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Trust as a Problem of Management: Improving Social Relations by Consciously Chosen Managerial Strategies

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Abstract In post-apartheid South Africa there is a strong need to build new relations of trust within and between agencies of public administration. The paper demonstrate how, in the latter part of the 1990s, a group of managers in a municipal health agency in the province of the Western Cape successfully transformed internal relations from a situation of insecurity and distrust to one of reliance and trust. It is argued that the outcome was conditioned on the adoption of a broad repertoire of managerial strategies aimed at building reliance and trust by reducing the uncertainties and vulnerabilities of related risks.

Keywords Trust, Confidence, Leadership, Management

1. Introduction

In the mid 1990s health management in South Africa was identified by the Department of Health as one of the priority teaching areas in health care. Not only was health management identified as a neglected educational area, the traditional way of thinking about and practicing management was also highly criticized. In a report compiled by a British consultant it was stated that health management had been *"…administered in a closely and centrally regulated way…"* [12], leading to a rigid hierarchical organizational and occupational structure. The consultant suggested that one of the key challenges facing public health service was the requirement of *"…moving from bureaucratic to enterprising, responsive and accountable service delivery…"* using *"…entrepreneurial and leadership, rather than administrative skills…"*[12]

Observations of a smooth and successful implementation of these visions of "change management" in the South African health sector after the fall of Apartheid are few. During the last decades South African newspapers have steadily reported incidents of misadministration in the health sector, indicating that it is easier to state new values and ideas than to implement them. The outcomes of the many health reforms of the latter part of the 1990's, frequently attempting to fuse the separated and racially based administrations of Apartheid into new coherent management systems, seem to vary. A few health administrations seem to have been able to innovate and increase capacity for co-operation and service delivery, but many others have ended up with internal struggles, increased inefficiency and corruption. Proposed explanations for such prevailing problems of management and service delivery in the public health sector are at best suggestive, however, and there is obviously a need for more systematic knowledge of how the values of equity and justice have actually been transformed into new administrative practices.

A simple assumption underlying this study is that trust may be a crucial challenge, and a resource, in any attempt to build public health systems able to fulfill expectations of equity, accessibility and quality. Trust is said to make co-operation and mobilization of resources and capacities easier, distrust or lack of trust makes it harder. Trust is assumed to liberate and mobilize human agency, to release creative, uninhibited, innovate, entrepreneurial activism towards other people. Distrust, by comparison, is said to paralyse human agency, eroding social capital, leading to isolation and atomization, alienating and uprooting individuals, raising transaction costs and hindering the chances of cooperation [19]. Contrasting the beneficial effects of trust with the destructive consequences of distrust, the former seems to be preferrable. In South Africa trust has become a scarce resource, however, due to the emotional, perceptional and structural continuities from the Apartheid area. South Africa may not generally be a 'low trust society', but it is to be expected that its particular historical trajectory have contained trust to particular identities or group memberships, making interaction and co-operation across such entities very difficult. Because of this a major challenge facing health managers in the 1990s was how to generalize trust in new health institutions set up by the fusion of prior distinct organizations, bringing groups of employees together who initially felt they had all the reason to distrust and suspected each other.

2. Managing Trust: Strategies for Reducing Uncertainty and Vulnerability

As emphasised bySztompka[18] a multidimensional

theory of trust must move beyond its rational dimensions and take other aspects of trust into account. Explanations for trustfulness may be found in the personality of the trustor and may be conceived as a sort of personal capital we accumulate, during our life-course. Trustfulness may also be considered as something more than individual attitudes, as a cultural or "social fact" [3], allowing for societies to be characterised as communities of high or low trust. Viewing trust as basically a cultural artefact easily leads to the assumption that it is primarily a by-product of various cultural processes and as such not something that may easily be managed or 'administrated'. While there is some truth in this argument, the position taken in this paper is that trust is essentially a product of human interaction and therefore something feasibly fostered by consciously chosen strategies and policies.

Trust, in my view, should be conceptualized as a function of risk [11] and knowledge [8]. Trust is an appropriate way of relating to the other when the risk involved is perceived to be within acceptable limits, and when the knowledge one has of the trustee is experienced as incomplete, but as sufficient to allow for some perception of the risk involved. Choosing to trust we transfer decision making power to the other, taking the chance that the trust will be honored. Conceptualizing trust as a particular combination of risk and knowledge situations allowing for or requiring entrusting acts may be distinguished from relations of distrust, enmity, confidence and faith, as the following model seeks to visualize:

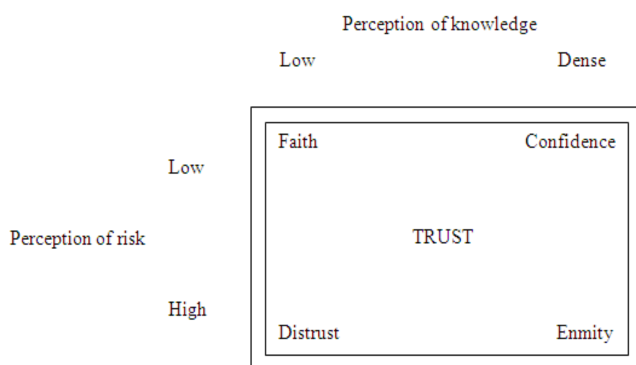

Figure 1. Trust Perceived as a Combination of Risk and Knowledge

If the risk involved is perceived to be high and the knowledge of the other is very limited, the most likely response will be distrust and withdrawal from the relationship, if that is a possible option. If both risk and (empirical) knowledge is low we may assume that the act is not within the domain of trust and rationality. Behavior is not based on rational thought, but on (blind) faith inspired by a conviction that is total and unquestionable. When the knowledge of the other is regarded as being sufficient and is perceived to confirm the high risk of entrusting, we approach a field of relations defined by enmity, even this a space beyond the limits of trust. If, by contrast, we think we know the other and perceive the risk of entrusting to be minimal, we do not need to trust. In such situations we have the privilege to base our actions on confidence, being assured that the other will not use his or her power to harm us. If the initial situation is one of distrust, the major managerial challenge will be to move social relations from this state of affairs towards trust and confidence.

Conceptualizing trust as a particular combination of risk and knowledge points to two basic strategies that can be used to increase the attractiveness of entrusting: actors can take steps to reduce uncertainty by increasing knowledge or they can reduce the risk involved by reducing vulnerability. From a managerial point of view, building trust by reducing uncertainty can be seen as a ‘strategy of appearance’, while building trust by reducing vulnerability basically becomes a question of organizational and institutional design.

A face-to-face relationship of trust may in principle be initiated in two ways, either by the trustor deciding to trust, or by the trustee consciously attempting to appear as worthy of an investment of trust. An important difference between these options is that trusting is more risky. When we trust we become vulnerable, because of the loss we experience if our trust is dishonored. When trust is attempted evoked by the trustee, by contrast, the element of risk involved is not so significant. In principle the trustee does not transfer decision-making power to the trustor and risk is limited to the eventuality that his or her attempt to appear as trustworthy is not convincing and trust is not mobilized. The importance of distinguishing between trust and trustworthiness has also to do with the element of instrumentality introduced by the latter concept. In the words of Russell Hardin *“… trustworthiness might be instrumental, as when one works to establish a reputation for reliability…”* [8]. On the side of the trustor, rationality is related to the act of entrusting, based on some limited degree of knowledge and risk taking. On the side of the trustee, rationality is related to the management of trustworthiness, which may be promoted in different ways. What makes the building of trustworthiness interesting from a managerial point of view is that it is a less risky strategy than trusting and more within a field of administration, power and control.

Initiating and diffusing trust through the building of trustworthiness may be seen as a form of dramaturgical action in which the actor attempts to create a picture of himself in the eyes of an audience, a form of ‘impression management’ to use the words of Goffman [5].

Hardin would like us to think of all forms of trustworthiness as ‘encapsulated interests’, building trust by taking others interests into account [8]. He argues that even relations such as friendship and love should be seen as being within this category, as they make us be certain that the other genuinely will take our interests to hart. The fruitfulness of this approach, however, aiming to subsume such relations of identity within the broader category of ‘interest’, is strongly debatable. Such a position implies a stretching of the concept of interest beyond its proper domain, creating unnecessary analytical ambiguity. Trustworthiness may be built in other ways, for instance by offering knowledge about dispositions and moral commitments to engage in trust-based interaction,

or by creating collective identities, enabling the other to think as self.

An additional and even more serious problem with Hardin's approach, apart from tying the concept of trustworthiness too tight to the concept of interest, is that the fundamental difference between trust and confidence is conflated on the part of the trustee. As argued by Seligman trust as confidence relates to the proper performance of institutional roles, while trust relates to the ability to interpret roles, choose between them and move in the undetermined space between them [18]. Trusting is a leap out in the unknown, though with some conscious attempt to calculate the risk involved.

In my view the conceptual distinction between trust and confidence must be upheld on the part of the trustee. He or she may engage in two distinct forms of 'impression management'. On one hand the trustee may attempt to appear as a reliable person, trying to evoke an attitude of confidence on the side of the trustor. To do this he must act in ways proper to the expectations of how particular roles and functions ought to be performed. On the other side the trustee may attempt to appear as a trustworthy person, signaling a willingness to engage in the insecure adventures of trust-based forms of interaction, inspiring the trustor to trust. Trust, according to Seligman, is only possible when we know that we, and others, may step out of roles and engage in the negotiation of roles [18]. When we think we can predict the outcome of social interactions, trust is superfluous. It will be sufficient to rely on our confidence in role structures, expert knowledge and standard operating procedures. When the future is insecure, however, as when members of formal organizations acknowledge that they have to engage in collective searches for new solutions or new ways of perceiving old problems, trust, not confidence, becomes the crucial factor. To build trustworthiness, appearing as an honest person with authenticity and moral integrity becomes more important than to conform to established role-expectations. Trust and confidence give rise to different questions about the social relations that we as trustors and trustees are embedded in. For the trustor the important questions are when to rely upon, and when to trust the other. For the trustee the challenge is to know how and when an impression of reliability should be built, and when the appearance of trustworthiness is more required. A major challenge may actually be how to strike a balance between such opposing demands.

Impression management, however, is only one of the two principle ways in which reliance and trust may be mobilized. As important is the conscious design of organizational structures and the careful construction and promotion of normative arguments concerning institutional meaning, mission and identity [13] Organizational regulation and design; shaping systems of roles, introducing rules and standard operating procedures, creating systems of incentives based on rewards or punishment, are all mechanisms that in principle can be used to reduce the vulnerability of reliance. But institutions, as 'organizations infused with values' [16] may also reduce the vulnerability implied by the risk of trusting, to the extent that members or clients come to acknowledge and value the 'ethos' that such institutions (and their management) state to be the reason for their existence. The 'spirit' of the institution is expected to be transmitted to members and to condition their loyalties and make them trustworthy [13]. In addition, institutions may promote a feeling of common identity and belonging allowing for the growth of 'categorical trust'. Management may in various ways attempt to build 'imaginary communities' among organizational members that otherwise have few social ties or common experiences. To the extent that they succeed sheared codes, scripts or stereotypes of the 'we', as distinct from 'others' or 'outsiders', increase the likelihood that trust will be generalized. A cross-tabulation of potential managerial strategies for building reliance and trust, as they relate to the problems of uncertainty and vulnerability, looks as follows:

A frequently stated argument holds that contemporary strategies in problems of trust are more likely to be those that reduce actors' vulnerability [1, 9, 11]Accordingly it is assumed that in role differentiated and heterogeneous societies mechanisms that generate trust across neighborhoods and identities, such as various forms of regulations, the justice system, or the use of insurance, will be the more important and prevailing. While there is some truth in this argument, it is not quite the position taken here. Acknowledging that strategies for reducing vulnerability have increased their significant in the modern age, this should not make us disregard the continued relevance of strategies that seek to reduce uncertainty. Such strategies can play themselves out as conscious attempts of 'impression management', emphasizing either the reliability or the trustworthiness of the trustee.

	Building reliability:	Building trustworthiness:
Knowledge; the problem of uncertainty	Impression management to promote reliability	Impression management to promote trustworthiness
Risk: the problem of vulnerability	Organizational design and regulation	Institution building and identity-making

Figure 2. Managerial Strategies for Building Reliance and Trust

3. Building Trust: The Municipal Health Services Organization of the SouthPeninsula Municipality[1]

This paper focuses on a 'positive' case of South African trust building that is both unusual and extra-ordinary, documenting how a group of managers in one particular municipal health agency was capable of transforming internal relations from a situation of insecurity and distrust to one of reliance and trust. My interest it not to speculate about the degree to which these empirical observations may be generalized, however, but to use them to illustrate the various options, opportunities and challenges confronting managerial attempts to build trust.

The formation of the South Peninsula Municipality (SPM), covering a geographical area extending from the south of Cape Town to the Cape of Good Hope, was an outcome of the local government reforms in the latter part of the 1990s. It was set up during 1997 out of four earlier local authorities, the old CapeMetropolitan (Service) Council, the Cape Town Metropolitan Council and the local governments of Fish Hook and Simons Town. Only the first two of these had their own health services, but all the municipalities had their own distinct laws and regulations pertaining to health. Late 2001 the SPM was integrated into the new more centralized local government structures of the Cape Town Unicity, and thus ceased to exist as an autonomous sphere of government.

The focus of this paper is on the Municipal Health Services Organization of the SPM set up in 1996-97 by the fusion of two prior distinct agencies, the health services organizations of the Cape Town City Council (CTCC) and the Cape Metropolitan Council (CMC). The MHSO divided its services into four directorates, including the "Municipal Health Services". The health directorate organized its services into four divisions; "Community health", "Community development", "Environmental health" and "Health support services". Of these the Community Health Division was the largest unit with approximately 127 staff members. It managed seventeen health clinics and the five satellite clinics within the SPM.

The cultures of CTCC and the CMC were rather different, the CTCC described by most informants as a very top down and bureaucratic system, though quit well run. The CMC, by contrast, was characterized as much more 'relaxed', with less hierarchy, more involvement of staff and closer personal relations. The fusion of such different cultures encountered many problems. Just to set up a unified financial system out of two distinct ways of thinking about finance and of operating cost control systems, is said to have been 'quite a nightmare'. Even more problematic was the challenge to fuse two organizational systems operating with dissimilar professional categories, each a unique system of conditions of service, salaries, regulations about sick leaves, and so on. And further 'down', on the level of the clinics, the different cultures and practices expressed themselves in many ways; through different ways of doing things, different ways of treating patients or ordering patient queues, different job descriptions, guidelines, firms or folder systems. The fusion of these different practices encountered many problems and sustained resistance from employees.

The two first years after the formal set up of the MHSO were by many informants described as 'a hell', characterized by on-going conflicts and high levels of suspicion and distrust between the two categories of staff, one coming over from the Cape Town City Council and the other from the Cape Metropolitan Council. Within the Community Health Division the situation was clearly one of 'we' and 'them', staff clustering in different groups following old identities, each group defining the other category of staff as 'outsiders'.

Late 2000, however, as I initiated my study of the MHSO, the organization had gained a reputation of being a well-run health agency focusing on output and with a strong capacity for problem solving. Members were generally expected to perform and to contribute towards stated goals, and the top managers were acknowledged as working hard to achieve these outcomes themselves. During the latter part of the 1990s the MHSO had been able to set up a system of budget control and health information that was utilized to control behavior and to focus on performance. The head of the Support Services, for instance, regularly made feedback on spending patterns, using this as an opportunity to discuss why some facilities were spending too much, others too little on particular functions, indicating how some ought to modify their priorities, others to attend more seriously to certain task and responsibilities. At the facility managers meetings health statistics were regularly used to discuss performance and compare achievements, as with the TB results. The building of a strong managerial capacity to gather, interpret and use quantitative data had been a deliberative policy, with the head of the Community Health Division acting as a cultural broker between the everyday working world of the staff at the facilities and the computer technology and information science of management and consultants [4].

Survey-data, interviews and participant observation all indicated that a high level of interpersonal trust and reliance had been built in the MHSO by late 2000. The important question is of course how this was possible, given the initial situation of suspicion and distrust that characterized organizational relationships half a decade earlier. The argument put forward here is that the transformation of social relations within the MHSO to a large extent can be explained as an outcome of conscious and successful managerial efforts to promote reliance and trust.

4. Managerial Strategies Used to Build Reliability

Reliability, in the form of familiarity or confidence, is a

[1] The analysis is based on 16 interviews of employees in the MHSO including the director, four division heads, three area managers and six clinic managers in the 'Community Health Division' and two environmental health officers in the 'Environmental Health Division', a questionnaire sent to all administrative personnel of the MHSO (response 86%) and review of a number of health policy documents produced by the MHSO and other municipal and provincial health agencies in the Western Cape in the 1990s.

requirement for all kinds of organized action. To engage and feel secure we need to know that others will behave in accordance with the roles they are supposed to arrogate. If we doubt that others will behave in a predicable and proper manner, the most likely strategy is to withdraw from the relationship, if that is a possibility, or to invest small amounts of resources, or loyalty. Trust is to have faith in the goodwill of the other, beyond role-expectations. Trust does not imply blind faith, however, and therefore it cannot stand alone, it needs to be nurtured by some certainty. A sufficient degree of reliability, acquired by intimate knowledge of others` character or by the insight of how social systems operate and make people accountable, is necessary for trust to be mobilized. That is why managerial strategies designed to build reliability are essential to make a space for trust.

4.1. Reducing Uncertainty

4.1.1. Demonstrating Capacity

Within organizations, managers develop relationships with their subordinates and among themselves on the basis of reliability, were reliability is defined in part in terms of competence. It does not help if management demonstrates an intention to be reliable, if their followers do not rely on them to make competent decisions, if they are not seen as having the necessary capacity to attend to assigned tasks and responsibilities. In the Community Health Division of the MHSO all the managers of the local clinics were nurses, and the appointed head of the division, was a doctor. This was a troublesome relation in the beginning, as the majority of the nurses wanted the division to be headed by a nurse, not a doctor. A lot of the staff refused to communicate with the manager, due to a lack of recognition. As one of the area managers stated the original attitude was one of suspicion, the nurses asking *"…how can a doctor supervise the nurses, she will not have the knowledge…"* [2] Gradually the relationship changed, however, as the nurses interacted with the doctor and learned about her competence. At the point of my investigations a typical statement was that she was doing *'an excellent work'*. A high level of reliance in the ability of management was not limited to this relation, but seemed to permeate the interaction between superiors and subordinates in the MHSO.

4.1.2. Demonstrating Commitment

During the latter part of the 1990s the MHSO gradually got a reputation for being a well-run agency with a strong problem-solving capacity. All members were expected to perform and to contribute towards stated objectives. None seemed to suspect that the leaders were not working hard to achieve such outcomes themselves. On the contrary, subordinates typically pictured them as being both very demanding and very busy, as *'workaholics'*. Such statements even reflected, however, the existence of a consciously chosen strategy of 'impression management' on behalf of the top leadership. Working hard and long hours may have been a necessity, but it also allowed management to demonstrate its commitment towards organizational goals and purposes and to signal to everybody else that it expected them to behave in an equally proper and reliable manner.

4.1.3. Promoting Co-Operation and Compliance with New Roles

A similar strategy was applied to soften the division between the two categories of staff, mobilizing lower management to reconcile the opposition. Of the three so-called 'area managers', two came from the CTCC and the third from the CMC. This group of middle managers took a conscious decision to foster mutual reliance and organizational coherence by maintaining a front of unity towards the staff. The importance of such a strategy of 'leading by example' should not be underestimated, and one of the clinic managers explicitly stated its importance as a mechanism of change: *"...seeing that the area managers were able to do it, to co-operate…"* [3]

4.1.4. Playing with Open Cards

Distrust may not be the obvious outcome of organizational conflicts, if such processes play themselves out fairly and openly. In open struggles over power and resources people confront each other with particular interests, demands and threats about sanctions. A situation may originate where both parties know what the other want and can make rational decisions on how values and interests are affected by choices of compliance or non-compliance. With manipulation, by contrast, the person who is manipulated has no real choice as to the appropriate course of action. This is so because the manipulator is able to hide his or hers actual motivation to the relationship, or what will be the real consequences of the course of action taken by the manipulated person. If we anticipate that the other is dishonest or interacting on the basis of hidden motives or knowledge his or her reliability will be seriously undermined.

In the MHSO, management strongly emphasized the need for open dialogue and 'honest' conflicts. As stated by one of the area managers, *"…we believe in getting the conflicts out in the open, to try to talk it out, to resolve our differences…"* [4] As a tendency such a culture also seemed to be diffused to the local facilities, as indicated by the following statement by one of the clinical managers, *"…the important thing is that you play with open cards. That you say what you mean and expect and that others act in the same way towards you…"* [5]

Offering information about relevant social and political processes is an adjacent strategy to reduce staff insecurity, and to build a managerial reputation for being honest and open. In the Western Cape Province the prevailing view in local government is that of a striking difference in perceived levels of knowledge among municipal and provincial staff,

[2] Interview of area manager, March 2001

[3] Interview of clinic manager, April 2001

[4] Interview of area manager, February 2001

[5] Interview of clinic manager, March 2001

as stated by a couple of health managers in the Cape Town City Council, *"...our staff is informed, their staff don't know..."*[6]Most of my observations of the processes playing themselves out within the MHSO of the SPM seemed to validate this interpretation. In the interviews employees frequently pointed to the positive relation between information and trust, *"...The gradual building of trust, I think it was a fact of all the meetings, of keeping people informed on every step of the process..."* [7] The staff emphasized the importance of being informed about the bigger policy processes effecting the organization, so that people got a clue as to where the agency and various categories of staff where going, counteracting the spread of a feeling of anxiety and insecurity. Employees that had been transferred to the SPM from the earlier health agency of the Cape Town City Council contrasted their new and former work environment, *"...The City Council, it was very bureaucratic, very top down. In this system, more information is at hand. The relations are closer, more accessibility, more insight. I can identify problems easier. More empowerment comes with more knowledge..."*[8]

This strategy of diffusing information to staff had a tendency to backfire, however, when it was not disciplined and kept in line by other considerations. One illustration was a debate in the agency about confidentiality. The debate originated due to some instances of staff being informed about decisions that had actually not been made, only reflected upon at the monthly clinic managers meeting. Top management argued that everything that was being discussed at these meetings were not meant for all staff, and that reports backs about all ideas and suggestions being discussed could sometimes lead to more insecurity or to unrealistic expectations that it would be impossible to redeem. Gradually this position became more accepted among the clinic managers.

4.2. Reducing Vulnerability

Demonstrating a will and capacity to act in a reliable and predicable manner, congruent with organizational roles and stated objectives, are important mechanisms for generalizing a feeling of certainty and reliability within an agency. The conscious design of organizational structures and processes, however, are potentially even more important mechanisms for building reliance, reducing vulnerability. Among these the capacity to hold members accountable for their actions is fundamental.

Various mechanisms installed to secure accountability in formal organizations may be seen as ways of controlling behavior, making actions more predictable, members more reliable. In the literature on trust control is often believed to be detrimental to it because such regulations imply a sense of distrust. Proper control mechanisms, however, may in fact increase trust, in the form of reliance "…because objective rules and clear measures help to institute a 'track record' for people who do their jobs well…"[2]. Strict rules and relations of control, to the extent that such ordering mechanisms impact on behavior, decrease the likelihood of non-compliant behavior, allow members who rely on others to be less vulnerable and therefore limit the amount of risk involved.

4.2.1. Introducing New Mechanisms of Accountability

As a general indication a large majority of the employees of the MHSO, eighty-nine percent, disagreed with a formulation in the survey stating that '…There is no accountability in this agency…' The crucial test of accountability is, however, what happens when somebody breaks the rules. Do members think that he or she will be held responsible? Survey-data showed that eighty-two percent of the staff was confident that '…If I experience an incident of corruption and notify my superiors, I can be sure that something will be done about it…'Both observations tested to a fairly high level of accountability in the organization.

Observations from a particular problem area seemed to confirm this picture. In most South African public health agencies absenteeism has long been a big problem. The rules were there, but they were not enforced. In the MHSO, however, a system of clear rules and strict supervision was implemented. All employees were obliged to learn the rules of appointment and had to sign a contract to state their willingness to comply with them. Each day the three area managers supervising the clinics registered all staff and checked the absent rate. Members of staff who showed a high rate of absence were called in for counseling: *"...You could easily see the pattern, that some repeatedly did not show up after a holiday. The staff thought we did not know. When we called them in for counseling, it was an eye-opener for some..."* [9] All managers of the MHSO went through training courses to learn how to deal with capacity and incapacity problems, designed to increase their ability to deal with issues of staff not attending to their duties.

4.2.2. Regulating Interaction

Apart from designing organizational roles and introducing mechanisms of accountability to make action conform to role-expectations, management utilized the option of regulating organizational processes and forms of interaction suited to the particular tasks ahead. A major challenge was to reconcile the opposition and suspicion between the two groups of employees that had been recruited to the MHSO from different local authorities with disparate traditions, conditions of service and occupations structures. Management attempted to alter this situation by involving large parts of the staff in continuous work shopping and team building, deliberately creating more contacts between the two categories of employees. Gradually this had an effect on

[6] Interview of two top health managers in Cape Town City Council, April 2001
[7] Interview of nurse, April 2001
[8] Interview of nurse, February 2001
[9] Interview of area manager, April 2001

staff perceptions,

> "…The common training sessions were important, we went there in our usual clothes and you got to know the persons, to chat. You saw that they were not that bad, you realized that it was not the persons that crated the problems, but the different system. Gradually people realized that they were in this together…"[10]

A similar technique was to shop staff around between the different local clinics. Officially the reason for this rotation was quite practical, it was said to be necessary due to uneven daily shortage of staff among the clinics. But according to several informants it was in fact a deliberately chosen strategy to expose the staff to other ways of doing things, and often with the effect of assuring them that many of procedures were not that different: *"…we got to know each others, that we experienced much of the same problems, that certain things were universals…"*[11]

Deliberately setting up new arenas for social interaction between different categories of staff management initiated and facilitated a learning process through which employees came to realize that problems were frequently of an organizational kind, not due to the evil character or the lack of capacity of the others. This made the option of relying on others to appear less risky and attention could instead be concentrated on the many challenges that both groups confronted. It is likely that the interaction even increased reliability by reducing uncertainty, as members of the opposing groups came to learn more about each other's character, attitudes and capacities.

5. Managerial Strategies Used to Build Trust

5.1. Reducing Uncertainty

Reliability has fundamentally to do with proper behavior of roles and it is promoted as people demonstrate that they are committed towards such role expectations and have the capacity to fulfill them, or as organizational measures of surveillance and enforcement are introduced to keep members accountable as to how they enact their roles. Expectations of trustworthiness are fundamentally different. Trustworthiness is something that becomes a need as behavior based on arrogating roles does not solve the problems, or give contradictory results. To trust is to move into an undetermined, insecure landscape, though not in a totally blind or irrational way. Trust has elements of faith, but also of knowledge, of some effort to know if the risk involved is within reasonable limits. The importance of this is that it opens a space for management. To the extent that managers are able to demonstrate a will and capacity to take part in the insecure adventures of trust-based forms of interaction, trustworthiness will be produced.

5.1.1. Signaling a Will to Deliberate

One way to signal trustworthiness is to demonstrate a willingness to engage in open dialogue and to listen to the arguments, ideas and advices of others. In the survey three fourths of the staff of the MHSO reported that they experienced the introduced of new ideas in the agency to be appreciated and sixty percent even stated that such ideas were frequently having an impact on current practice, testing to an organizational milieu underscoring the need of free opinion, debate and change. The interviews confirmed this picture; employees thought their superiors to be easily approachable, they emphasized that all kinds of problems could be raised, that they were listened to, and that there was respect from both sides. Such an organizational culture seemed to have been fostered in a deliberate manner:

> "…dr. A (division head) has been a strong driving force. She allowed herself to be personally attacked; she said 'ok, what can I do about it'. Last week she was very angry with us for not telling her that she was incorrect about something, she turns it around…" [12]

Attendance at one of the monthly clinic managers meeting attested to a culture of free and open discussion. Clinic managers had a nerve; they dared to speak and to challenge authority. At the level of the clinic the tendency seemed to be for such a culture of engagement and deliberation to perpetuate itself, as expressed by one of the managers: *"…We have weekly meetings, everybody attending. The relations are very good. I ask them to tell me if I'm wrong. We have open discussions, everybody has a say and many of the issues are up for voting…"*[13]

5.1.2. Encapsulating Others' Interests

A potential strategy of building trustworthiness is to appear worthy of trust by 'encapsulated interests' [8], demonstrating that it is in one's own advantage to see to the interests of others. Focusing again on the Community Health Division of the MHSO the general picture was that the nurses, the largest occupational group of the agency, seemed certain that their interests were taken care of. In the interviews, positive evaluations of the division head were repeatedly related to the experience of her acting on behalf of the nurses: *"...she has done a lot for us…", "...she showed to be all for the nurses, not for the others…", "...she always come up with concern for the nurses, refuses to cut posts…"*.[14]

Beyond demonstrating empathy for the needs of others, the strategy of building trustworthiness as 'encapsulated interests' has important symbolic value, allowing the trustee to signal a commonality of interests. At a clinical managers'

[10] Interview of clinic manager, March 2001
[11] Interview of nurse, February 2001
[12] Interview of clinic manager, April 2001
[13] Interview of clinic manager,March 2001
[14] Interview of clinic manager, April 2001

meeting in Fish Hook in February 2001 a discussion concerned the problems of using non-permanent staff, supplied by various private agencies. The disadvantage of using nurses supplied by private firms was that some of them repeatedly did not show up for work. Some clinic managers suggested that it would be a better solution to extend the work responsibilities of the permanent staff nurses. The division head argued against this proposal, however, and deliberately used the occasion to demonstrate her concern for the interests of the nurses and how she identified with them, *"...It becomes a problem, if we don't ask for them. If we apply a staff nurse instead of a professional nurse, they will say that we manage without them. It will come back on us, next time they downgrade..."*[15]

5.1.3. Signaling Value-Commitment

The idea that trustworthiness might be evoked as trustees demonstrate 'encapsulate interests' should not lead us think that such a strategy can be followed uncritically or without due limits. My trust in somebody may increase if I feel I have reason to believe that he or she has an interest in fulfilling the trust. Taking the risk of entrusting, however, may not be acted out because I know the other person to be especially focused on my own interests. As an alternative I may think I know that the other has some strong moral commitment to fulfill certain kinds of trust placed on him or her, quite unrelated to a concern for my particular needs [8]. Offering knowledge about such commitments or dispositions is potentially another way of managing trustworthiness. The appearance of trustworthiness is frequently associated with being fair and impartial, which is something quit different - in fact the opposite of - acting on behalf of someone [14]. What this indicates is that the strategy of looking after others' interests must be combined with and disciplined by other considerations and values, such as universalism and equality. Accordingly, for management to appearing as trustworthy may require that it have the courage and the ability to turn down particular demands.

In some instances, however, the management of the MHSO introduced measures and policies that contradicted the stated interests of the nurses. A strong concern of the nurses was the issue of career paths. In line with the traditional system of incentives the occupation wanted the new agency to adhere with the principle of seniority advancement. But top management was committed to the idea of introducing a new policy relating rewards to output and performance, and it did not back out on this. Gradually a system of appointment placing much stronger emphasis on evaluation of results and competence was institutionalized, replacing the more rigid system of rank promotion.

The nurses also demanded that the Community Health Division be headed by a nursing manager, and did not initially accept management's proposal of a generic manager based on the evaluation of qualifications. As stated by one of the area managers, *"...Some people had a strong professional drive. The idea of a nursing manager was supported by many individuals, but not by a huge amount of people, probably not by the majority of the nurses. But eventually the whole idea of building professional empires felt down..."*[16] On this occasion a compromise was struck, and to satisfy nurses' demands a new post of a training and quality control officer was set up.

Committed to the idea of designing systems facilitating the rendering of comprehensive services top management initially wanted the environmental health function to fit in with the organization of the health clinics, and proposed to integrate it as a part of the Community Health Division. The environmental health officers had big problems with such a structure placing them under the authority of the nurses, however, and they strongly opposed this solution. Confronted with this opposition the head of the MHSO decided not to challenge occupational interests, and personal and environmental health services ended up in separate organizational units.

When management encapsulates the interests of some, as indicated by these incidents, it will have to reject legitimate demands put forward by others. The play of interests is usually a complicated one and management have to care for some, turn others down, try to conciliate contradictory demands and pay attention to organizational objectives. The general impression is that the management of the MHSO attended to such conflicting requests in a fairly capable manner. Not totally undeserving it gained a reputation of caring for its staff, but not to the extent that major policy goals and stated organizational values suffered. The predominant view among employees held management to be fair and unbiased, simultaneously as it was largely seen to be standing above particular interests, promoting the overall objectives of the agency.

5.1.4. Demonstrating a Compromising Attitude

There is an additional point to be made here. The theory on trust-based forms of interaction, as outlined by Sztompka[18], have some resemblance to Habermas' theory of deliberative democracy and his idea of policy making through 'ideal speech situations' and communicative rationality [6-7]. Both models emphasize the need to step out of prescribed role expectations and engage in collective search for new meaning and new solutions. The rationality of trust, however, is placed somewhere on the continuum between strategic and communicative rationality. It does not assume that the actors will behave totally disinterested, putting aside all their emotions, passions and desires to the advantage of the 'better argument'. As emphasized byValverde[20] there are potentially strong elitist and exclusionary elements embedded in such an interpretation of democratic politics, prioritizing formal speech. The trust-model, by contrast, assumes that we will not be willing or able totally to dispense with our conceived interests or what our conscience tells us is the right thing to do, relying

[15] Interview of the head of the 'Community Health Division', March 2001

[16] Interview of area manager, April 2001

exclusionary on the strength of arguments. It does predict, however, that actors might be willing to engage in trust-based dialogues, which conceives of the possibility of reframing interests beyond rigid positions, of closing the gap between different understandings and of reaching solutions of mutual gains. A precondition, however, is that actors do not go for optimal utility, but demonstrate their intention to search for satisfactory solutions [17]. In complex and insecure situations, usually the context when a plurality of actors and interests are involved, strategies of optimal utility risk breaking down the interaction, diffusing distrust through social networks, while orientations of 'satisfaction' might e keep the dialogue open and promote trust. Trying to impose solutions based on the 'best argument' may well be devastating for trust, appearing to be willing to search, with others, for argumentative and substantive compromises might enhance it.

The argument put forward here is that the examples of policy making described above indicate such a basic attitude of 'satisfaction' on the part of the management of the MHSO, pragmatically engaging in search for new solutions, trying in various ways to strike a balance between a plurality of considerations, demands and organizational objectives. It is not accidental that the unique character of liberal democratic forms of policy making has frequently been associated with a powerful commitment to the virtue of compromise [10]. One of the reasons that such processes seem to have the capacity to produce good results, more often than not, is the close relation between such compromising attitudes, strategies of satisfaction and the appearance of being trustworthy.

5.2. Reducing Vulnerability

5.2.1. Allowing for the Growth of Strong Selves

Trusting is a risky business, particularly because we know that role descriptions and systems of accountability will not really prevent us from being hurt, if the other decides not to honor our trust. Trust-based forms of interaction take part in the spaces between roles, and cannot in any significant degree be nurtured by them. That is why trust requires strong selves, daring to move in these spaces of opaque and ambiguous expectations. What management can do, however, is to arrange organizational processes in such a way that strong selves are likely to develop and prosper. As emphasized by Tyler there are important procedural and relational judgments related to the question of trusting. Generally, if people experience decision-making processes to be fair, if they evaluate the actions of authorities to be neutral and unbiased and if they feel to be treated with politeness and dignity, inferences of trustworthiness are more likely [15].

In the MHSO a system of decision making arenas was set up allowing both management and staff to participate in operations and decisions, inviting representatives of staff even below the clinic managers to engage. The area managers claimed to be treated with much respect by their superiors and in a similar way they emphasized the importance of showing concern for the needs of their own subordinates as a way of building trust. As one of them stated, "*…I think they experience me as a caring manager…", "…I think they see me as being very understandable…", "…I think the clinic managers feel they can trust me with their problems…"*[17]

When people make positive or negative judgments about the trustworthiness of others it impacts on the assessment of their own status. According to Tyler two aspects of status are important. The first is pride, the assessment of the status of the group or the organization to which one belongs. The other is respect, the evaluation of one's status within the community to which one belongs [15]. As management in the MHSO tried to show concern for the needs of the staff and to treat subordinates with dignity and respect, the self-worth and self-esteem of most employees grew. The employees, at least the professionals, felt appreciated and took pride in their organization. One of the area managers contrasted this with the attitudes of some of the agency workers,

> "…You can see the traditional attitudes among the general assistants. They work without pride, just because they get their payment. Cleaning the floor, but putting the dirt onto the walls. It's another culture, a culture of cleaning work, of not being appreciated, of standing on the outside…"[18]

Treating staff with dignity and respect, showing concern for their needs and wants, management in the MHSO arranged for the growth of strong selves who had the capacity to trust, and who were not afraid to do so.

5.2.2. Constructing New Collective Identities

Russel Hardin would like us to think of identity based trust as a special case of trust as 'encapsulated interests', arguing that relations such as friendship or love make us be certain that the other genuinely will take our interests to heart [8]. But the fruitfulness of this approach, aiming to subsume the concept of identity within the broader category of 'interest', is strongly debatable. In my view such a position implies a stretching of the concept of interest beyond its proper domain, creating unnecessary analytical ambiguity. Identity concerns should be approached as something distinct from interest and resource-exchange [15]. The key to an understanding of the mechanisms of identity-based trust is to acknowledge that it is always based on a mutual acceptance of *the validity* of the preferences, norms or values that are shared by the identifying parties. As identification increases such preferences, norms or values may be internalized, becoming something unquestionable or even unconsciously given. Members of a strongly identifying community will typically think, feel and respond like all others, thus permitting them to act as each other's agents, substituting for each other in various kinds of social interactions. The

[17] Interview of area manager, March 2001
[18] Interview of area manager, February 2001

interesting questions if of course what the more specific dynamics of identity-based trust are and how such trust is generated and diffused in organizations.

In the MHSO, while social relations were most often described as 'excellent', a closer look indicated manifest tensions between different units about overall visions and major organizational objectives. As a matter of fact both the Community Development Division and the Environmental Health Division felt rather unhappy in the municipal health agency and somewhat dominated by the strong position of the Community Health Division and its emphasis on individual health services. As stated by one of the environmental health officers,

> "…in personal health, the focus is on the individual, while in environmental health, the emphasis is on the environment and its impact on health. But personal health is the heaviest, the most influential. The medical profession keeps you under the thumb. In such a position, we cannot really move forward…"[19]

The environmental officers often saw themselves as falling out of the health organization, as dealing with question wider than personal health. A similar position was taken by most employees of the Community Development Division who felt that that there was an insufficient understanding of what they were trying to do in the municipal agency,

> "…The medical model, it's not easy to change. The position as we are in, it creates tensions, in particular in relation to the allocation of resources. We have a more developmental role and our function goes across the different sectors. Our position is that we ought to play a more strategic role and we would like to be closer to the important decision making arenas…"[20]

The important fact, however, was that the managerial system of the MHSO seemed to functioning quite well in spite of these tensions. The conflicts were acknowledged and were often spelt out when decisions about priorities and allocations of resources had to be made. The different outlooks and interests of the various divisions and occupational categories did create tensions, but such oppositions were not allowed to disrupt the proper functioning of the managerial system of the agency. A general climate of trust and openness seemed to keep tensions at a manageable scale. We have already seen how various strategies of `impression management` as trustworthiness contributed to the building of such a working environment in the agency, reducing some of the uncertainty always confronting investment of trust. As management demonstrated its care and respect for the staff, its commitment towards values like fairness and equality and its will to engage in collective search for satisfactory solutions, staff could enter trust-based interactions with the certainty that their trust was not likely be dishonored.

Right from the beginning top management of the MHSO worked with the vision of creating a unique organization that would have an impact on peoples` life and health status within the new health district. With the help of middle management they used every opportunity to promote the new identity of the 'we' of SPM, addressing anybody who continued to talk about the 'we of the CMC' or 'we of the CTCC'. A symbolic way of doing this was to create new uniforms for all staff. Initially, the different uniforms of the CMC and CTCC staff underscored the differences between the two categories of employees. Setting up a 'uniform task team', inviting all staff to take part in the process, was a simple but important mechanism to promote the new identity.

Of more importance, however, was how top management throughout the process engaged in the building of a common vision or 'script' of the MHSO and its objectives. The slogan of the agency was formulated as *'together we can make it happen'* and the managerial language defining the work and the goals of the organization emphasized the typical modern values of efficiency and output orientation, client identification and the ethic of customer service. Gradually these values became important elements of the way that the employees of the MHSO defined themselves. Working in the MHSO of the SouthPeninsulaMunicipality was something that most employees did with pride and with a feeling of belonging to an agency acknowledged for its ability to solve problems and move forward. This sheared organizational `spirit` and the common identity it promoted created a sort of community among members that reduced the risk of trusting others.

5.2.3. Fostering Sheared Norms and Understandings

The attempt to create such a 'script' of common values and understandings have effected performance in the MHSO largely because it has been related to and mediated by a continuous process of building more specific and shared norms on lower managerial levels. Observing the interaction among the participants in one of the clinic management meetings gave several examples of how such common norms developed through open discussions about the different kinds of challenges confronting staff in their daily practice. One was the issue of the proper geographical boundaries for receiving patients by the various local clinics. The director of the Community Health division emphasized the need not only to regard what was the most convenient clinical solution, but also to put weight on practical arrangements that the local communities would respect. Another question debated was the problem of political fighting in the communities, often related to demands about additional public services or to requests about changes in the distribution of existing services. During the debate the director pointed to the need to be involved with community issues, but warned against the

[19] Interview of environmental health officer, March 2001

[20] Interview with head of the 'Community Development Division', March 2001

danger of getting too involved with such processes, as 'politics is not our job'. As a last example an issue concerned the policy of giving food parcels to patients at the clinics, as a way of promoting patient's compliance with TB-medication. Several clinic managers claimed that many of the patients showed great apathy, coming to the clinic only to get the parcels. The director replied that the justification of the parcels was to hug patients to the treatment, and as that was by fare the most important objective of the practice, it had to continue.

Through such debates managers developed common understandings and shared norms of how to handle the many challenges confronting daily clinical work. In this way the broader visions and values of the MHSO were translated into actual clinical practice. As indicated the debates implied a significant element of educational influence exercised by the director of the Community Health division, using each opportunity to enlighten the more principle aspects of the various issues. On the other hand the impression was clearly a confrontation of different meanings and viewpoints in open and moving debates, with argumentative contributions from many of the participants. Solutions where sought and reached through the debates and not taken directly from textbooks or by a sole adherence to predefined managerial principles. It is likely that the arrangement of such deliberative processes, generating sheared norms and meanings, reduced the amount of risk participants assumed to incur by trusting others.

6. Conclusions

The account offered of the trust building mechanisms in the MHSO may appear as a charming little story of extra-ordinary managerial skills and abilities. It is not the argument, however, that context did not affect these processes of building and maintaining trust. As a matter of fact some favorable conditions for such endeavors were present as the MHSO was set up in 1997. Administrative reforms had already been introduced in the health department of the Cape Metropolitan Council (CMC) from 1994 onwards with the deliberate intention of cutting across many of the traditional barriers, culturally, politically and professionally. [21]

The reforms focused on the need to develop new 'Participative Management Style and Structures', and the principles adopted in the latter part of 1994 stated, among other things, the necessity "…to create a more inclusive team approach to service delivery, thus 'destroying' the individuality of the respective professional groups…" [22]To do this a system of representative team management structures was set up on each administrative level from the so-called 'local venue committees' at facility level to the top decision making arenas. Most of these reforms were quite successful and they contributed to a change of professional relations towards more trust and co-operation. Gradually the health department was opened to new influences and new forms of knowledge. Public health specialists were recruited, graduates from the Community Health departments of the Universities of Cape Town and Stellenbosch. Registrars and trainers were also allowed into the organization, doing student projects and evaluating on-going processes. A dynamic mixture of people was created, all engaged in the search for new solutions and ways to promote administration and services in the health sector. Many of the top positions in municipal and provincial health institutions in the Western Cape, both on the political and administrative side of government, and even in some of the most influential Non-Governmental organizations, are today occupied by individuals who embarked on their careers from this milieu. In this manner new managerial principles diffused to other agencies and levels and areas of management, including the MHSO of SPM.

As mentioned the CMC was only one of the two public health institutions that in 1977 surrendered parts of their staff as the new health services organization of the SPM was established. The other was the health department of Cape Town City Council (CTCC), the most powerful and prestigious local government structure within the Cape Metropolitan Area, and with a tradition of having much more centralized and bureaucratic structures than the CMC. According to several informants, however, the managers leaving the CTCC were those who wanted to create something new, a group of leaders who were dissatisfied with the old top down administrative system.

The ambition to create a new system of 'change management' in South Peninsula Municipality was not confined to the health sector, however, put pervaded much of the new political and managerial milieu set up to administer the various policy sectors. The reform process in health became linked to a larger managerial reform movement including the entire administrative apparatus of the new municipality. A very competitive group of managers was created that decided to make South Peninsula a for-runner of administrative creativity and efficiency, despite the rather strict financial condition of the new municipality compared to most neighboring local governments.

All this tests to some favorable conditions for building trust present as management of the MHSO embarked on its institution building efforts from 1997 onwards. The management culture already institutionalized in the CMC became a strong impetus, even though the new director, recruited from the CTCC, did not directly copy the specific managerial structures of this agency. Both the director and the manager of the Community Health Division, however, were strongly committed to the process of creating new managerial arrangements and to involve the staff in the process.

Admitting to the importance of such contextual conditions, the argument forwarded in this paper is still that the

[21] Western Cape Regional Service Council, Memorandum from Chief Director of Health Services Department, AE/CR, 1996/05/03

[22] Health Services Department, Western Cape Regional Service Council, AE/CR, 30.4.96, 'Management Style and Structures', p. 2

generalization of trust within the MHSO can to a large extent be seen as an effect of deliberative managerial strategies consciously chosen to build reliance and trust. While it is true that trust cannot be directly demanded, the increase of trust was to a large extent a product of the way management handled the challenges of organizational development and institution building. Contextual conditions did not in itself change social relations within the MHSO. Trust was built because management had the capacity to utilize the space for action and the 'window of opportunity' opened up by such conditions.

Building reliability is essential to create a space for trust. Demonstrating skill and capacity, signaling commitment towards organizational objectives, promoting co-operation and compliance with new organizational roles and appearing to be frank, honest and open, management of the MHSO seemed to be worthy of reliance. Staff uncertainties about superiors' will and ability to perform their roles in a proper way, was reduced, and reliance strengthened. Consciously designing organizational structures and processes, introducing mechanisms of accountability and regulating interaction to promote interpersonal learning about common problems and challenges, were even more important measures to build reliance. Higher levels of accountability increased the likelihood that opportunistic behavior would be detected and punished, and reduced the risk of relying on others.

Trust need a minimal base of security and reliability, if not the level of risk involved may appear to be too high. Showing concern for role expectations, however, cannot in itself evoke an attitude of trust. Appearing as trustworthy is to demonstrate a will and capacity to move beyond arrogated roles, and still not to dishonor trust. Signaling a will to listen and deliberate, caring for others' needs and interests, balancing, however, the acting on behalf of with a commitment for universal values, demonstrating a will to search for satisfactory solutions and compromises, management of the MHSO cultivated an appearance worthy of investments of trust. On the organizational and institutional level management promoted a culture that allowed for the growth of strong selves among the employees, carefully constructed new 'imaginary' identities, and contributing to the development of sheared visions, norms and understandings, all measures that in various ways reduced staff vulnerability and the risk of trusting.

A major reason for the transformation of social relations within the MHSO in the period from 1997 to 2001 was therefore how management somehow succeeded in balancing the needs for building both reliance and trust. To do so it adopted a broad repertoire of strategies ranging from 'impression management' to organizational and institutional design, enabling it to address both 'the knowledge problem' to reduce staff uncertainties, and 'the risk problem' of reducing the vulnerability of trustors. In combination these strategies translated into an effective organizational reform process that gradually improved social relations and diffused trust within the agency.

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