SOC499 – Capstone II

In Public Health we trust: The Experiences of Kazakhstani Citizens on Interpersonal and Institutional Trust in Public Healthcare Systems

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Abstract:

This study explores trust in the healthcare context by analyzing interpersonal (patient=doctor) and institutional factors (patient=healthcare system). The study was conducted in Astana city in Kazakhstan among working-age adults (25-35 years old) during January 2024. In the scope of the research, trust is defined as a belief by the trustor (A) – patient, that an action (X) – medical treatment, will happen at some time (Y) in the future by the trustee (B) – the doctor/healthcare system. This belief is based on some factors that make up the trustworthiness of the trustee (B). The findings reveal four interpersonal factors such as hostility of doctors, lack of contact with doctors, in-group trust and ineffective treatment. Also, three institutional factors were revealed – the lack of funding, the lack of health promotion and the mistrust in government. The correlation between institutional and interpersonal factors produced mixed results. Some participants believe that institutional trust arises from interpersonal and that doctors are the direct executors of the healthcare system, thus they must do their best to provide quality care in order to raise the institutional trust in the healthcare system. However, other participants claimed that doctors are the "prisoners" of the healthcare system, and that interpersonal trust arises from institutional, so the system must provide good conditions and infrastructure for the doctors in order to foster trust.

1. Introduction

Trust between patients and healthcare professionals is crucial because patients rely on healthcare providers when they share their personal information, accept medical treatment, and undergo medical procedures. Basically, healthcare professionals are responsible for the outcome of people's lives, so deciding whether to trust and place your life in the hands of a doctor is important. Research has shown that when patients trust the healthcare system and professionals,

they are more likely to seek care, follow treatment plans, and engage in open communication with their providers. Therefore, trust in doctors and in the healthcare system provides better patient-provider relationships and empowers patients to make informed decisions about their health (Meyer et al., 2008). Trust is valuable for understanding the main relationships within the systems of healthcare. It sheds light on aspects of these relationships that are often overlooked, offering fresh insights into how healthcare management could be enhanced. Understanding how trust affects the effectiveness of a healthcare system helps figure out what changes are needed to build or improve trust. (Hardin, 2006). A healthcare system built on trust can create bigger value in society because the healthcare system is not only about delivering medical treatment, but also a social institution that influences the behavior of people by creating/acting on social norms (Gilson, 2006). In order to figure out whether trust in the healthcare system can truly provide a social value, the trust and its factors should be analyzed first.

Trust is based on having good reasons to believe that the person you are trusting has an interest in being trustworthy at the specific time and in the relevant manner (Hardin 1991). Trust is necessary when people lack information, but in situations where there's full understanding, it is not needed (Giddens, 1990). Therefore, trust allows to reduce the ambiguity and complexity of social systems with generalization (Gambetta, 1988). Trust is compared to a glue that allows for social cohesion which makes decision-making simpler and for a world that is easier for people to navigate despite uncertainties (Luhmann, 1979; Meyer & Ward, 2013). If you place trust or distrust in someone, it simplifies societal complexity as both act as rational means to pursue individual interests. For example, if the patient trusts their doctor, they will probably follow the prescribed medical treatment and believe that it is the best for their health, based on their experience with the doctor and the expertise of the doctor. On the other hand, if the patient

distrusts their doctor or does not like the proposed treatment, they may consult other doctors or visit other hospitals, because the distrust allows to pursue a patient's individual interests. Therefore, the decision to trust or distrust the doctor makes it simpler for the patient to decide what to do.

Trust is formed by assessing and judging the interests of the person you are trusting; thus, trust is not only about your own interests. Some perspectives on trust don't explicitly consider the trusted person's interest in being trustworthy. Instead, they focus on the expectation that the trusted individual will fulfill their commitments (Gambetta 1988). The reasons for expecting someone to fulfill trust are often based on past experiences and the expected future incentives that the trusted person might have. As Hardin says "To say we trust you means we believe you have the right intentions towards us and that you are competent to do what we trust you to do (Hardin 2006, 17). Therefore, trust can be seen as a belief by the trustor (A) that an action (X) will happen at some time (Y) in the future by the trustee (B). This belief is based on some factors that make up the trustworthiness of the trustee (B). In the context of healthcare, the factors of trustworthiness towards the doctor might be their qualification, the way they dress in the doctor's office, their speech, the correctness of the diagnosis, etc. These trustworthiness factors depend on past experience as it was stated at the beginning. Thus, there are four components of trust from this definition: relationality (believing that B (the trustee) will act in a consistent manner in the future), vulnerability, risk, and expectation that B will care about A's (the trustor) interests (Gilson, 2006). When talking about vulnerability and risk, mutual trust makes sure that both sides will not use the vulnerability of each other to their own advantage (Sabel, 1993). When a patient trusts a doctor, they acknowledge the risks that come with this dependence, however, the importance of these risks might be alleviated with

familiarity that gives a fundament for trust based on previous experience (Meyer & Ward, 2013). For example, if a patient has visited a doctor many times and their diagnosis is correct, it would be easier for a patient to trust the doctor compared to someone whom they have met only once.

There are two main forms of trust: institutional and interpersonal (based on the theories of Giddens and Luhmann). Interpersonal trust is individual, for example, trust between a doctor and a patient (a decision to trust a doctor or not); institutional trust is trust in an abstract entity like a healthcare system in the scope of this research (Meyer et al., 2008). Giddens (1990) and Luhmann (2018) have different views on trust in modern societies when it comes to institutional and interpersonal trust. Luhmann believes that trust starts with trusting the system and then evolves into trusting the actors of this system, meanwhile, Giddens argues the opposite, that trusting individuals extends to trusting the system – trust in a doctor leads to trust in a healthcare system. I think exploring this juxtaposition is interesting as it allows us to figure out the interplay between institutional and interpersonal trust, where the trust comes from in the healthcare context, and what trustworthiness factors play a role in establishing the trust.

Therefore, the main question of my paper is "what trustworthiness factors are there that contribute to the trust in doctors (interpersonal trust) and to trust in healthcare system (institutional trust)?". And from those questions stems another: "based on the experiences of people, is there a correlation between interpersonal and institutional trust, or are they separate notions?".

2. Literature Review

Situtation in Kazakhstan

In Kazakhstan, there is a lower life expectancy and health indicators compared to similar-income nations in OCED. Kazakhstan has actively pursued compulsory social health insurance since 2020 and tried to improve accessibility while maintaining that it is free (Gulis et al., 2021). The insurance covers diagnostics, lab services, outpatient drugs, inpatient care, and medical rehabilitation, which benefits all residents. The state tries to ensure equal access to primary care, emergency services, and treatment for critical diseases, with 80.5% coverage in 2019.

There is a recent State Program for the Development of Healthcare of the Republic of Kazakhstan, which is planned for 2020-2025 years. In this program, the government outlines major changes that it expects to see within the sphere of healthcare. Unfortunately, trust in healthcare is not mentioned in the program, however, the government provides current disadvantages of the healthcare system in Kazakhstan that can be related to trust - insufficient level of health literacy; aging infrastructure of medical organizations, and insufficient medical equipment; uneven level of service and quality of medical care; decreased patient compliance (non-compliance with the recommendations of medical workers) (Government of the Republic of Kazakhstan, 2020). All these negative sides might be mentioned by respondents in the interviews or I can ask whether these weak sides affect the patients' perceptions of healthcare in Kazakhstan. Also, according to the data by the Ministry of healthcare in this program, the satisfaction of patients with medical care was 47.84% in 2018 and is projected to increase up to 65% in 2025. The government also plans to conduct annual questionnaires that will analyze the quality of healthcare services.

According to the report on Kazakhstan's healthcare system in 2021 satisfaction with the quality of medical care amounted to 73% (Official Information Source of the Prime Minister of the Republic of Kazakhstan, 2021). Thus, contrasting this data with the state program for 2020-2025, the government has already reached its goal and after the pandemic, the level of trust should be higher, as satisfaction with medical care also rose. However, this report does not mention the trust of residents towards healthcare. A similar report from 2022 also does not mention the trust of residents as one of the goals (Official Information Source of the Prime Minister of the Republic of Kazakhstan, 2022).

Literature on Trust in healthcare context

Trust in healthcare has a direct association with the usage of medical care and access to it. Trust mainly depends on the relations with a physician, whether the patient is satisfied with them and feels a sense of loyalty (Ozawa & Sripad, 2013). Trust in a healthcare system can also be impacted by professional norms and power dynamics among nurses, doctors, and other staff within the organization, influencing attitudes and practices toward patients. The greater the trust, the higher the likelihood that the patient will adhere to the treatment and recommend it to others. Trust in healthcare allows patients to self-report their health as better, than without trust (Wang et al., 2009).

Previous research on trust in healthcare mostly focused on the quantitative measurement of trust through scales and mainly relationship between doctors and patients (interpersonal trust), rather than healthcare system and patient (institutional trust) (Ozawa & Sripad, 2013). Thus, my research would try to analyze both these types of trust qualitatively and try to draw connections between them. Authors claim that interpersonal and organizational trust are

complementary, meaning that if people trust doctors, they will also trust the healthcare institution as well (Zheng, Hui & Yang, 2017).

Institutional trust.

Analyzing institutional trust is important, because trust in hospitals, provision of insurance, and healthcare system can impact patients' utilization of services, thus influencing the economic and political sustainability of healthcare system (Rowe & Calnan, 2006)

Healthcare in Kazakhstan is funded with taxes, which are then used to pay hospitals directly or transferred to authorities from the region and they use it to treat diseases that the government deems socially important (generally diseases that cause major outbreaks like tuberculosis) (Zhatkanbayeva & Saipinov, 2014). People who pay taxes expect medical services to be of high quality, thus citizens are more likely to trust the institution. Additionally, there are specialized local healthcare budgets. Most healthcare facilities are managed by the Ministry of Health (MoH) and provide coverage to the entire population.

Among OECD countries the government of Kazakhstan invests a low amount of funds on healthcare and spends most of it on providing health insurance for every citizen, making it compulsory. Despite compulsory health insurance, citizens still spend a lot of money on medication out-of-pocket. As not everyone is able to pay the extra money, access to healthcare drops and only financially stable people are able to benefit from it (Wagstaff, Eozenou & Smitz, 2020). This might negatively impact citizens' institutional trust in the healthcare system because their taxes are not spent efficiently.

Interpersonal trust.

Skirrbek et al. (2011) give a definition of interpersonal trust as “trust is characterized as a patient’s confidence in a doctor’s ability to choose the best course of action in a vulnerable situation, to keep a patient’s best interests in mind when choosing the course of treatment”. When there is trust between patient and doctor, then patients feel safer revealing sensitive information, interact better with doctors, and follow the prescription that doctors give them and vice versa, if the patient does not trust the doctor, then there are difficulties in setting the correct diagnosis or the patient does not follow the prescription (Rolfe et al., 2014).

The connection between a patient and a doctor hinges on vulnerability. The patient relies on the doctor for support, giving rise to trust or mistrust in this dynamic (Skirbekk et al., 2011). This dynamic is important in Kazakhstan because all citizens are required to register with a doctor (general practitioner / terapevt) in the hospital based on their location, so there is a constant connection of one doctor and a patient (Zhatkanbayeva & Saipinov, 2014).

Sometimes the environment at work might negatively affect doctors and subsequently quality of care. For example, bureaucratic work might lead to doctors spending most of the time filling out papers, rather than discussing with the patient (Brown & Calnan, 2016). Thus, the management and organization inside the hospitals are also important when talking about quality of care. If the management is bad and the work environment suffers, then patients might be less likely to trust doctors, as the quality of care drops. Also, it raises a question such as “do people mistrust public healthcare institutions because doctors spend not enough time with patients during the checkups (because they mostly spend time filling out papers and doing bureaucratic work)?”

Aside from bureaucracy, patients' trust in healthcare might be influenced by corruption (bribes), rude behavior of healthcare workers, and doctors being preferential toward some specific patients (Gilson, 2006). Therefore, managers of hospitals and the providers of healthcare (doctors, nurses) shape the citizens' trust in healthcare.

Kazakhstan and Trust in Public Healthcare

The research in Kazakhstan on trust in healthcare is scarce. One of the quantitative research projects was done in the former soviet union states (including Kazakhstan) in 2012 by Balabanova et al. According to the research, 60% of citizens in Kazakhstan consult doctors, while 40% do not. The research also shows types of illness and consultation pathways that patients take, when they are not consulted patients state several reasons - need for self-treatment, treatment being too expensive, drugs being too expensive, poor quality/mistrust in healthcare, lack of time, far health facilities and lack of health insurance. The statistics are quite old, as the study was published in 2012, but they still give some background to the research on trust in healthcare in Kazakhstan. One of the important outcomes of the research is that if the patient does not seek care, we need to analyze the individual experiences of each person and determine the problem, rather than conducting a qualitative questionnaire as it cannot fully reflect the reasons for trust/mistrust.

A study by Craig, Almatkyzy, and Yurashevich (2020) analyzed the influence of in-group membership on trust in doctors in Kazakhstan. This is the closest study I have found to mine, however there are some major differences. Firstly, this is quantitative research that involves surveys and it uses a special scale for measuring the trust in physicians. My research will be qualitative and focus on individual experiences of trust, and the correlation between interpersonal and institutional trust, rather than the measure of scale. Secondly, the research

focused more on in-group membership, for example, if people had doctors in the family, they were more likely to trust healthcare professionals and the system, and vice versa. My research will focus on the trust in doctors in general, despite the in-group membership, and whether this trust correlates with institutional trust in the healthcare system as a whole. As the authors claim, "It is important to recognize other sources of low trust and that they may extend beyond the doctor-patient interaction if efforts are to be made to increase trust" (Craig, Almatkyzy & Yurashevich 2020, 558), this study will focus on more than doctor-patient interaction.

According to the STADA report in 2022, only 61% of Kazakhstani citizens trust official medicine (outpatient and in-patient hospitals). Of these 61%, only 35% check the information online. The survey data show that Kazakhstanis mainly trust scientists in health issues - this figure reached 47%. The second place is occupied by therapists (41%). Epidemiologists (40%) are also in the top three in terms of trust, and every third respondent in Kazakhstan trusts pharmacists. Europeans, on the other hand, trust GPs (general practitioners) the most (65%) and also other medical, and hospital staff (60%). It shows that there is much lower trust in physicians in Kazakhstan, rather than Europe, so there must be some reason for such low rates.

3. Research Design

My research focuses on analyzing trust in the public healthcare context in Kazakhstan among the working population in the city of Astana. Trust can be regarded as an ambiguous and vague concept, as each person has a different understanding of what trust is and it creates the difficulty of investigating it. However, trust is important to investigate in the healthcare context, because the whole system of healthcare is built on relationships between different parties. The

act of receiving healthcare connects not only patients and doctors but also other people involved in the institution of healthcare - lawmakers who shape the industry of healthcare, pharmacists who give access to medications, nurses, and even people at the reception of a hospital who might act as a gatekeeper for a patient. Measuring trust across these relations shows whether the healthcare institution is effective or not and whether patients believe that the healthcare institution can provide support and save their lives. These measurements of trust can be helpful for the lawmakers involved in healthcare, healthcare workers, and researchers to improve the healthcare system and subsequently the health of the entire population. In my research, I analyze the experiences of people in public hospitals and how these experiences shaped their trust in the healthcare system. I will try to determine the trustworthiness factors that shape the trust, and these factors will be divided into two sections: interpersonal trustworthiness factors (between healthcare workers and the patient) and institutional trustworthiness factors (between the public healthcare system in general and the patient). It is important to note that this study does not presume that people generally mistrust public healthcare systems, and positive accounts might also be helpful in shaping the results of the study.

Methodology

As it was shown before, trust is a social concept, as it involves communication between people and institutions. It is not always possible to "measure" some social qualities like trust, so there is a need to develop concepts in order to measure these social indicators. In my paper, I will use "social theory" by Meyer & Ward (2014) as the main methodological framework. This framework aims at breaking down an abstract theory into a set of concepts and then using empirical design to examine the phenomena (operationalization). Trust in my research can be divided into different components as preconditions for trust, as was done by Meyer & Ward

(2014): bureaucracy, corruption, amount of time spent on patients, ability to pay for medications, attitude of health workers, organization of hospitals, etc. All these preconditions can be analyzed with questions that will be used in semi-structured interviews (for example, whether a bureaucracy in the context of hospitals is a precursor for interpersonal/institutional trust)

The research population for this study comprises people of working age (25-35 years) in Astana city, Kazakhstan. This selection is deliberate, as these individuals possess a higher degree of agency when it comes to choosing the place to receive healthcare compared to students and the elderly who often have limited choices (they are often restricted to the hospitals based on their residential address). The people were chosen through convenient/snowball sampling. I was interested in controlling for patients who had some kind of health concern in the last two years (since the end of the pandemic) and also those, who had experience of living through COVID-19 pandemic time in Kazakhstan (not in another country). All the participants that I interviewed had this experience, so they were chosen for the interview. I did not include any terminal patients in my list of respondents, however, I tried to gather people with unique backgrounds such as a mother with children, a person with a disability, a married woman, and a fresh master's graduate, for example, in order to gather unique narratives that would allow to look at the problem of trust from different perspectives. In total, I interviewed 7 people. The pool of participants was recruited through acquaintances and also through social media like Instagram/Telegram where I posted the announcement about my research and gathered people who were willing to participate.

Data collection tools.

Through a qualitative approach, the study used semi-structured interviews as the primary methodological tool. All the interviews were coded and analyzed. Trust is tightly connected with individual experience, feelings, and interactions; therefore, it is better analyzed through a discussion rather than a metric of "how much do you trust X on a scale of 1 to 10". Semi-structured interviews facilitate an open dialogue and enable interviewees to share their experiences freely. This allows the research to be exploratory in nature and find underlying reasons for trust/mistrust in the public healthcare system.

Qualitative interviews were conducted to analyze the experiences and observations of patients who had recently received treatment in private or public hospitals. The main aim of the interviews was to investigate the interpersonal and institutional trustworthiness factors and the relation between them. I was interested in narratives of people and how they navigated themselves when seeking help, what preferences they have when choosing a doctor, deciding to go to a private or a public hospital, and specific positive or negative experiences. The participants described their experience inside the hospitals not only as patients but sometimes as mothers or as people with impairments.

Narratives offer a rich source of information, allowing for an in-depth exploration of personal experiences that might not be captured in a survey. While a survey may collect data on actions and beliefs, it does not explain the 'why' behind these actions. Qualitative methods solve this issue and provide a chance for individuals to express the rationale behind their beliefs and actions. Furthermore, trust in public healthcare systems is a complex concept that is affected by different factors, including cultural, social, and historical contexts. A survey, with its predetermined questions and limited scope, might not capture this complexity, and a qualitative

approach, on the other hand, allows for a more holistic overview of the trust and more specifically the links between beliefs (trust) and actions in the context (visiting public hospitals).

People were not divided into groups by “public hospital visitor” or “private hospital visitor” because during the interviews almost every participant had experience of visiting both and therefore participants were able to make their own comparisons. The interviews were conducted in January 2024 at a quiet place that was convenient for the participants – their home, coffee shops with few amounts of people, and coworking offices. Each interview lasted for around 30-40 minutes and was recorded on a laptop. Three interviews were conducted online through the Zoom platform, and four were conducted in a private meeting with participants. The interview questions were divided into two parts: those related to interpersonal trust (questions about doctors/medical workers) and those related to institutional trust (questions about the healthcare system in general, health promotion).

For the interview guide in English and Russian check Appendix 1.

For the consent forms in English and Russian check Appendix 2.

Ethical considerations

The first ethical consideration might be the breach of data. I protected every recording and transcript on my personal computer with a password that is only known to me. The identity of the participant was never asked during the interview and will never be revealed in the paper. As it was stated in the consent form, participant could opt out of doing interview at any time and skip any questions they might have deemed uncomfortable. Another risk might have been emotional discomfort during the interview that might have been caused by the questions which

can trigger unpleasant memories. Participants could also stop the interview at any time they would like to. Overall, I guaranteed that the risks are no more than minimal.

Data analysis

Every interview was transcribed and then analyzed based on the transcript. For transcription, I used the voice recognition feature of Microsoft Word. There were three stages of analysis: pre-coding, conceptual categorization, and theoretical categorization. Pre-coding stage gathers the description of the issues that arise in the data, mostly it focuses on keywords in interviews. Conceptual categorization involves putting keywords into large categories and selecting them into concepts that would explain big bodies of texts. Theoretical categorization analyzes the ways that concepts correlate with each other in order to explain a theory. In this stage, the categories that were developed in the second stage are grouped into broad big categories based on the empirical gaps and how the data fills these gaps. The analysis in the last stage is done using deductive, inductive, abductive, and retroductive inference (Meyer & Ward, 2014). As this methodological framework is very detailed and has a published guide, I used it in my research. All the data analysis was done using Atlas.Ti software on a personal computer. Each interview was coded according to five categories: public health system, public health doctors, public hospitals, private hospitals, and trust. Inside these five categories, I divided codes into other more specific categories (for example: Trust: price, public health system: lack of promotion, Doctors: busy and overworked). Based on these specific categories, it will be easier for me to pinpoint exactly the trustworthiness factors that participants were talking about. Overall, the highest number of quotations was found inside the Trust category with 154 entries, while the lowest was in private hospitals with 12 entries.

4. Findings and Discussion

4.1 Interpersonal Factors

The passages below do not presume that all public health doctors are prone to be hostile or prone to give ineffective treatment, for example. The passages show through the experiences of patients what trustworthiness factors play a role in increasing/decreasing the trust of the patient towards the doctor. The public hospital acts as a medium through which such experiences were allowed to happen.

4.1.1. *Hostility and attitude of doctors*

Six out of seven respondents reported hostile, rude, and nonchalant behavior from doctors in public hospitals at least once according to their experience. Two of the female respondents (25 and 26 years old) told me, that rude behavior from a doctor in a public hospital is "something to be expected, before visiting a doctor", that is the visit to the public hospital is not the same without such behavior. Two male respondents (28 and 32 years old) had similar experiences, where the doctor called them "fat" and neglected the whole health issue of the patient, urging them to "just go to the gym" instead and did not even assign any treatment or any health tests. Because of this, one of the participants said: "I'm really always scared [before visiting a doctor in a public hospital]. It feels like sometimes they can just yell at you… Say some horrible things. Sometimes instead of being scared of the disease, you're being scared of the doctor." (Male, 28). Sometimes, doctors can be missing during their working hours, so patients are left wondering where they might be, they waste their time waiting for the doctor. As one of the respondents said: "I feel like sometimes doctors neglect their duties (имеют халатное отношение). When I ask for a doctor, the nurse tells me that she will be here now, but then you see the doctor arrive at

her office 30 minutes later in a winter jacket and my trust immediately goes down" (female, 34). Similar situations happen during lunch breaks when doctors leave early, and patients have to wait until the end of the lunch break to enter the appointment. It seemed like the trust of people towards doctors really diminished due to the lack of "soft skills" of doctors, passive-aggressive behavior, and their inability to communicate with their patients in a polite way. As one of the respondents said: "Doctor appointment is a very intimate thing and sometimes it makes me feel like they are doing it against their will, so I think the environment needs to be friendly" (male, 32). This finding goes in line with the literature, for example, the paper of Gilson (2006) that revealed rude behavior of healthcare workers as one of the trust precursors or the paper of Ozawa & Sripad (2013) that claims that trust depends on the relations with a physician, whether there is a sense of loyalty among patients and doctors. Of course, the rude behavior and hostility of doctors would not lead to loyalty and therefore, trust, thus this factor is one of the interpersonal factors of trustworthiness that I identified during my research.

4.1.2. Ineffective Treatment and Different Doctor Conclusions

Ineffective treatment was a significant part of narrative of some participants. Woman, 25, stopped visiting public hospitals due to a bad experience with dermatologist who prescribed her ineffective treatment.

> "The doctor did not consider the nature of my skin and I was not asked to take any medical tests, and the doctor just prescribed me some antibiotics without any warning. She also urged me to go on a strict diet. I think that was the most negative experience for me. Nobody really monitored my condition and the progression of my acne after the diet, and the doctor did not ask me whether I had any eating disorders before putting me on a diet." (Woman, 25).

It seems like the doctor was just following a protocol and did not really personalize the treatment of a patient, thus leading to decreased trust in public health doctor, however, the decrease of trust was offset due to the lack of information on the patient's side. The participant said that she followed this treatment initially, but only years later realized how bad it was for her skin after doing her own research and asking about it in a private hospital.

Another woman, 34, says:

> "Sometimes it feels like some doctors are just incompetent. Whatever the disease we get diagnosed with, they prescribe antibiotics right away. For me, it seems like a red flag, because we have not done any tests yet and we are already given antibiotics. What if it is a virus and it does not need antibiotics?"

I think this account shows that doctors do not really explain to the patients why they prescribe specific medicine to patients and thus, patients are forced to wonder and make their own conclusion. In the case of this woman, she did not understand the logic of a doctor, so she is less likely to trust them and more likely to think of them as "incompetent".

This woman, 34, also had a similar experience with a dermatologist as the woman in the first passage, but it happened when she took her daughter to the public hospital.

> "Recently my daughter had some irritation on her elbow and the doctor told us to take a skin scrape test, so we had to go to another hospital to do it since it is not available in all public hospitals. When we arrived there, another doctor told us that we do not need a skin scrape and that was just an irritation on the elbow. This doctor gave us different diagnosis and we did not even need to take extra tests. When we asked our pediatrician doctor, she gave us a different conclusion too and told us to cauterize the elbow (прижечь йодом),

but it was really painful for my daughter, so my trust in the doctor lowered. Overall, we had three different conclusions from three different doctors."

In this passage, the woman opens up an issue of non-homogeneity among public doctors that is prevalent in other accounts as well. Different doctors provide different diagnoses, therefore patients do not really know whom to trust and it might lead to a decrease in trust, as there is no single truth on the matter. This negative account can be contrasted with her positive account with public doctors:

"We had a therapist and I really trusted him. Why? Because whenever he would make a diagnosis, it would always later get clarified with medical tests that he prescribed. And it was not just once, it happened every time, that is why I trust this doctor." (Woman, 34).

The correct diagnosis and appropriate medical tests increased the trust of this participant towards a certain doctor, while different/varying diagnoses with no medical tests or irrelevant tests led to more distrust.

A woman with a visual impairment, 31, shared that once she was diagnosed with "glaucoma" in one of her eyes that she can see with. The woman got really scared because there was a risk of her losing her job, as she would not be able to work anymore/pay her mortgage with such a diagnosis, and therefore her condition worsened. However, the diagnosis turned out to be incorrect, so based on her own experience and her friends' account she realized that the doctor was just "inadequate (инадекватный)". One of the male respondents, 28, also had an experience where he was offered surgery on his eye and another doctor told him that there was no need for surgery, so he "did not know whom to trust, because their opinions and treatments differ". The treatment of the doctor from the public hospital did not help and he was suggested to go to the private hospital by his friends after a month. Not only did the patient have to spend his

out-of-pocket money on the private hospital, but also had to suffer an additional month without proper treatment, as he said, “I still have some problems with my health, because the treatment was ineffective, so I do not really have much trust in treatment from public hospitals” (man, 28).

While most participants agreed that in public hospitals doctors give ineffective treatments, one of the participants revealed the opposite by comparing private and public hospitals:

> “In private hospitals, they might fool you and give you medicine that you don’t really need. In public hospitals I think it is the opposite, they give you only the medicine that you are required to take and the doctors work for results (работают на результат). I have more trust in public doctors, than private doctors. But I trust the effectiveness of the treatment, not the quality of their work.” (Woman, 27).

It is interesting to see that some patients never really experienced the notion of ineffective treatment or the different conclusions of doctors, perhaps it might be due to the frequency of visits to the hospitals. However, when talking about the quality of work, the participant meant that despite giving her good treatment, doctors still were prone to act rude and hostile, as it was described in passage 4.1.1. I think these accounts clearly show how ineffective treatment and non-homogeneity of doctors’ opinions on health matters shape distrust in public doctors, however not all patients might be subjected to this issue.

4.1.3. In-group trust

Some respondents had doctors as relatives and the responses of such respondents revealed an impact of in-group (doctors/medical workers as relatives) on trust in public hospitals/doctors. Woman (26) claims that in general she trusts doctors in public hospitals because her mother is a doctor in a public hospital too, however she tends to visit hospitals less

because her mother can always give her medical advice. What was interesting is that the mother gives advice to the respondent to visit private hospitals, instead of public hospitals:

> "I had severe allergic reaction last spring, and my mom advised me to go to the private hospital, because there are long queues in the public hospitals, and it would take a long time before I get my care. So, I listened to the advice of a person who has more experience in this matter and went to the private hospital." (woman, 26).

Therefore, there is a double-edged sword, while the respondent trusts public doctors in general, she would not visit public hospitals, as her doctor mother advises against it due to her experience of working in public hospitals.

Another respondent (woman, 31) revealed that her trust in a certain doctor depends on what her family thinks about a doctor:

> "Almost all the relatives in my family are from a medical sphere, so they know what doctor is bad or good. I have a doctor back in my home town that I have been visiting since I was 16 and I still trust her, but basically it all started with my relatives and their trust in this doctor first."

Thus, in-group plays a role in forming trust in either specific doctors as it is shown here, or forming trust in public hospitals in general, as it was shown in the previous example.

4.1.4. Lack/presence of contact with a doctor

Another trustworthiness factor is the lack/presence of contact with a specific doctor. In Kazakhstan, one is assigned to a specific hospital based on the area of the city you live in. There is a special governmental website “egov” that keeps track of all your private info including your assigned general therapist. Some respondents revealed that while they knew that they had an assigned doctor, they never actually met them in real life. So while on paper you have a doctor, you never really formed a connection with them. Lack of this contact leads to some problems, for example, one woman (34) revealed that if doctors do not know you, then there is a chance they will not be able to call you when it comes to something important like getting a vaccine for your child, so there is an additional risk that comes with lack of contact with a doctor. In general, lack of contact means an absence of trust. In contrast, the presence of tight contact with a doctor allows for the development of higher trust. Woman, 31, said that she visits the doctor from her hometown with whom she established a good connection and despite living in another city she feels more inclined to go back to her hometown and get treatment there, rather than in the capital where she lives now. This finding is consistent with the notion of familiarity that was mentioned at the beginning of the paper when trust was defined. Familiarity with a doctor makes it possible to forget the risks and possible hurdles (such as going to another city to visit a doctor) associated with receiving medical treatment and helps to build interpersonal trust (Meyer et al., 2013).

4.2 Institutional factors

4.2.1 Lack of health promotion from the public health system

Six out of seven respondents claimed that there are not enough health promotion measures from the public health system in our country. Some people were concerned with the

large amount of “anti-vax” (anti-vaccination) people and blamed the healthcare system for the inability to deal with them. Mostly, they call back to COVID-19 and how the number of anti-vax people increased during that time, but also draw parallels in the present as well, citing the recent measles outbreak and how even with a disease that has been known to cause deaths for a long time, there are still anti-vax people. As one of the respondents said: “COVID-19 was something urgent, and they did not know how to treat it, but they have known about measles for a long time and the government still failed to promote vaccines and prevention of the disease among the population. This is a big indicator that not enough is being done.” (woman, 27). People need some active involvement of the system with the population, not just “brochures about vaccines in hospitals” or “billboards on the street” (man, 31). And mostly, people blame the measles outbreak on the way the healthcare system ignored the preventive measures that they should have undertaken. Some respondents urged for “medical, scientific knowledge in accessible form” in social media and the distribution of such accessible knowledge among the population. One of the respondents raised a point that due to the lack of health promotion from the healthcare system, not many people do yearly health checkups that are available for everyone, so the patients find out about their health problems only later, when their diseases may have progressed, thus hospitals treat “post-factum” not “preventively”.

Kazakhstan launched mandatory social health insurance (MSHI/OCMC) in 2020 in order to provide “equal access to medical care” and allow citizens to pay small monthly tax in exchange for a wide variety of medical services for free (Electronic Government of the Republic of Kazakhstan, 2023). On this point, four out of seven respondents revealed that they lack knowledge of MSHI, some people pay the fee each month but never use it and one man heard of

it for the first time during the interview. Despite having an option to receive free medical services, people are not able to do it mainly due to the lack of information.

> "I see information about MSHI in public hospitals on those information stands, but it is presented in such a convoluted way, that I think nobody would ever read it and try to make sense of it." (Man, 32).

People who do use it report positively and think it is great that as citizens they can get most medical services for free and even prescribed medicine can be given for free from specific drugstores, thus leading to an increase in trust in the healthcare system. Perhaps, if more people were aware of MSHI, then there would be more overall trust too. Therefore, lack of health promotion is one of the biggest trustworthiness factors when it comes to institutional trust. However, MSHI's biggest flaw is long queues that are associated with receiving free medical care and it leads to the next point.

4.2.2 Lack of funding.

All respondents reported a lack of funding for healthcare as one of the problems that affects their trust in the system. The respondents reveal that hostile doctors in public hospitals (4.1.1) and ineffective treatment (4.1.2) are understandable, as there are not enough hospitals to handle the workload, therefore not enough doctors to take care of all patients and thus, longer queues and doctors in public hospitals have to take additional patients, so it leads to overworking and lower quality of care.

> "Public hospitals are not really terrible at their jobs, they are just overwhelmed." (Man, 28).

Respondents revealed that doctors always fill out something on paper or in their computers, so their job involves managing several tasks at once and such tasks should be managed under a good infrastructure. Some respondents actually empathize with doctors in public hospitals:

> "Sometimes the doctors just can't handle the patients who come to hospitals just to scream at everyone and make a conflict. I think doctors should be valued more in society and we should give these people the credit where it's due. We, ordinary people, can plan our schedule, while doctors often have to come to the hospital in spite of their personal lives, otherwise, a person would die. I think it is a big psychological burden, so that is why the salary of doctors should be higher and they should be valued more." (woman, 31).

Another woman (27) said that she does not write complaints about doctors if they do a bad job, because these doctors already have a small salary and horrible work conditions, so my complaint would just make their lives even worse. In a way, I think this empathy helps to contain trust in doctors from public hospitals because patients expect doctors to fulfill their duty of saving a patient at any time in the future despite the bad conditions or sometimes hostile attitude, so it goes in line with the definition of trust that was outlined in this paper.

To conclude this point, patients would trust doctors more if they worked in good conditions without overworking and bad salary, it would lead to higher quality of care and overall satisfaction with the experience in the hospital. If that were to happen, the patients would believe that the healthcare system is doing a good job of financing the hospitals. However, even when such conditions are not met, patients still hold on to trust through empathy. Therefore,

there is an interesting outcome of the institutional trustworthiness factor acting on interpersonal trust. This finding is also consistent with literature and scholars argue that interpersonal trust is a two-way process that "requires both parties to demonstrate behavior that allows each to trust the other" (Gilson, 2006). Patients express this behavior with empathy, while doctors might express this behavior by being diligent in their work and providing correct treatment.

4.2.3. General mistrust in government leads to institutional mistrust

Some participants associated the healthcare system heavily with the government and believed that the government was not doing a good job of managing the system. Woman (26) has doubts about the system and the government, despite actually having good opinions of doctors:

> "I respect the work of doctors and the institute of medicine in general, but this institute is based on the government, and I have conflicting opinions about it. Like, the government is not doing enough for the citizens."

Another woman (25) reminisces on the COVID-19 policies and how the government dealt with the pandemic, describing that decision-makers were the main reason why she thinks the reaction of the government towards the coronavirus was not adequate, yet again emphasizing that there is a higher emphasis on trust towards the government (decision makers) rather than a specific doctor:

> "The policy to prevent the spread of the coronavirus was handled directly by the Ministry of Health, special convocations that met to address this issue. And, of course, some initial actions, some orders, they came from above, and the doctors had to do it, had to fulfill those orders that were sent from above. That is why, first of all, I have complaints to the

state. Because there was concealment of statistics, and they could not solve the issue of the vaccine for a long time. Therefore, if we consider this vertical of power,
I have distrust not specifically to some therapist or some hospital, but directly to those from whom the decisions came. And how activities were coordinated in this situation."

Male, 32, believed that any state services that are funded by taxes are not effective (including healthcare), so he has skepticism towards it that stems from his childhood and hometown experience. Despite moving from his hometown around 10 years ago, the mistrust towards the government public services is still prevalent in his narratives and now he prefers the private alternatives instead. The time frame is interesting because 10 years is a long time, it includes two state health programs that were completed, but the participant still did not see any results:

"Growing up in my hometown, I experienced the bad quality of public services, like the educational system, which tends to be really horrible, particularly for those born outside big cities. This pattern of low quality extends to other government-funded institutions, such as healthcare, and I personally don't trust and don't use any public services. Like I pay taxes for it, yeah, but I'd rather not use it and prefer alternatives."

When asked whether the situation could be changed in any way he replied:

"I'm kind of cautious towards the government as a whole, you know, the political atmosphere in our country. My mistrust comes from the mistrust of governmental facilities as I already mentioned before and yeah I don't know what would make me trust

them more at this point. There needs to be a complete change in public perception. I'm not sure. It's kind of hard to say."

The image of poor service is ingrained into the perception of participation and needs a complete change. Perhaps, it would be the new acting government, but the participant struggled to give a defining answer to this question, so I did not press further to not make it uncomfortable. However, the participant noted that the "political atmosphere" and general disillusionment towards the government are his main concern.

Overall, the participants highlighted the notion that mistrust in government in general leads to mistrust in the healthcare system. The decision maker in question is the government that decides how to deal with the pandemic or how to develop the healthcare system. The mistrust towards the system takes on a more prevalent role for these participants when deciding on whether to visit public hospitals or not, as opposed to the mistrust towards a specific public hospital doctor that is subordinate in this case.

4.3. Institutional and Interpersonal trustworthiness factors

If I were to contrast the interpersonal and institutional trust from my findings, I would say that for most respondents (but not all) the interpersonal and institutional trust are separate notions. There might be a good doctor in a public hospital, but they might be working in horrible conditions that are caused by the healthcare system. The medical workers are "prisoners" of this system (as one of the respondents mentioned) and sometimes respondents trust public doctors more than the system itself. Trust/distrust towards the specific doctor in a public hospital does not mean more trust/mistrust in a healthcare system. Therefore, on one side, the findings of the

paper do not support the notion that institutional trust arises from interpersonal that was proposed by Giddens (1990). In our case - even if I trust a public doctor (interpersonal), does not mean I will trust the healthcare system (institutional), that is the notion that was proposed by Luhmann (2018) – interpersonal trust arises from institutional trust, from trustworthiness factors like lack of funding and lack of health promotion.

The doctors might be good or bad, but it does not affect the trust of the patient, as the patient understands the poor conditions of doctors, sees the poor infrastructure, and looks at systematic problems of the institution. According to the respondents the healthcare system "might be written by people who do not understand what the hospital, medical treatment, patients and diagnoses are" (Woman, 31). There is a heavy emphasis on "might be" which raises an important theoretical link to uncertainty that was mentioned at the beginning. The decision for people to distrust the healthcare system (the institution) made it easier for them to decide not to visit public hospitals, but interestingly it did not make them distrust the public doctors. As some respondents mentioned, if the conditions of the public hospitals improved and they received proper funding, then there would be no barriers to visiting public hospitals.

Finally, the argument about the general mistrust in the government also showed that institutional trust is more prevalent than interpersonal because the government acts as a decisionmaker that directs the healthcare system, and all the subordinate elements like doctors, hospitals, and ministries are controlled by the government. This association is ingrained in the perceptions of some participants and their narratives. If we were to accept this and go back to the definition of trust:

> “Trust can be seen as a belief by the trustor (A) that an action (X) will happen at some time (Y) in the future by the trustee (B). This belief is based on some factors that make up the trustworthiness of trustee (B).”

The trustworthiness factors of trustee B (the doctor) are shaped by C (the institution), the regulator of B. However, shaping the factors of B by C directly affects the X (the medical treatment: the quality of care, access, queues, correct treatment, and infrastructure). Therefore, A (the patient) can mistrust the system (C), as it directly does not allow for the proper execution of action X by the doctor (B).

However, not every participant seemed to agree with this idea and some participants believed that “doctors, healthcare workers are the direct representatives of the healthcare system”, so the quality of their work is connected firstly to them and only then to the institution. In this case, interpersonal factors are more important and despite the poor conditions of the hospitals, public doctors must perform well to maintain the trust of the patients, that is the view that is consistent with the theory of Giddens (1990).

5. Conclusion

This study has looked at interpersonal and institutional trustworthiness factors among adults (25-35) in Astana city in Kazakhstan. The experiences of adults as patients through the medium of public hospitals were taken as a basis for the analysis. Four main interpersonal factors were revealed – hostility of doctors, ineffective treatment/difference in conclusions of doctors, and lack of contact with the doctor and in-group. The first three factors were directly influenced by institutional factors such as lack of funding for the health system/public hospitals

and lack of health promotion among the population. The doctors work in bad conditions and are underpaid, so they have less motivation to service the clients in a proper way, this is combined with bad infrastructure and long queues of patients. While patients are affected by such negative experiences, the blame lies on the healthcare system that does not provide enough resources for doctors, so understanding that the patients empathize with doctors leads to the development of interpersonal trust through the reduction of institutional trust. The institutional trust is further diminished by the mistrust in the government and the general notion that the government is bad at its job across different institutions, including healthcare. When interpersonal and institutional factors were juxtaposed, some participants believed that institutional trust leads to interpersonal trust and that institutions are mainly responsible for the quality of care, however, some participants did not agree and said that doctors/healthcare workers are direct executors of the system, thus they should be responsible for providing quality care and if they do so, then the institutional trust can be achieved. Finally, the definition of trust was revised on the micro level and the C (the institution) was added to the equation. C is interested in the proper work of B (the doctor) and the delivery of proper service of B to A (the patient), thus creating a chain of trust, however, in reality, C does not allow B to deliver proper service due to factors that were described in this paper. Perhaps, there is a lack of proper management across the whole bureaucratic institute of healthcare in Kazakhstan and a long chain of command, combined with corruption that is prevalent in Kazakhstan might be why some problems like the lack of proper funding, poor salaries of public doctors and aging infrastructure of the public hospitals remain prevalent throughout the years. Still, the government does not see trust as a point of interest in its state health program, so maybe the institution is not even aware of problems that exist in regard to public healthcare.

This study has looked at the narratives of trust in public healthcare in a big city like Astana. Further research might shed light on how trust is compared between big cities and small cities or even villages. Villages receive less funding than big cities, so analyzing whether a trust is higher or lower in low-populated areas might be insightful. Furthermore, the analysis of other age groups might be interesting, because this study has only looked at the age group of 25-35, perhaps analyzing older generations and their opinions might reveal other trust issues that were not present in the narratives of participants in this study.

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Appendix 1: Interview Guide

Questionnaire RU

Спасибо, что нашли время для этого интервью, давайте начнем!

Посещаете ли вы государственные (общественные) поликлиники/больницы? Если да, то, когда Вы были в последний раз?

- В случае ответа "Да"

  o Можете ли вы описать свой опыт посещения гос. больницы? Вы можете рассказать как о положительном, так и об отрицательном опыте.

  o В целом, можете ли Вы сказать, что доверяете гос. системе общественного здравоохранения в Казахстане? Почему (нет)?

  o В целом, что вы думаете о гос. медицинских работниках в Казахстане?

  Вопросы ниже основаны на том, что участник сказал или не сказал ранее.

  o Приходилось ли Вам сталкиваться с бюрократией в гос. больницах? Опишите ваш опыт.

  o Опишите поведение медицинских работников при вашем посещении в городские больницы.

  o Всегда ли Вы следуете предписаниям своего врача? Почему (нет)?

o Есть ли у Вас свой закрепленный терапевт (врач общей практики) или Вы всегда посещаете другого?

o Ставили ли Вам когда-нибудь неправильный диагноз?

- Стали ли Вы меньше доверять работникам здравоохранения после этого? Как Вы считаете, это вина врача или вина всей системы гос. Здравоохранения.

- В случае ответа "Нет"

o По какой причине Вы не посещаете государственные больницы?

o Предпочитаете ли Вы вместо этого частные клиники или лечитесь дома?

o В целом, можете ли Вы сказать, что доверяете государственной системе здравоохранения в Казахстане? Почему (нет)?

o В целом, сказали бы Вы, что доверяете государственным медицинским работникам в Казахстане? Почему (нет)?

Как бы Вы оценили прозрачность информации, предоставляемой государственными медицинскими учреждениями?

Какая информация, по Вашему мнению, должна быть более прозрачной для укрепления доверия к здравоохранению в Казахстане?

Существуют ли особые культурные факторы, которые, по Вашему мнению, способствуют доверию или недоверию к здравоохранению?

Считаете ли Вы, что государственные медицинские организации эффективно взаимодействуют с населением?

Как, по Вашему мнению, можно повысить уровень доверия к государственному здравоохранению? (Чего Вам не хватает для того, чтобы доверять системе здравоохранения?)

Повлияли ли на Ваше доверие к системе здравоохранения чрезвычайные ситуации, на подобии COVID-19? Почему (нет)?

Существуют ли конкретные законы или гос. программы, которые, по Вашему мнению, положительно или отрицательно повлияли на ваше доверие к здравоохранению?

Questionnaire ENG

Thank you for taking your time to take this interview, let's begin!

Do you visit public hospitals? If so, when was your last time?

- In case of "Yes"
    - Can you describe your experience of visiting the public hospital? You can talk about both positive and negative experiences.
    - In general, would you say that you trust public healthcare **system** in Kazakhstan? Why (not)?
    - In general, what do you think of public healthcare **workers** in Kazakhstan?

Questions below are based on what the participant said or did not say prior.

- Have you ever encountered bureaucracy in public hospitals?
- Can you please describe the behavior of health workers when you were visiting the public hospital?
- Do you always follow the prescriptions of your doctor? Why (not)?

    - Do you have your own assigned therapist (GP), or do you always visit a different one?
    - Have you ever been misdiagnosed?
        - Did it make you trust public healthcare workers less? Do you think it was the fault of a doctor or the fault of the whole system?
- In case of "No"
    - What is your reason for not visiting public hospitals?
    - Do you prefer private hospitals instead or do you treat yourself at home?
    - In general, would you say that you trust public healthcare **system** in Kazakhstan? Why (not)?
    - In general, would you say that you trust public healthcare **workers** in Kazakhstan? Why (not)?

How would you rate the transparency of communication from public healthcare institutions?

What kind of information do you believe should be more transparent to build trust in healthcare?

Are there specific cultural factors that you think contribute to trust or mistrust in healthcare?

Do you feel that public healthcare organizations effectively engage with the community?

How can trust in public healthcare be improved in your opinion? (What lacks for you in order to trust the public healthcare system?)

Has your trust in the healthcare system been affected during public health emergencies like COVID-19? Why (not)?

Are there specific policies/laws that, in your view, have positively or negatively influenced trust in healthcare?

Appendix 2: Consent Form

Consent Form RU

Введение.
Приглашаем Вас принять участие в исследовании под названием "Доверие в здравоохранение: Опыт казахстанцев по доверию к государственным системам здравоохранения в городе Астана. В данном исследовании я хотел бы проанализировать доверие между пациентами и врачами, а также доверие к системе здравоохранения в Казахстане в целом. Мне интересно посмотреть на опыт людей с государственными больницами и через этот опыт проследить их доверие, либо же недоверие. Доверие - очень сложное понятие, и каждый человек по-своему понимает, что такое доверие, поэтому интересно посмотреть на возможные связи между разными людьми и их опытом.

Метод.
Основной целью данного исследования является проведение интервью с людьми из числа работающего населения города Астаны (25-63 года). Перед началом интервью участник должен внимательно прочитать и согласиться с данной формой согласия. Участникам будет задано около 10-15 вопросов об их опыте с государственными больницами и доверии к государственному здравоохранению. Предполагаемая продолжительность интервью - около 15-30 минут. Интервью будет записано исследователем и расшифровано в дальнейшем. Расшифровка и запись будут храниться под паролем, который известен только исследователю, и никто другой не сможет получить доступ к файлу. Участник может в любой момент отказаться от участия в интервью и пропустить вопросы, на которые он не хочет отвечать. Интервью может проводиться как дистанционно, так и очно, в зависимости от пожеланий участника.

Риски.
Потенциальным риском участия в данном исследовании являются негативные эмоции, которые могут возникнуть в ходе интервью при ответах на вопросы. Но если участник не хочет отвечать на вопрос и считает его деликатным, то он готов его пропустить. В данном исследовании гарантируется, что риск будет не более минимального.

Преимущества.
Ожидаемая польза от данного исследования заключается в потенциальной пользе для науки и изучения доверия, поскольку эта тема недостаточно изучена в Казахстане. Результаты данного исследования могут быть использованы для выработки политических рекомендаций для Министерства здравоохранения и образования Казахстана.
Компенсация.
Никакой материальной компенсации не будет предоставлено. Копия результатов исследования будет доступна по окончании исследования, если участник пожелает ее получить. Я могу выслать результаты исследования на электронную почту участников.

Конфиденциальность.
Любая информация, полученная в ходе данного исследования, будет оставаться конфиденциальной. В пределах разумного будут предприняты все усилия для сохранения

конфиденциальности вашей личной информации, однако полная конфиденциальность не может быть гарантирована. Каждая запись и расшифровка будут иметь специальный пароль, известный только исследователю, и храниться на компьютере исследователя. Возможной опасностью является кража компьютера исследователя, однако пароль будет защищать информацию участника. Имя участника в записи или в самом исследовании не будет раскрыто.

Добровольность исследования.
Участие в данном исследовании является строго добровольным, и если согласие на участие дано, оно может быть отозвано в любой момент без ущерба.

Контакты.
Предполагается, что в случае возникновения вопросов или замечаний по данному проекту или получения травмы, связанной с проведением исследования, следует обращаться к главному исследователю Александру Лопухову, +77718347530, alexander.lopukhov@nu.edu.kz. С любыми другими вопросами и замечаниями можно обращаться в Комитет по этике институциональных исследований Назарбаев Университета, resethics@nu.edu.kz.

Положение о согласии.
Я,_____,
Даю добровольное согласие на участие в данном исследовании.
Исследователи четко объяснили мне исходную информацию и цели исследования, а также то, что предполагает мое участие в данном исследовании.

Я понимаю, что мое участие в данном исследовании является добровольным. Я могу в любое время и без объяснения причин отозвать свое согласие, и это не повлечет за собой никаких негативных последствий для меня.

Я понимаю, что информация, собранная в ходе данного исследования, будет рассматриваться как конфиденциальная.

Подпись: _____ Дата: _____

Исследователь:

Подпись: _____ Дата: _____

Consent Form ENG

Introduction. You are invited to participate in a research study entitled *In Public Health we trust: The Experiences of Kazakhstani Citizens on Trust in Public Healthcare Systems in Astana city.* In this study I would like to analyze the trust between the patients and doctors, as well as the trust between the healthcare system and the patients in Kazakhstan. I would like to analyze the experiences of people in public hospitals and observe their trust through these lived experiences, rather than looking at trust in a metric manner. Trust is very complex concept, and every person has their own interpretation of

what trust is, so it is interesting to look at possible connections between different people and their experiences.

Procedures.
The main purpose of this study is to conduct interviews with people from working population of Astana city (25-63 years old). The participant must agree to this consent form before the start of the interview. The participant will be asked around 10-15 questions on their experience in public hospital and trust in public healthcare. The expected duration of the interview is around 15-30 minutes. The interview will be recorded and transcribed by the researcher. The transcription and recording will be stored with the password that is only known to the researcher and no other people could access the file. The participant can decide to leave the interview at any moment and might skip any questions that they do not want to answer. The interview might be conducted both remotely and in-person depending on the wishes of the participant.

Risks. The potential risks of participating in this study are negative emotions that might arise during the interview while answering questions. But if the participant does not wish to answer the question and deems it sensitive, then they are willing to skip it. This research guarantees the risk to be no more than minimum.

Benefits. Anticipated benefits from this study are add the potential benefits to science and study of trust, as this is a topic that is not well-studied in Kazakhstan. The outcomes of this research might be used to provide policy recommendations for the Ministry of Health and Education in Kazakhstan.

Compensation. No tangible compensation will be given. A copy of the research results will be available at the conclusion of the study if the participant wishes to obtain it. I can send the results of the study to the participants' emails.

Confidentiality & Privacy. Any information that is obtained during this study will be kept confidential to the extent permitted by the law. All efforts, within reason, will be made to keep your personal information in your research record confidential but total confidentiality cannot be guaranteed. Each recording and transcription will be given a special password only known to the researcher and stored on the computer of the researcher. The possible danger is the theft of the researcher's computer, however the password will protect the participant's information. The name of the participant in the recording or the paper will not be revealed.

Voluntary Nature of the Study. Participation in this study is strictly voluntary, and if agreement to participation is given, it can be withdrawn at any time without prejudice.

Points of Contact. It is understood that should any questions or comments arise regarding this project, or a research related injury is received, the Principal Investigator, Alexandr Lopukhov, +77718347530, alexander.lopukhov@nu.edu.kz should be contacted. Any other questions or concerns may be addressed to the Nazarbayev University Institutional Research Ethics Committee, resethics@nu.edu.kz.

Statement of Consent.
I,_____,

Give my voluntary consent to participate in this study.
The researchers clearly explained to me the background information and objectives of the study and what my participation in this study involves.

I understand that my participation in this study is voluntary. I can at any time and without giving any reasons withdraw my consent, and this will not have any negative consequences for myself .

I understand that the information collected during this study will be treated confidentially.

Signature: _____ Date: _____

Researcher:

Signed_____ Date_____

Appendix 3: Academic Honesty Declaration Form

Academic Honesty Declaration

By completing this assignment, I declare:

I understand that the University expects all students to complete coursework and assignments with integrity and honesty. As a member of Nazarbayev University's student body, I declare that this assignment was completed in a fair, honest, responsible, and trustworthy manner.

This means that:

- I did not seek out any unauthorized help in completing this assignment.
    - Please note: unauthorized or unacknowledged help includes seeking assistance or advice from anyone or any tool, using a tutorial or answer service whether in person or online, asking fellow students, friends, or family, etc.
- I did not discuss or share the content of the assignment with anyone else in any form, including any social media platform or messaging service within the assignment period, beyond the conditions stipulated by the course instructor.
- I did not reproduce and/or share the content of this assignment in any domain or in any form where it may be accessed by a third party.
- I am aware that Nazarbayev University may use Turnitin or other plagiarism-detecting methods as part of a process to check the authenticity of my content.
- I declare that this assignment is my own work, except where acknowledged appropriately (e.g., use of referencing or through an accompanying statement).
    - Please note: It is not appropriate (and will be considered plagiarism) to reproduce or copy the material provided by your instructors, including lecture slides, assignment samples, lecture notes, and/or course readings. All content must be written in your own words and referenced appropriately. If quoting a source, quotations must be used and referenced appropriately.
- I declare that this work has not been submitted for academic credit in this course or another Nazarbayev University course, or elsewhere.
- I acknowledge that I have adhered to the course rules surrounding the use of permitted artificial intelligence, software, and 3rd party assistance.
- I declare that I have generated the calculations and data and/or composed the writing/translations in this assignment independently, using the tools and resources defined for use in this assignment.
- I understand that Nazarbayev University expects all students to complete coursework with integrity and honesty and declare that this assignment has been completed in accordance with the required academic integrity standards and values.
- I give permission to reproduce this work and provide a copy to another member of staff for crosschecking and moderation and to take steps to authenticate its originality.
    - Please note that you may be contacted by one of our staff members to confirm the validity and authenticity of your work.

Any breach of this statement or identified academic misconduct will be followed up and may result in disciplinary action according to the NU Student Code of Conduct.

Name Alexandr Lopukhov
Student ID 201798971
Date 29.02.2024
Assignment Capstone First Draft
Signature Alexandr Lopukhov

Appendix 4: AI Declaration Form

AI Declaration Form

Completing the AI declaration is compulsory for assignments in this course. Please declare how you have used any AI tool (e.g., ChatGPT) for any part of completing this assignment, including the approved usage. This form should appear immediately after your cover page.

Have you used any AI tool for this coursework (including the approved usage)?

Please select one option:

☐ Yes (please provide details below)

Provide details of how you used an AI tool, including the prompts you used:

☐ I acknowledge the use of [insert AI system(s) and link] to [specify use of generative artificial intelligence]. The prompts used include [list of prompts]. The output from these prompts was used to [explain use].

Example

I acknowledge the use of [1] ChatGPT (https://chat.openai.com/) to [2] structure my materials for drafting of this assignment (link to Google document (initial draft) here). I entered the following prompts on 4 January 2024: [3] Write your prompt(s) here. [4] The output from the generative artificial intelligence was adapted and modified for the final response.

Legend: [1] AI system(s) and link; [2] specific use of generative AI; [3] prompt; [4] explanation of use.

☒ No content generated by AI technologies has been used in this assessment.

Signature: Alexandr Lopukhov

Date: 29.02.2024