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ARTICLE

Conceptualising trust in aged care

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Abstract

This article calls for a sociological understanding of the importance of trust to aged care. It connects existing theories of trust to empirical evidence from gerontology and nursing research. Trust is defined as a response to and management of social vulnerability. It is argued this makes trust a fundamental concept for understanding human service and social care institutions, including aged care. In light of Australia's Royal Commission into Aged Care Quality and Safety, as well as generational shifts in consumer expectations and care ethics, the article highlights four distinct yet interrelated forms of trust: interpersonal, institutional, organisational and public trust. All of these forms are shown to be critical in conceptualising and evaluating the perceived trust deficit facing contemporary aged-care systems, and existing evidence shows how these forms of trust can reinforce, conflict and misalign with each other. Efforts to rebuild trust in aged care at an organisational and institutional level should ensure mechanisms facilitate rather than hinder the formation of interpersonal trust relations between individual service users, their families and aged care staff. Broader social policy reforms must also consider and address the way cultural understandings of ageing, and media representations of aged care, have diminished the public's trust in the sector, and how the cycle of scandals, reviews and piecemeal reforms contributes to this.

Keywords: Australia; aged care; interpersonal trust; institutional trust; organisational trust; public trust; trust; vulnerability

Introduction

In September 2018, Australian Prime Minister Scott Morrison announced his government was launching the Royal Commission into Aged Care Quality and Safety by stating, 'Australians must be able to trust that their loved ones will be cared for appropriately and the community should have confidence in the system' (Hasham, 2018). The Royal Commission, Morrison argued, was needed to 're-establish trust' in Australia's aged-care sector (*The Guardian*, 2018). The announcement pre-empted the airing of an investigative report the next day on ABC television programme *Four Corners* which portrayed Australian aged care as an system 'in crisis' (Connolly, 2018). The report documented disturbing incidents of neglect and abuse

faced by residents of aged-care facilities, as well as broader dysfunction in regulation and quality assurance processes of the sector. It claimed that 'every day stories of neglect and inattention, poor quality food, lack of personal care, boredom and heart-breaking loneliness' were typical for much of the sector and drew on crowd-sourced stories from members of the Australian public as evidence. Now launched, the Royal Commission has called for further stories from the public, through hearings and submissions, and these have prompted more media reports of incidents of abuse, neglect, mismanagement and systemic failure.

Rapidly changing institutional structures and regulatory frameworks are often symptoms of trust problems (Lewis and Weigert, 1985). The Royal Commission is the latest in a long line of government and independent probes into the quality of Australia's aged-care system (Braithwaite, 2001; Cullen, 2003; Productivity Commission, 2011; Royal Commission into Aged Care Quality and Safety, 2019*a*, 2019*b*). In another highly publicised incident in 2017, the Oakden nursing home in South Australia was shut down by the State Government after a review by the South Australian chief psychiatrist revealed disturbing incidents of assault, over-medication and clinical neglect involving residents with dementia and Parkinson's disease had failed to be recognised by regulators (Groves *et al.*, 2017). The incident prompted the then Federal Minister for Aged Care, Honourable Ken Wyatt, to commission a review of quality in the aged-care system as a whole, which argued that current regulations meant providers were focusing on 'box-ticking', with poor engagement with consumers' needs and expectations. It therefore raised the possibility of a conflict between adhering to accreditation processes and providing quality care (Carnell and Paterson, 2017). In the interim report, the Royal Commission has been critical of the selective and reactive way successive governments have acted on recommendations from the various reviews. They note that policies have generally fallen short of offering the 'the fundamental overhaul of the design, objectives, regulation and funding of aged care in Australia' that is required to re-establish trust in the sector (Royal Commission into Aged Care Quality and Safety, 2019*b*: 10).

Publicised scandals have a damaging impact on the public's trust in the implicated institutions (Gilson, 2003; Gille *et al.*, 2017). The Australian Aged Care Quality Agency (AACQA) was established in 2014 as a body that determines the accreditation and ratings of aged-care providers in accordance with the quality of care standards specified by the Aged Care Act 1997. This was followed by the appointment of an Aged Care Complaints Commissioner (ACCC) in 2016 to review and mediate individual complaints against care providers independently. The two bodies were combined into an independent Aged Care Quality and Safety Commission (ACQSC), a portfolio of the Commonwealth Department of Health from 2019. Aged-care providers' compliance with standards are published on the Department of Health's My Aged Care website and are intended to afford potential consumers a method of reviewing and comparing aged-care options. The AACQA, ACCC and ACQSC were established in the wake of shortfalls in the public's trust in the aged-care system. These bodies act as 'trust guardians' (Shapiro, 1987) by overseeing the evaluation of care facilities and independently administrating the complaints process. Both the AACQA and ACCC were criticised in the *Four Corners* report for failing to act on complaints and retaining full

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compliance ratings for providers after incidents of assault in their facilities were exposed and care staff were criminally convicted (Connolly, 2018). The Royal Commission is an effort to forestall any further regressive decline in trust, by appointing another independent third-party trust guardian, as Prime Minister Scott Morrison has directly stated.

Despite Australia's aged-care system being highly regulated (Smith, 2019; Productivity Commission, 2011), a 2018 survey by an independent consulting firm in Australia found only 18 per cent of respondents reported 'a high degree of trust' in organised aged-care services (Faster Horses, 2018).[1] The survey results have been taken by journalists and industry stakeholders as indicative of a broader deficit of trust in Australia's aged-care system (Skatssoon, 2019). The timing of the survey seems prescient, undertaken just prior to the launch of the Royal Commission. The survey also comes in the context of what some scholars are calling a 'crisis of trust' in governments, organisations and individuals across the contemporary Western world (Bachmann *et al*., 2015; Ward, 2019), which has especially impacted health and human services institutions (Gille *et al*., 2017; Hutchinson, 2018). According to this narrative, governments and organisations and can no longer assume *de facto* trust from the public, and must now invest resources into trust-building and public relations strategies that gain and maintain it (Ward, 2017).

Scholars in sociology and organisational studies have been researching trust for several decades and have developed a wide range of conceptual and methodological tools (Gilson, 2003; Bachmann and Zaheer, 2006). Curiously, there has been little application of these tools to understanding aged care as a professional practice or social institution. A notable exception to this is Braithwaite and Makkai (1994). While the term trust is often mentioned in research on aged-care quality and nursing practices, it has hitherto been primarily used in a vernacular sense or upheld as an ethical imperative, rather than as a framework for sociological analysis (*see* Dinc and Gastmans, 2013). In addressing this gap, this article demonstrates how some conceptual tools from trust research can be applied to aged-care research, and how such an application can enhance our understanding of issues regarding quality of care, workforce and policy. This is a timely exercise given ongoing political and media controversies, as well as generational shifts in consumer expectations (Phillipson, 2013; Aged Care Workforce Strategy Taskforce, 2018), as it offers new ways to understand current challenges facing the sector.

The article proceeds as follows. Trust is defined as a response to, and way of managing, vulnerability. The article then examines four distinct yet interrelated forms of trust: interpersonal, institutional, organisational and public trust. All of these forms are useful in understanding and evaluating dynamics of trust in aged care. Drawing upon gerontology and nursing literature, the article argues that interpersonal trust between staff, aged care residents and their families is a fundamental component of providing 'quality' aged care and is implicitly embedded in dominant industry values. It describes some ways through which interpersonal trust enables, and is enabled by, institutional and organisational forms of trust. It also describes ways that institutional and organisational trust mechanisms can sometimes create barriers to forming interpersonal trust within aged-care contexts. The article finishes with a discussion of the relation between public trust, media coverage, and the

cultural logics of the 'third age' and 'fourth age' (Higgs and Gilleard, 2014). Examples in this article primarily concern long-term residential aged-care services. However, this does not imply trust is any less relevant in community care or respite services.

Trust, vulnerability and care

Trust has been defined in various ways, but a succinct and widely accepted definition is 'the *optimistic* acceptance of a *vulnerable* situation in which the trustor believes the trustee will *care* for the trustor's interests' (Hall *et al.*, 2003: 615). Another similar definition is the 'intention to accept vulnerability based upon positive expectations of the intentions of the behaviour of another' (Rousseau *et al.*, 1998: 395). Crucially, acceptance does not necessarily mean having extrinsic awareness that one trusts another. Trust is better thought of as sub-cognitive – implicit in one's relations and actions rather than being an explicit thought process (Lewis and Weigert, 1985). Referring to optimism or positive expectations here does not mean to trust is to assume that things are going well. Rather it is optimism about the way in which the trustee handles the trustor's vulnerability. Further developing this idea, Misztal has argued that trust and vulnerability occur in a circular and self-reinforcing relationship:

> While creating an opportunity to trust, at the same time vulnerability also increases the probability of distrust as situations of high vulnerability increase sensitivity of vulnerable parties to the trustor's behaviour and this higher level of sensitivity has the potential to erode their trust. (Misztal, 2012: 213)

Accordingly, we can speak of a trust relation when the responsibility of the trustee is to reduce the trustor's vulnerability by compensating for the conditions that make them vulnerable. This allows the trustor to 'bracket out' risks associated with their vulnerability and on that basis commit to more complex and risky courses of action than they otherwise would (Luhmann, 2017; Morgner, 2018; Kroeger, 2019). However, at the same time, conferring trust increases the trustor's vulnerability by making them dependent upon the trustee, and creating the opportunity for the trustee to exploit or abuse that trust. This raises the stakes of trust and the severity of consequences for breaches in trust, which makes both gaining and keeping trust in such situations all the more sensitive (Misztal, 2012).

Vulnerability implies asymmetrical social relations. Trust research has mostly been concerned with organisational relations, or the engagement of consumers with 'expert systems' like medicine and law. Trust researchers therefore usually define vulnerability as asymmetries of authority or information between managers and subordinates or asymmetries of expertise between professionals and their clients. By contrast, in relations between aged care staff and residents, vulnerability is corporeal and primarily defined by asymmetries in physical or cognitive capacities. We can define residential aged care as a situation when professional staff 'are more able to look after the residents than the residents themselves and also have more power to represent and enact the "reality of care" than do the residents' (Gilleard and Higgs, 2018: 238). Yet, different vulnerabilities entail different forms of trust, and by extension different approaches to care.

When vulnerability is the result of physical disability alone, the resident is competently able to judge their own best interests, and staff are expected to respect that

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individual's competence and provide high-quality, consistent and sensitive care that enables them to live well with their disability. Trust relates to this expectation. The service user expects carers to compensate for their physical disability, but questioning their own representation of their needs and preferences damages trust. If carers conflate physical disability with cognitive impairment, or otherwise assume physical disability means the person lacks capacity to make decisions, this can constitute a violation of trust.[2] The principle of 'dignity of risk' is oriented towards this problem. The principle holds that people living with illness, frailty or disability have as much right to decide to take physical, psychological or social risks as other members of the community. Consequently, for a person in residential aged care, trust is not just about managing their physical or psychological vulnerability to harm. Trust also extends to the vulnerability of their rights, which can be denied if aged-care staff are overprotective and prevent them from participating in activities where harm is risked (*see* Ibrahim and Davis, 2013).

People with cognitive impairments, such as dementia, constitute over 50 per cent of aged-care residents in Australia (Australian Institute of Health and Welfare, 2017). The primary rationale of dementia care (as with care for people living with intellectual disability or mental illness) is that their cognitive vulnerability represents a risk to themselves and others, meaning distrust in their capacity to manage their vulnerability alone, as cognitive vulnerability affects their capacity to do so (Luhmann, 2017: 47f). Jennings has explored the implications of this, and distinguished between guardianship – protecting a person from harm by minimising exposure to risks – and conservatorship – maximising their agency and capacity by affording them scope to take risks – as two conflicting ethical perspectives on care (Jennings, 2001). The latter is in line with current Australian quality standards (Aged Care Quality and Safety Commission, 2018); but as care ethics, both presuppose some degree of distrust in the person with dementia's ability to manage their own vulnerability (Ibrahim and Davis, 2013). If they were trusted, they may not need care at all.

Reports of people with dementia being subjected to wilful harm or neglect within aged-care homes indicate a multi-level betrayal of trust. First, it is a betrayal of the prospect that the person receiving care could possibly entrust the person providing care to compensate, rather than exploit, their vulnerability. Second, it suggests the individual providing care has betrayed the institution's trust in them to uphold and enact what are ostensibly its core values: enablement through the management of vulnerability. Third, and most troubling, it raises the possibility of 'lawful betrayal of trust' (Vassilev and Pilgrim, 2007: 355), when the betrayal of service users' trust through wilful harm and neglect is actually tolerable within the range of institutional routines and norms, but has been hidden from public scrutiny. By extension, the public becomes implicated in this betrayal because our mistrust in those deemed cognitively vulnerable legitimated our trust in institutions organised to manage their vulnerability, which may have, in turn, exposed them to harm.

Forms of trust

To explore this idea further we need to examine the way trust researchers have analysed trust as a multifaceted phenomenon that is gained and maintained in various

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ways. Sociologists distinguish between 'interpersonal' and 'institutional' forms of trust, which correspond to *micro* and *macro* levels of analysis (Ward, 2019; Turner, 2007). Public trust refers to how an institution is viewed from the outside, whether in media coverage or community members' everyday communications (Gille *et al.*, 2017). In organisational studies, a concept of 'organisational trust' is also sometimes used to refer to a *meso* level of analysis (Kroeger, 2011; Morgner, 2018). By observing how different forms of trust are interdependent, and how they can mutually reinforce, counteract or misalign with each other in institutional settings, we can develop a better understanding of how trust is won and lost in formal aged-care contexts.

Interpersonal trust

Broadly, interpersonal trust refers to the relationships between individuals, and the expectations people have about each other's behaviour based on familiarity with their personality and their reputation. Conferring interpersonal trust is a way of managing the fundamental opacity of other individuals – their capacity to behave in unpredicted ways, the complexity of their environmental and biographical influences, and their ability to manage appearances and thereby disguise their motives.

In aged-care contexts, interpersonal trust relationships are variously formed between members of staff, residents, families and management. Some empirical studies have stressed the importance of 'building trust' between residents and staff (Dwyer *et al.*, 2009; Cook and Brown-Wilson, 2010; Shin, 2015), between family members and staff (Rosemond *et al.*, 2017), and between staff and management (van der Borg *et al.*, 2017). Even when trust is not operationalised, its logic is implicit in much of the literature (*see* Bradshaw *et al.*, 2012), and arguably the guiding principle of person-centred care (Kitwood, 1997).

Evidence suggests that when residents trust staff they feel more at home and positive about their living situation (Bradshaw *et al.*, 2012; Minney and Ranzijn, 2016), more comfortable with being assisted for private tasks like bathing and toileting (Shin, 2015), more likely to disclose changes in their health and wellbeing (Brownie and Horstmanshof, 2012), and more likely to advocate for themselves (Falk *et al.*, 2013). Residents who do not trust staff are likely to be socially isolated, experience depression, and challenge staff or want to leave (Fossey *et al.*, 2006; Popham and Orrell, 2012; Oudman and Veurink, 2014). The factors which support consumer satisfaction align closely with those that would suggest high levels of interpersonal trust between staff and service users of residential care (Chou *et al.*, 2002).

In addition to the trustor becoming familiar with the trustee, interpersonal trust is also supported by the trustee's familiarity with the trustor. This familiarity orients the 'facework' through which the trustee builds and maintains trust relationships (Giddens, 1990; Kroeger, 2017). 'Good' aged-care work involves 'emotional labour' (Hochschild, 2012), where competence in following routine procedures alone is not sufficient to demonstrate commitment to the professional values of care, and workers are expected to engage flexibly and emotionally with the people in their care. Staff are building trust with residents when they address them by their name, ask about their family, show awareness of their preferences and

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circumstances, as well as displaying customary concern for their wellbeing (Chou *et al.*, 2002; Bidewell and Chang, 2011; Bradshaw *et al.*, 2012). Connected iteratively over time, these interactions establish trust relations by demonstrating a staff member's enduring awareness of and emotional concern for a resident as a unique subjective individual (Luhmann, 2017).

Australia's aged-care industry has generally poor rates of staff retention (Aged Care Workforce Strategy Taskforce, 2018). This not only means staff–resident relationships are disrupted by workers leaving the job, but it also means fewer workers develop the interpersonal skill-set that comes from years of experience (Boscart *et al.*, 2018). Facility design can also facilitate interpersonal trust, and models of age care based on small, home-like units of up to 15 residents are generally better suited than large, hospital-like facilities to facilitating familiarity between staff and residents (Dyer *et al.*, 2018). Moreover, organisational policies such as unlocking doors in dementia units can mean aged-care workers must engage in face-to-face trust-building negotiations with residents who are at risk of 'wandering', rather than relying on physical locks and walls to contain them (Driessen *et al.*, 2017).

Trust-building is implicit in the professional principles of person-centred care (Kitwood, 1997), as well as quality standards which demand dignity and choice, cultural safety and recognition of individual needs of service users (Aged Care Quality and Safety Commission, 2018). Such requirements imply a level of personal understanding, which cannot be reduced to instrumental routine tasks. Efforts at sustaining trust through connecting interactions can be especially important when the trustor has impaired memory due to dementia or another condition (Beard, 2008). Such interactions need not necessarily be verbal, and trust can also be either gained or lost through extra-linguistic communication, bodily contact, gestures and other physical actions (Twigg, 2000). These embodied aspects of trust-building, relatively unexplored from perspectives of trust research, would appear especially critical in the later stages of dementia (Kim and Buschmann, 1999; Bidewell and Chang, 2011).

Interpersonal trust is managed through symbolic performances that vary across cultures and languages (Buch, 2015; Black, 2018). A lack of shared familiarity in these symbols can impede the success of trust-building (Gilbert *et al.*, 2019). This has been cited as a rationale for ethno-specific aged-care services in countries such as Australia (Runci *et al.*, 2014), and also as an issue arising from the age-care sector's migrant workforce (Nichols *et al.*, 2015). Nonetheless, the capacity to form interpersonal trust relations, through prolonged and meaningful mutual contact, is highly dependent on the institutional and organisational context.

Institutional trust

Aged care is a contemporary social institution that should be understood as part of the functional differentiation of modernity (Luhmann, 2013; Schirmer and Michailakis, 2016). It emerged as expectations that care is to be performed within the family weakened, leading to an expansion of substitutive arrangements whereby people entrust care for themselves, or for an older relative, to strangers working within aged-care services (Fine, 2006; Braithwaite *et al.*, 2007). Care provision shifts from being facilitated through interpersonal trust bonds, secured within family

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relations, to impersonal trust bonds facilitated by institutions and organisations, which are specialised in providing the service (Shapiro, 1987; Luhmann, 2017). Nonetheless, interpersonal trust remains a crucial feature of formal care, and trust relations between those providing and receiving formal care is a standard of 'quality' in aged-care services. Anthropologists have described a process of 'state kinning', when state-employed staff care for and care about residents as if they were family, creating tensions between the institutionalisation of their roles and the affective relations they develop with older people receiving their care (Thelen *et al.*, 2014).

Institutions are patterns of social arrangements and relations which allow the behaviour of actors to be structured according to equivalent, institutionally defined, roles (Giddens, 1990; Bachmann and Inkpen, 2011). These patterns act as bridges between different moments in time and space, allowing actors to define their situations based on generalised institutional expectations rather than the particular characteristics of other individuals involved. Institutional expectations are not free floating, but rather embedded in the patterns of interaction, work routines, legislation, training, discourse and pathways of accountability between staff, managers, aged-care provider organisations, regulatory bodies (like the ACQSC) and government.

Bachmann and Inkpen (2011) argue that institutions establish trust in three distinct ways. First, institutions define potential situations before actors involve themselves in them. This pertains to generalised social understandings that allow actors to anticipate institutional functions and the performances of institutional actors as the means to achieving their goals. Defining a context as 'aged care' allows one to assume that certain types of service and roles are performed there, and brackets risk associated with a vulnerable person being placed, or placing themselves, into the care of unfamiliar role-bearing individuals. Institutionalised expectations circulate throughout the public sphere via interpersonal communications about people's experiences and perceptions of the aged-care system, as well as through representations and descriptions in mass media and the internet (Gille *et al.*, 2017; Luhmann, 2017). I return to this aspect of institutional trust below when in the discussion of 'public trust'. Second, as one becomes involved in an institution, familiarity with the common patterns of behaviour of those working within them grows. These patterns constitute 'institutionally provided templates' (Bachmann and Inkpen, 2011: 288), which manifest shared expectations about conduct and behaviour, as well as expectations of how institutional functions are performed. Here, risk is bracketed because it is assumed that the institutional role-bearer will abide by familiar routines and scripts, making their behaviour predictable and consistent with institutional functions and values. The establishment of and adherence to clear routines within aged-care services therefore becomes the basis for trust, since it allows residents, their families and staff greater certainty in anticipating when tasks are to be performed and to co-ordinate their actions accordingly. Third, institutions themselves become objects of trust. In this case, we do not need to trust individuals working in institutions directly because we can trust the impersonal processes and pathways of accountability that define and govern them.

Institutional trust is built through several mechanisms (Bachmann and Inkpen, 2011; Bachmann *et al.*, 2015). *Legal regulation* allows compliance with the law to

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become the basis for trust. The consequence for non-compliance is criminal sanction or litigation through the legal system. However, the purpose of law is to establish expectations of behaviour beforehand, so stakeholders know what compliance requires and can thereby avoid non-compliance and sanctions. Australia has a range of legislation governing aged care, including the Aged Care Act 1997, the Privacy Act 1988 and the Age Discrimination Act 2004. Legislation like this, along with the broader legal and legislative context, forms the institutional background of trust (Bachmann and Inkpen, 2011). It allows service users to bracket risk by assuming government, courts and regulatory bodies are acting as 'trust guardians' who will regulate and penalise violations of trust (Shapiro, 1987). *Certification* refers to industry-specific standards, which fall short of being mandatory legal requirements. In Australia, the Aged Care Quality standards, administered by the ACQSC, are a form of certification. The standards apply to aged-care providers who are supported by Commonwealth Government funding, and establish the minimal requirements for acceptable quality in aged care (Aged Care Quality and Safety Commission, 2018). Recent changes to the Aged Care Act 1997 have strengthened the penalties for non-compliance, including the possibility of revision of funding arrangements to providers from the Federal Government. Braithwaite and Makkai (1994) suggest that compliance with quality standards is best achieved when care providers are trusted by regulators to implement change on their own initiative. This affords scope for care providers to focus on and internalise core professional values, as opposed to being coerced into making changes, thereby prompting resistance and avoidance. However, they also argue a 'background of distrust', in the form of potential financial and criminal penalties, should back up quality standards when non-compliance is enduring or egregious (Braithwaite *et al*., 2007). Both legal regulation and certification are 'antecedents of the relationship' (Bachmann and Inkpen, 2011). That is, their purpose is to establish service users' trust in the institution before committing themselves to trust relations with individuals or organisations.

Community norms, structures and procedures are institutionalised practices at the community level, which guide the performances of organisations and individual role-bearers. Examples are the care values that are instilled in staff through training and professional development, embedded within care plans and work routines, and reproduced through discourses about what constitutes 'good care practice'. Organisations may implement quality monitoring tools, such as consumer satisfaction surveys, to monitor their own performance and address shortfalls (Chou *et al*., 2002). The ACQSC recently commissioned development of a standard consumer experience survey to be rolled out across all Australian residential care homes, with data fed back to the ACQSC to help inform consumer choice. An initial pilot of this tool with over 15,000 residents or proxies indicates aged-care residents have a generally very high level of satisfaction with providers (Wells and Solly, 2018).[3] Residents overwhelmingly reported feeling safe in aged-care homes, but reported less agreement with the statement: 'If I'm feeling a bit sad or worried, there are staff here who I can talk to'. Nonetheless, a recent report by the Aged Care Workforce Strategy Taskforce (2018) argues that Australia's aged-care sector has been slow to meet community expectations. They call for a voluntary code of practice, which clarifies and strengthens commitment to a shared set of values

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and goals underwriting the sector. The rationale is that if aged-care providers and their peak industry bodies voluntarily sign on to the code, and if they genuinely and transparently undertake measures that align their practices with it, the aged-care sector itself will be leading the progression of community expectations rather than trailing behind them. Not only would this rebuild the public's trust in providers, it would also relax the need for coercive regulation of quality standards by government.

A paradox of trust is that rigid adherence to institutionalised procedures of trust-building may result in 'protocol ritualism' where providers or workers adhere to the letter of the regulations, but not in a way that enacts the norms that regulations are intended to uphold (Braithwaite *et al.*, 2007). This inhibits the formation of trusting relationships between care staff and aged-care service users (Bachmann *et al.*, 2015). Here it is necessary to distinguish between 'role competence' (Shapiro, 1987) and 'facework' (Giddens, 1990). One is competent in their role when they meet the minimal requirements of the job, and are able to perform the routine, comply with laws and regulations, and have the relevant credentials. However, in practice, if professional roles are treated in a rigid and prescriptive way, adherence can appear cold and uncaring, and impede interpersonal trust (Ostaszkiewicz *et al.*, 2016). In contrast, 'facework' constitutes an intersection between interpersonal and institutional notions of trust, where the trustee simultaneously signifies their commitment to the individual and their commitment to the values of the institution, reinforcing both trust in themselves and the institution and organisation that defines their role (Kroeger, 2011, 2017). Accordingly, it is through ground-level interpersonal performances of staff members, enacted through their hands and from their mouths, that institutional trust in aged care is gained and maintained. Evidence suggests that aged-care service users and their families trust staff members when they perceive them to be performing their role well, but not when this means institutionalised routines crowd out opportunities for personalised care (Dwyer *et al.*, 2009; Ryvicker, 2011; Ryan and McKenna, 2015; Rosemond *et al.*, 2017). Facework is therefore an important bridge between interpersonal and institutional forms of trust, acting as a 'virtuous cycle' that reinforces both (Kroeger, 2019).

Conversely, a 'vicious cycle' can result when care staff are over-worked and time poor. Staff who are 'role competent' but just perform their role mechanistically, and without regard for the individuality of the person receiving care, do not appear 'individually credible' as practitioners of institutional values (Kroeger, 2017: 506). The ability of staff to win trust from family members seems to depend on positive mutual communication (Boogaard *et al.*, 2017). Staff may feel unable to demonstrate their commitment to ethical care values when instrumental or bureaucratic aspects of their work take precedence, and there is insufficient time afforded for interpersonal and affective facework (Tuckett, 2007; Tuckett *et al.*, 2009; Bradshaw *et al.*, 2012; Nordstrom and Wangmo, 2018). The inability to form interpersonal trust relations with aged care residents can contribute to low morale and high workforce turnover, as care workers perceive that they are not trusted by residents and their families, and are employed in a lowly and disrespected industry (Tuckett *et al.*, 2009). Rosemond *et al.* (2017) found that when residents' families reported low trust in staff, they had negative perceptions about the welfare of their family member, and they were more likely to refer to institutional policies

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and procedures as a way of challenging staff work practices. This suggests that any institutional approach to improving quality must take into consideration staff members' time and opportunities to gain and maintain interpersonal trust relations with residents and their families.

Organisational trust

Organisations enact some of the aspects of interpersonal trust and some aspects of institutional trust (Kroeger, 2011; Morgner, 2018). Organisations must maintain a sense of identity, or branding, within a network of other competing and related organisations. For example, aged-care providers deploy branding strategies on their websites, in advertising, in their décor, through the behaviour of their staff, and so on. This is a form of reputation management, which projects an organisational identity through symbols of trustworthiness, such as smiling and professional-looking staff, clean and up-to-date facilities, and satisfied customers. Many aged-care providers in Australia also explicitly deploy language like 'you can trust us' or 'we are trusted' in advertising and on their websites.

At the same time, organisations have institutionalised policies, processes and routines that define how they operate. The presentation of an organisational identity and the institutionalisation of organisational operations are interconnected, as failure to operate according to self-presented standards can damage trust with existing service users. This may also influence potential clients through word of mouth, through consumer reviews (increasingly on online platforms like Google) or in extreme cases through court hearings and negative media coverage. The declaration of providers' compliance with quality standards on the My Aged Care website is a mechanism for facilitating first-order organisational trust. Yet, this presupposes a background of institutional trust in the validity of the standards themselves and the processes through which providers are reviewed, just as it presupposes trust in the public organisations (the ACQSC) reviewing compliance with standards. The Royal Commission received testimony from community members who criticised the My Aged Care system for concealing negative information, including violations of standards, about providers from its website (Royal Commission into Aged Care Quality and Safety, 2019*b*). When the trustworthiness of these second-order trust guardians is in significant doubt, responsibility typically flows to government who may initiate third-order trust rebuilding measures such as a Royal Commission (Shapiro, 1987; Bachmann *et al.*, 2015).

Another aspect of organisational trust takes place at the intra-organisational level. This concerns whether employees consider the organisation to operate in their interests, whether they feel appropriately supported and remunerated, and whether management are perceived to act responsibly, and the organisation's processes and routines are conducive to upholding its ostensible professional values. Research on correctional facility staff has shown that lack of trust in supervisors and management is associated with staff burnout, which denotes emotional exhaustion, feelings of ineffectiveness, and a depersonalised and callous attitude towards others, especially clients who are vulnerable (Lambert *et al.*, 2012). Hence, incidents of abuse and neglect within aged-care homes may be partially attributed to 'toxic'

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organisational cultures, rather than solely blamed on individual care staff (Pickering *et al.*, 2017). Intra-organisational trust is crucial when, in addition to managing the vulnerabilities of residents, care provider organisations must also manage the vulnerabilities of their staff, who can feel conflicted between upholding professional care values, conforming to organisational realities and maintaining their own moral integrity (Nordstrom and Wangmo, 2018).

In 2018, the Aged Care Workforce Strategy Taskforce commissioned a survey of 2,817 aged-care staff working in home and residential care. The survey results show only 40 per cent of respondents report having 'trust and confidence' in their organisation's management (Aged Care Workforce Strategy Taskforce, 2018).[4] The Taskforce argues that this is symptomatic of the devaluation of front-line workers' contribution to the industry. They recommend strategies to boost the professionalism and vocational appeal of front-line aged-care work, such as establishing more promising career pathways, better remuneration, clearer articulation of work roles, better feedback processes between management and front-line staff, and education and accreditation requirements that are responsive to workforce needs. These recommendations partly reflect a broader point made by Turner (2007), that people tend to feel more optimistic about their situation and have greater trust in institutions and organisations when they are afforded positive status and see their role as valued and rewarded by others.

A final aspect of organisation trust is the interface between aged-care providers and other organisations, such as health-care services. Ibrahim argues that there has been a 'worrying trend' in downplaying the importance of medical care for aged-care residents, as 'quality standards' have become increasingly framed solely in terms of individual rights, and lifestyle or social fulfilment (Ibrahim, 2019: 439). The profile of long-term aged-care residents has shifted towards increasingly complex health needs and multiple comorbidities, largely due to growth in both informal and formal home care (Cullen, 2003; Braithwaite *et al.*, 2007). This implies that the trust aged-care residents place in providers must also extend to the latter's competence and capacity to provide medical care and effectively interface with external medical professionals and health-care organisations (Ibrahim, 2019).

Media, culture and public trust

For much of the Australian public, their primary source of knowledge and perspectives on the aged-care system is the media. How this institution is portrayed in the media, and how this filters throughout the discourse of members of the public, is a key determinant of 'public trust' (Gille *et al.*, 2017). Trust-building is often necessary in the wake of media scandals. However, media influence is not restricted to dramatic events like scandals. Miller *et al.* (2017) examined American newspaper articles about nursing homes over ten years and found an overwhelming prevalence of negative or neutral over positive stories, contributing to negative attitudes towards aged care among the American public. American newspapers have focused on publishing stories about elder abuse, negligence, fraudulent providers and poor service quality, with very few positive stories about satisfied aged-care users or successful care models and activities (Miller *et al.*, 2018). Other research shows how

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newspapers 'objectify' care recipients as problems that must be managed, especially those receiving state-subsidised care (Rozanova *et al.*, 2016). People with dementia are portrayed especially negatively, with combinations of images and words invoking connotations with death, frailty, social isolation, dependency and vulnerability (Brookes *et al.*, 2017).

Media coverage provides an important vehicle for publicising and discussing breaches in trust, which can prompt institutional processes of justice-seeking and repair. Yet an over-representation of bad news stories can contribute to a cultural environment where older people consider aged care a 'fate worse than death' (Innes, 2002). When the wider public view aged care as an overwhelmingly negative situation, they are more likely to avoid contact with or consideration of aged-care users (Phillipson, 2013), reinforcing a culture of avoidance where people are not proactively planning for their future care needs (King, 2007). The combination of scandals and dehumanising representations in the media make it difficult for much of the public to see how it could possibly be in anyone's best interest to become a resident in aged care. During a recent Royal Commission hearing, the national director of UnitingCare Australia – a large non-profit aged-care provider – reported that some public respondents to a consumer survey claimed they would 'rather die' than live in residential aged care (Royal Commission into Aged Care Quality and Safety, 2019*c*: 490). If the institutional function of aged care is to support corporeally vulnerable older people to live well, then those who say they prefer death instead are expressing a profound lack of trust in the operations of that institution.

The above, in part, reflects cultural individualisation. Gilleard and Higgs (2018) argue that 'old age' no longer makes sense as a reliably chronological stage of the lifecourse but has instead been bifurcated by the possibilities of the 'third age' and 'fourth age' (Higgs and Gilleard, 2014). The third age is a cultural logic (as opposed to an accurate account of most people's reality) which exalts post-retirement life as the culmination of individualised consumerist aspirations, where people can live autonomously and independently, with ample time for leisure, and free from the burdens and stressors of the workforce. This contrasts with the prospects of the fourth age, which is defined by corporeal decline, frailty, and the increased chances of chronic illness and disability late in life. They argue that policy efforts to support people ageing in place by remaining in their homes and relying on informal or community care have led to the 'densification of disability' within aged-care homes (Gilleard and Higgs, 2018: 239), where only the most desperate or seriously disabled now live. Consequently, residential aged care now symbolises 'society's greatest fears of old age', where those 'unlucky' enough to fall victim to corporeal decline end up in a state of dependency and abjection, excluded from the hedonistic promises of the third age. A lack of institutional trust in aged care is, therefore, more than simply a reaction to bad stories in the news media and word of mouth, it is also partly distrust of an institution that symbolises the point at which one's vulnerability comes to consume and define their whole life. It is a distrust of vulnerability itself, rather than the ways in which it is managed; underwritten by prevailing Western cultural ideals of autonomous individualism, self-responsibility and self-sufficiency (Beck and Beck-Gernsheim, 2002).

Proximity and trust

Yet cultural aspirations of autonomous individuality are characteristically middle-aged life priorities. They can shift as one comes to encounter the embodied vulnerabilities of older age, and develop a mature understanding of essential human co-dependence (Biggs and Lowenstein, 2011). Care may then be seen no longer as a threat to the self, but as key to its flourishing. Moreover, as people age or their family members and friends age, they are also likely to come into greater proximity with the aged-care social institution. They may meet individuals with roles in that system, visit the aged-care providers, know others in their social networks using aged-care services, encounter and pay closer attention to the branding and advertising of providers, and become more familiar with the regulatory context and the institutional mechanisms (such as assessment services and My Aged Care) through which aged care operates. Nilsson (2019) has suggested that increased social proximity can support trust-building, because such encounters provide opportunities for interpersonal, organisational and institutional trust to form – provided they are positive encounters.

Nusem *et al.* (2017) argue for a 'new aged care business model' that institutionalises trust-building in the lead up to a person becoming a user of aged-care services. In this model, people engage with aged-care providers earlier by participating in 'wellness services' which are oriented to the holistic promotion of wellbeing and healthy ageing, alongside offering various aged-care services. They suggest that bringing people into proximity with providers of aged care earlier affords opportunities for greater familiarity to be established between future users and organisations. This supports aged-care services users' 'option recognition' (Peace *et al.*, 2011), by ensuring that people are informed about and prepared for their future care pathways, and only enter residential care when they recognise they need it with consultation from a trusted wellness provider who is familiar with them and their needs. This is an alternative to the 'forced options' (*see* Brown and Meyer, 2015) model that dominates Australia's aged-care system currently, where many users are channelled into the nearest of the large traditional aged-care providers through government-administered aged-care assessment services (Nusem *et al.*, 2017).

Conclusion

The Royal Commission's interim report illustrates the cycle of media scandals, reviews and piecemeal reforms that have haunted the aged-care sector since the Aged Care Act 1997 was legislated (Royal Commission into Aged Care Quality and Safety, 2019*b*). This cycle eroded the public's trust in the sector to crisis point, when the Commonwealth Government called for a Royal Commission. Recent reforms have tinkered at the regulatory edges of the system, strengthening standards and their enforcement in residential aged care, and boosting supply of home care places. Yet the assumption remains that a 'consumer-directed' model, based on market demand, will facilitate providers' self-innovation. Despite this, supply remains largely shaped by the availability of government-subsidised places. The Royal Commission argues that innovation has been slow and insufficient in this environment, and have shown concern for the ritualistic adherence to quality standards. They have signalled that their final report will contain recommendations

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for a 'fundamental overhaul' of Australia's aged-care system (Royal Commission into Aged Care Quality and Safety, 2019*b*: 10).

This article argues that a fuller theoretical understanding of trust is an important step in approaching such an overhaul. Understanding what trust means and how it can be gained is crucial, owing to the often extreme corporeal vulnerability of aged-care users. There exists a vast literature of trust research that can advance this understanding, which has only partly been explored here. The purpose of this article is not to argue for particular policies or aged-care models that address these concerns, nor does it propose tools for measuring trust in aged care. The development of any such tools is an outstanding task, and would need to be specifically attuned to the vulnerabilities and demographic factors of aged-care users, workers and any other respondents.

Trust occurs at four levels: interpersonal, institutional, organisational and public. Both the fundamental basis of trust in vulnerability, and the four levels at which trust manifests, need to be kept in mind. Otherwise, efforts to build trust at one level can end up inhibiting the conditions for trust at another level. In particular, the analysis offered here suggests that institutional, organisational and public trust can all be indirectly lost or gained by the kind of work staff in direct contact with aged-care users are willing or able to do. Supporting front-line aged-care workers with the skills, facilities, time and resources to build interpersonal trust is therefore an essential ingredient to the sector's success.

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Notes

1 The construct validity of this survey can be questioned because a 'yes', 'no' or 'don't know' choice about holding a 'high degree of trust' seems too restrictive. Respondents who considered themselves to have some trust but not a high degree may have felt compelled to reply with 'no' or 'don't know'. Moreover, the question arguably conflates *trust* and *perceived trustworthiness* (*see* Gillespie, 2015). There is clearly a need for more rigorous surveys of public trust in Australian aged care.

2 I thank the anonymous reviewer for making this excellent point.

3 A limitation of consumer surveys in contexts like aged care is that power, not just trust, emerges in contexts of asymmetrical social relations (Luhmann, 2017). There is not scope to explore this important matter here. Nonetheless, vulnerable groups may feel more compelled to provide positive evaluations of their circumstances when they feel disempowered and lack the trust in others to speak openly about it. The Royal Commission has illustrated this, and evidence from their hearings suggests aged-care users avoid speaking out, as they feel vulnerable to retribution from providers for lodging complaints (Royal Commission into Aged Care Quality and Safety, 2019*b*).

4 Again, this survey question has questionable construct validity. The question does not address whether the respondent accepts situations that make them vulnerable to their employer, but rather addresses whether they perceive their employer as trustworthy (*see* Gillespie, 2015). This is an important difference, as the latter is easily conflated with a moral or character judgement.

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