaboration and so it might be useful to check whether the scandals in the British NHS (especially but not only at Staffordshire) resonate in Australia. Has Australia had similar problems and do Australians pick up on the British news about the NHS?

We have made specific comments of this in the Introduction. Australia seems to have been relatively ‘unsathed’ for large scale scandals – there have been a few (Dr Death in Queensland a few years ago) but nothing which researchers suggest has changed public views.

Third, this is touched on but is really important: surely the enforced trust of acute and especially emergency medical care brings with it different interpersonal implications to chronic care, especially with the shift to self-management of long term conditions. What views from the data are relevant to those distinctions?

We have made this clearer in the Discussion section


I already had this on my bookshelf, having read it a couple of years ago – thanks for reminding me – it is now properly cited in the paper.

**Reviewer - Lorelei Jones**

**Reviewer's report:**

My main concern regards the way the findings are located in the broader literature. The introduction currently seeks to do a number of things: review the theoretical literature, review existing empirical studies and present the background of this study (the Australian context) so as to provide a rationale for why this research needed to be done and where it fits. I feel this section needs a lot more work to make all these aspects clearer to the reader. Sometimes I felt that the authors may have felt constrained by the word length? The authors either need to spend more time unpacking these separate elements of the introduction or restrict their scope
in a way that is tailored to the purpose and audience of this journal.

We have expanded the Literature review to take on board comments from both reviewers – although this makes the paper longer, we think it greatly improves the paper.

Low SES groups generally have lower levels of trust in a range of government institutions, linked to their vulnerabilities, disempowerment and perceived broken promises by government. It therefore becomes comes critically important to both understand their (dis)trust in public hospitals and develop strategies to build trust which is grounded in experiences of quality care and trustworthy services. These two sentences are insufficient to provide the reader with an overview of the findings of previous empirical studies. I would want to know, for example, what you mean by 'lower levels of trust'. Lower than previously? Lower than people from higher SES also treated in public hospitals? Similarly you state that:

In contrast, US literature finds the opposite - private healthcare is generally less trusted than public healthcare which may reflect the much larger PHI business in the US and the sub-optimal government funding of public healthcare. However it isn't clear how suboptimal funding is linked to greater public trust. My inclination is that this section just need more work to improve clarity.

We have tried to improve the clarity by expanding this section much more.

The analysis also feels a bit muddled at present. The authors at times use the terms 'service', 'hospital' and 'doctor' interchangeably, but these are different levels, i.e. they relate to the macro/meso and micro respectively.

We have used the word ‘hospital’ and tried to remove the inconsistency in terminology

It is also unclear whether what they have captured relates to differences between planned/emergency treatment, or public/private hospitals, or having choice/not having choice, or having/not having PHI. I would recommend putting to oneside, at least during the analysis, the having/not having PHI distinction, because, as the authors note, participants often had experience of both public and private hospitals, and instead to concentrate on the accounts of experiences in public and private hospitals, but trying to unpack this in relation to planned/emergency care. Then perhaps in the discussion the implications/relationship to variation in SES can be drawn out.

We agree that the ‘messiness’ of the public/private split means that a true ‘private patient’ does not really exist, since private clinics operate in public hospitals etc. We have prefaced the Results section to alert readers to the messiness and tried to take the notion of PHI out of it – and focus on experiences in and trust of public and private hospitals.

I also caution comparison with the NHS in England, as two of the authors will be aware, 'choice' of planned care can exist in an entirely publicly funded and provided system.
Agreed – we have made the differences between the two countries more explicit.

My third concern relates to the interviews themselves. It is unclear whether interviewees were asked about their experiences, with the concept of ‘trust’ used as an interpretive category, or whether participants were asked directly to reflect on ‘trust’ which generates very different data.

The interviews were trying to understand patient trust – but our experiencing of exploring patient/consumer trust in many other aspects of health and social care (food systems, preventive screening, GP services, pharmacy etc) meant that we did not hit it ‘head on’ – we asked participants to tell us about their experiences in hospital, experiences with care, and as they were recounting their stories, we would probe around how it made them feel, their trust etc. We have tried to make this more explicit in the Methods section.

Finally, on page 15 you use the term ‘beauty contest’ which I don’t think captures the way the role of reputation in important in markets, whether in private markets or in public quasi markets.

We have removed this term.