## How Health-Related Professional Backgrounds Influence Perceptions regarding the Performance of and Trust in Healthcare Systems

**Abstract**

Background:
Trust in the healthcare system and its perceived performance are critical yet distinct constructs in public health research. While *trust* reflects individuals’ confidence in the integrity and reliability of the healthcare system, *perceived performance* captures their assessment of how well the system delivers care. This study examines whether having an academic or vocational background in a health-related field affects an individual’s perceptions of healthcare system performance and trust.

Methods:
Data were drawn from the 2023 Israeli Social Survey, which included 6,474 respondents aged 20 years and older. Participants were asked to rate the performance of the healthcare system and indicate their level of trust in it. The primary explanatory variable was whether respondents had studied or worked in a health-related field. Multivariate logistic regression models adjusted for sex, age, education, income, population group, self-rated health, insurance coverage, and interview timing (pre/post October 7, 2023) were created.

Results:
Respondents with health-related education (8.2% of the sample) were significantly less likely to rate the healthcare system’s performance as “very good” (13.1% vs. 19.9%; odds ratio [OR] = 1.501, 95% confidence interval [CI]: 1.489–1.514). However, no statistically significant difference was observed in the levels of trust (30.6% vs. 32.9%; OR = 1.00, 95% CI: 0.90–1.11). Other significant predictors of trust and performance evaluation were age, self-rated health, population group, and income. Following adjustment for confounding factors, the timing of the interview in relation to the Swords of Iron war was not significantly associated with the outcome.

Conclusions:
Healthcare professionals maintain levels of institutional trust similar to those seen in the general public, but tend to evaluate system performance more critically. These findings underscore the importance of integrating provider perspectives into health system evaluation frameworks; this has considerable implications for policy and practice.

# Literature Review

This literature review addresses the distinct but interrelated constructs of trust in health systems and their perceived performance. While both are essential to understanding public engagement with health services, they reflect different dimensions of perception: one is rooted in belief and expectation, the other in concrete evaluation. Together, they shape people’s willingness to seek care, respond to care, and maintain long-term trust in the system.

**(A) Variables Affecting Trust**

Empirical studies suggest strong social correlations for both trust and performance evaluation. Socioeconomic status, for example, has been associated with trust disparities: individuals from lower socioeconomic backgrounds often feel detached from healthcare institutions, resulting in lower trust, particularly in sensitive fields such as oncology (Wood & Patel, 2024).

Expanding on the role of socioeconomic factors, several studies have shown that income level independently affects institutional trust, with lower-income individuals often perceiving healthcare systems as less responsive or equitable, especially in privatized or fragmented healthcare contexts (Wood & Patel, 2024).

Demographic variables such as sex and age have also shown complex associations with trust. Some studies found no differences between the sexes in overall trust (Abd Hamid et al., 2018), while others indicate that women tend to be more engaged in medical decision-making, possibly reflecting higher trust in healthcare providers (Robles et al., 2024). Findings regarding age are mixed: Katz et al. (2024) observed increasing trust with age, while Beller et al. (2023) reported that older adults—especially those experiencing mental distress, financial strain, or unmet healthcare needs—show lower levels of trust.

In addition to demographic characteristics, health status itself may influence trust dynamics. Self-perceived health status has also been linked to trust. Individuals reporting poor or fair health often exhibit lower trust in healthcare institutions, potentially due to accumulated negative experiences or unmet expectations (Beller et al., 2023).

Cultural and ethnic differences are equally salient. In Israel, Jewish immigrants and Arab citizens reported higher levels of trust in the healthcare system than native-born Jews—a pattern that may reflect cultural expectations, gratitude, or differences in perceived authority (Pinchas-Mizrachi, Zalcman, & Daoud, 2020).

**(B) Variables Affecting Perceived Performance**

Perceived performance, on the other hand, refers to a person’s judgment of how well the healthcare system functions. This judgment often stems from direct experiences—such as wait times, service quality, accessibility, and provider competence—but is also shaped by media narratives, public events, and cultural context (Litovtseva, Brychko, & Srovnalíková, 2022).

Most studies have focused on the perceptions of the general public; however, far fewer studies have examined how health professionals themselves evaluate the system. Given their first-hand exposure to service delivery, resource constraints, and administrative processes, their assessments may differ significantly from those of the general public. This gap in the literature highlights the need to systematically examine professional perspectives alongside public perceptions.

Another structural dimension relevant to perceived performance is insurance coverage. Access to private insurance has been found to affect both healthcare utilization and perceived system performance. In China, individuals with supplemental private insurance showed different patterns of trust and utilization, often preferring higher-tier facilities, possibly reflecting stratified trust perceptions (Bie et al., 2024).

Similarly, in contexts where supplementary insurance provides faster or broader access to services (e.g., Israel’s public-private combination), it may mediate satisfaction and influence performance perceptions, though not necessarily institutional trust per se.

**(C) Theoretical Distinction Between Trust and Perceived Performance**

Trust and perceived performance are two central but distinct concepts in health services research. Trust refers to the level of confidence a person places in another person or institutional body, expecting them to act according to moral, professional, and social norms, especially in contexts of vulnerability or uncertainty (Carter, 2022). Healthcare exemplifies this dynamic: people approach it when they are physically, emotionally, or financially vulnerable. Thus, trust in the system is crucial for effective interaction.

Perceived performance, on the other hand, refers to a person’s judgment of how well the healthcare system functions. This judgment often stems from direct experiences such as wait time, service quality, accessibility, and provider competence; however, the judgment is also shaped by media narratives, public events, and cultural context (Litovtseva, Brychko, & Srovnalíková, 2022). One may trust the healthcare system but still rate its performance poorly, or vice versa. Hence, the conceptual and empirical distinctions between trust and perceived performance are essential.

Another theoretical distinction presented in the literature is that trust reflects a general expectation or predisposition to believe in a system, while performance evaluation refers to an outcome measured after an actual interaction (Carter, 2022). In this sense, trust pertains to perceived intention, whereas performance pertains to the success or failure of the action. A person may highly trust a physician, but if the treatment fails, the performance assessment may still be negative, even if the overall trust remains intact.

**(D) Literature on Health Professionals and Differences in Perceptions**

A central question in the literature is whether individuals with academic or professional backgrounds in health-related fields evaluate the healthcare system differently from the general population. These individuals—trained in disciplines such as medicine, nursing, pharmacy, psychology, and public health—may simultaneously maintain institutional trust while expressing more critical views of the system’s performance.

Their dual role as both providers and recipients of care exposes them to systemic constraints, clinical decision-making, and administrative inefficiencies, which can heighten sensitivity to performance-related shortcomings. However, their deep familiarity with professional norms and ethical commitments may reinforce trust in the healthcare system’s foundational mission (Greene & Wolfson, 2023; Kashefi et al., 2023).

Despite this unique perspective, few studies have empirically examined this subgroup using nationally representative data. The current study attempted to address this gap by analyzing the differences in trust and perceived system performance between healthcare-trained individuals and others, while controlling for background factors such as age, sex, income, education, health status, insurance coverage, and timing of data collection.

This analysis builds on conceptual distinctions between trust (which is rooted in perceived intent) and performance evaluation (which is shaped by specific experiences and outcomes) (Carter, 2022; Litovtseva et al., 2022). A healthcare professional may trust the system’s mission, yet remain critical of its execution. Understanding this dynamic offers valuable insights for health system evaluation and policy reform.

**Study Objectives**

This study aimed to examine differences in institutional trust and perceived healthcare system performance between individuals with and without an academic or professional background in health-related fields. *Specifically, we compared the attitudes of those with formal education in medicine, nursing, pharmacy, public health, psychology, or allied health professions to those of individuals without such education. Individuals meeting these criteria represented 8.2% of the study sample.*

A secondary objective was to assess whether a health-related educational background could independently predict levels of trust and performance evaluation, after controlling for key sociodemographic and health-related variables, including sex, age group, education level, household income, ethnic group, self-rated health, and private or supplementary insurance. This approach enabled us to isolate the unique contribution of professional health education to perceptions of the healthcare system.

**Methods**

This study utilized data from the 2023 Israeli Social Survey, which was conducted by the Central Bureau of Statistics (CBS). The survey is an annual, nationally representative cross-sectional study of adults aged 20 and older residing in Israel. The sampling design employed stratification according to age, sex, and ethnic group (non-Haredi Jews, Haredi Jews, Arabs, and immigrants), and incorporated statistical weights to ensure representativeness and reduce sampling bias. The 2023 dataset included responses from 6,474 individuals, representing approximately 6.18 million citizens.

Two binary dependent variables were analyzed. Perceived performance of the healthcare system was based on responses to the question: “How would you rate the performance of healthcare services in Israel?” Responses were recorded on a five-point Likert scale. Only responses of “Very good” were coded as 1 (positive evaluation); all others were coded as 0. Trust in the healthcare system was measured using the item: “To what extent do you trust the healthcare system in Israel?” Responses were recorded on a four-point scale. Only “Very much” was coded as 1 (high trust); all others were coded as 0.

The key independent variable was having a professional or academic background in a health-related field. This included individuals who reported past or current work experience or formal studies in fields such as medicine, nursing, pharmacy, psychology, public health, or allied health professions. Respondents who met these criteria were classified as having a health-related background (coded as 1). Those who reported neither studying nor working in any health-related field were coded as 0 and served as the reference group.

Multivariable models included a range of covariates to control for potential confounding. These included sex, age group (categorized according to decade), education level (academic vs. non-academic), household income per capita (based on CBS income brackets), ethnic group (non-Haredi Jews, Haredi Jews, Arabs), self-rated health (“Very good” or “Good” coded as 1), health insurance (coded as 1 if the respondent reported having either supplementary or private health insurance), and interview timing. The latter variable distinguished responses collected before and after October 7, 2023, when the Hamas attack on southern Israel initiated the Iron Swords War. Given the magnitude of the national crisis, the timing of the survey may have influenced public perceptions of governmental institutions, including the healthcare system. Adjusting for timing allowed for control of potential bias related to the temporal context of the survey.

Descriptive statistics were calculated to summarize demographic, socioeconomic, and health-related characteristics of the sample. Bivariate associations between the main explanatory variable and each outcome were assessed using chi-square tests. Logistic regression models were estimated in two steps: the first adjusted for sociodemographic characteristics, and the second further adjusted for self-rated health, insurance coverage, and interview timing. Results are presented as odds ratios (OR) with 95% confidence intervals (CI), and statistical significance was defined as α = 0.05. All analyses were conducted using SPSS version 29.

The study relied on publicly available, anonymized data collected by CBS. All participants provided informed consent at the time of data collection. As the dataset contained no identifying information and no direct contact was made with participants, institutional review board (IRB) approval was not required.

# Results

The analytic sample included 6,474 respondents from the 2023 Israeli Social Survey, representing approximately 6.2 million adults. Among these, 8.2% (about 531 individuals) reported holding an academic degree or vocational certificate in a health-related field such as medicine, nursing, pharmacy, public health, or allied health professions. The remaining 91.8% had no such education or training.

Regarding perceptions of healthcare system performance, 19.3% of the total sample rated the Israeli healthcare system as 'very good'. However, only 13.1% of respondents with health-related education gave a 'very good' rating, compared to 19.9% among those without such education. This difference was statistically significant (p < 0.001). Multivariable logistic regression confirmed this association. After adjusting for sociodemographic variables, health status, insurance coverage, and interview timing (before or after October 7, 2023), respondents without a health-related background had significantly higher odds of reporting a 'very good' evaluation (OR = 1.501, 95% CI: 1.489–1.514). These results suggest that individuals with professional exposure to healthcare systems may assess system performance more critically, even after controlling for relevant confounders.

In contrast, overall trust in the healthcare system was reported as 'very much' by 32.7% of the sample. Among those with a health-related background, 30.6% expressed high trust, compared to 32.9% without such education. This difference was not statistically significant (p = 0.27). Adjusted logistic regression models confirmed the null association (OR = 1.00, 95% CI: 0.90–1.11), indicating that health-related education did not significantly affect trust in the healthcare system.

Given the national trauma triggered by the Hamas attack on October 7, 2023, the interview timing was examined as a potential source of bias. Although slightly lower scores for trust and performance were observed among those interviewed post-October 7, the inclusion of this variable in regression models did not significantly alter the associations between professional background and the outcomes.

Additional multivariate analyses revealed consistent patterns among other variables. Older adults, particularly those aged 65 and above, were significantly more likely to report both higher trust and more favorable evaluations of the healthcare system. Respondents from Haredi and Arab communities also expressed more positive views than non-Haredi Jewish respondents, even after full adjustment. Self-rated health emerged as an important predictor: individuals with poorer health reported substantially lower odds of both high trust and positive performance ratings. Health insurance also played a role: possession of supplementary or private insurance was linked to higher odds of positive evaluation, although not of trust. Other covariates, including sex, income, and education, were included in the models but did not substantially modify the main association between health-related education and the outcomes.

Detailed results are presented in Tables 1 through 4. Table 1 summarizes perceived performance according to sociodemographic variables. Table 2 presents trust in the healthcare system using these same variables. Table 3 displays adjusted OR from logistic regression models predicting 'very good' performance ratings. Table 4 presents adjusted OR for reporting 'very much' trust in the healthcare system.

## Table 1. Perceived Performance of the Healthcare System by Sociodemographic Variables

|  |  |  |  |
| --- | --- | --- | --- |
| Variable | Category | % Rated 'Very Good' | Age and/or Sex Adjusted OR (95% CI) |
| Sex | Male | 19.4% | 1.00 (Ref) |
|  | Female | 18.1% | 0.948 (0.944–0.952) |
| Age Group | 20–29 | 21.3% | 0.947 (0.943–0.951) |
|  | 30–39 | 17.1% |  |
|  | 40–49 | 18.0% |  |
|  | 50–59 | 17.2% |  |
|  | 60–74 | 17.5% |  |
|  | 75+ | 22.9% |  |
| Household Income | ≤ 2000 NIS | 26.6% | 1.00 (Ref) |
|  | 2001–4000 NIS | 23.7% | 0.590 (0.586–0.593) |
|  | > 4000 NIS | 15.6% | 0.520 (0.516–0.523) |
| Education Level | Academic | 13.6% | 1.00 (Ref) |
|  | Non-Academic | 21.5% | 1.750 (1.742–1.759) |
| Ethnic Group | Non-Haredi Jew | 14.7% | 1.00 (Ref) |
|  | Haredi Jew | 24.0% | 1.256 (1.246–1.265) |
|  | Arab | 30.5% | 1.990 (1.976–2.004) |
| Self-Rated Health | Good/Very Good | 19.5% | 1.00 (Ref) |
|  | Not Good | 16.4% | 0.750 (0.746–0.754) |
| Private Insurance | Yes | 14.5% | 1.00 (Ref) |
|  | No | 21.9% | 1.577 (1.570–1.584) |
| Supplementary Insurance | Yes | 16.9% | 1.00 (Ref) |
|  | No | 27.1% | 1.701 (1.692–1.710) |
| Health-Related Education | Yes | 13.1% | 1.00 (Ref) |
|  | No | 19.3% | 1.501 (1.489–1.514) |

## Table 2. Trust in the Healthcare System according to Sociodemographic Variables

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| --- | --- | --- | --- |
| Variable | Category | % 'Very Much' Trust | Adjusted OR (95% CI) |
| Sex | Male | 35.4% | 1.00 (Ref) |
|  | Female | 30.2% | 0.879 (0.876–0.882) |
| Age Group | 20–29 | 31.2% | 1.00 (Ref) |
|  | 30–39 | 30.8% | 1.047 (1.043–1.051) |
|  | 40–49 | 31.4% | 1.070 (1.065–1.075) |
|  | 50–59 | 32.3% | 1.092 (1.087–1.097) |
|  | 60–74 | 34.6% | 1.163 (1.157–1.168) |
|  | 75+ | 35.7% | 1.183 (1.177–1.189) |
| Income | ≤ 2000 NIS | 35.4% | 1.00 (Ref) |
|  | 2001–4000 NIS | 33.0% | 0.929 (0.926–0.932) |
|  | > 4000 NIS | 30.4% | 0.860 (0.857–0.862) |
| Education | Academic | 32.8% | 1.00 (Ref) |
|  | Non-Academic | 32.5% | 1.062 (1.057–1.066) |
| Ethnic Group | Non-Haredi Jew | 32.1% | 1.00 (Ref) |
|  | Haredi Jew | 32.6% | 1.02 (0.97–1.08) |
|  | Arab | 34.6% | 1.07 (1.02–1.13) |
| Self-Rated Health | Good/Very Good | 33.4% | 1.00 (Ref) |
|  | Not Good | 29.3% | 0.825 (0.79–0.86) |
| Private Insurance | Yes | 32.9% | 1.01 (0.96–1.07) |
|  | No | 32.4% | - |
| Supplementary Insurance | Yes | 33.5% | 1.065 (1.02–1.11) |
|  | No | 32.0% | - |
| Health Education | Yes | 30.6% | 1.00 (Ref) |
|  | No | 32.9% | 1.00 (0.90–1.11) |

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| Table 3. Adjusted Odds Ratios for Rating the Healthcare System as 'Very Good' Multivariable logistic regression results across three models. All models are adjusted for interview timing (before/after October 7, 2023). Model 1 adjusted for sex, age, and health-related education. Model 2 additionally adjusted for education, income per capita, and population group. Model 3 additionally adjusted for self-rated health, private, and supplementary insurance. |
| Variable | Category | Model 1 OR (95% CI) | Model 2 OR (95% CI) | Model 3 OR (95% CI) |
| Health-related education | No (vs. Yes) | 1.51 (1.49–1.53) | 1.51 (1.49–1.53) | 1.501 (1.489–1.514) |
| Sex | Female (vs. Male) | 0.952 (0.948–0.956) | 0.950 (0.946–0.954) | 0.948 (0.944–0.952) |
| Age | 30–39 (vs. 20–29) | 0.951 (0.947–0.956) | 0.949 (0.945–0.953) | 0.947 (0.943–0.951) |
|  | 40–49 | 0.934 (0.930–0.939) | 0.932 (0.928–0.936) | 0.930 (0.926–0.934) |
|  | 50–59 | 0.925 (0.921–0.929) | 0.923 (0.919–0.927) | 0.923 (0.919–0.927) |
|  | 60–74 | 0.936 (0.932–0.940) | 0.935 (0.931–0.939) | 0.934 (0.930–0.938) |
|  | 75+ | 1.025 (1.020–1.030) | 1.026 (1.021–1.031) | 1.027 (1.022–1.032) |
| Education | Non-Academic (vs. Academic) | - | 1.753 (1.745–1.761) | 1.750 (1.742–1.759) |
| Income per capita | 2001–4000 (vs. ≤ 2000) | - | 0.592 (0.589–0.595) | 0.590 (0.586–0.593) |
|  | > 4000 | - | 0.522 (0.519–0.525) | 0.520 (0.516–0.523) |
| Ethnic group | Haredi Jew (vs. Non-Haredi Jew) | - | 1.263 (1.254–1.273) | 1.256 (1.246–1.265) |
|  | Arab | - | 1.998 (1.985–2.011) | 1.990 (1.976–2.004) |
| Self-rated health | Not good (vs. Good) | - | - | 0.750 (0.746–0.754) |
| Private insurance | No (vs. Yes) | - | - | 1.577 (1.570–1.584) |
| Supplementary insurance | No (vs. Yes) | - | - | 1.701 (1.692–1.710) |

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| Table 4. Adjusted Odds Ratios for Reporting 'Very Much' Trust in the Healthcare SystemMultivariable logistic regression results across three models. All models are adjusted for interview timing (before/after October 7, 2023). Model 1 adjusted for sex, age, and health-related education. Model 2 additionally adjusted for education, income per capita, and population group. Model 3 additionally adjusted for self-rated health, private, and supplementary insurance. |
| Variable | Category | Model 1 OR (95% CI) | Model 2 OR (95% CI) | Model 3 OR (95% CI) |
| Health-related education | No (vs. Yes) | 1.12 (1.10–1.15) | 1.07 (1.05–1.10) | 1.00 (0.90–1.11) |
| Sex | Female (vs. Male) | 0.876 (0.873–0.879) | 0.874 (0.871–0.877) | 0.879 (0.876–0.882) |
| Age | 30–39 (vs. 20–29) | 1.046 (1.042–1.050) | 1.048 (1.044–1.052) | 1.047 (1.043–1.051) |
|  | 40–49 | 1.069 (1.064–1.073) | 1.071 (1.066–1.075) | 1.070 (1.065–1.075) |
|  | 50–59 | 1.091 (1.086–1.096) | 1.092 (1.087–1.097) | 1.092 (1.087–1.097) |
|  | 60–74 | 1.162 (1.157–1.167) | 1.163 (1.158–1.168) | 1.163 (1.157–1.168) |
|  | 75+ | 1.182 (1.176–1.188) | 1.183 (1.177–1.189) | 1.183 (1.177–1.189) |
| Education | Non-Academic (vs. Academic) | - | 1.062 (1.058–1.066) | 1.062 (1.057–1.066) |
| Income per capita | 2001–4000 (vs. ≤ 2000) | - | 0.929 (0.926–0.932) | 0.929 (0.926–0.932) |
|  | > 4000 | - | 0.860 (0.857–0.862) | 0.860 (0.857–0.862) |
| Ethnic group | Haredi Jew (vs. Non-Haredi Jew) | - | 1.038 (1.031–1.045) | 1.02 (0.97–1.08) |
|  | Arab | - | 1.104 (1.098–1.111) | 1.07 (1.02–1.13) |
| Self-rated health | Not good (vs. Good) | - | - | 0.825 (0.79–0.86) |
| Private insurance | No (vs. Yes) | - | - | 1.01 (0.96–1.07) |
| Supplementary insurance | No (vs. Yes) | - | - | 1.065 (1.02–1.11) |

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**Discussion**

This study examined whether individuals with academic or vocational backgrounds in health-related fields differ from the general population in their trust in, and evaluations of, the Israeli healthcare system. The findings revealed a notable discrepancy: while no statistically significant difference was found in levels of trust, participants with health-related education were significantly less likely to rate the system’s performance as “very good.”

This apparent contradiction invites a conceptual distinction between institutional trust and professional or managerial trust. Institutional trust refers to a general belief in the legitimacy, values, and public mission of the healthcare system. It reflects confidence in the institution as a moral and necessary social framework, often shaped by long-standing cultural norms or ideological identification. In contrast, professional or managerial trust pertains to the operational conduct of the system: its managerial efficiency, quality of care, resource allocation, and responsiveness. Individuals with professional exposure to healthcare are more likely to critically assess these aspects, given their awareness of systemic limitations and internal inefficiencies.

This dual-layered trust framework offers a valuable lens through which to interpret our findings: while institutional trust may remain stable, those with insider knowledge often adopt a more critical stance toward the system’s performance, without necessarily rejecting its foundational legitimacy.

Even after adjusting for a comprehensive set of covariates—including age, sex, education, income, ethnic group, self-rated health, private and supplementary insurance, and interview timing—these differences remained robust. This suggests that disparities in perceptions of healthcare performance are not solely attributable to demographic or health-related factors, but may instead reflect the influence of direct professional exposure to the healthcare system.

This discrepancy between trust and performance evaluation is critical. It implies that health professionals and those trained in the system may retain an overall sense of institutional trust, rooted in values or long-term experience, while simultaneously holding more critical views regarding operational efficiency and systemic shortcomings. These individuals likely possess greater awareness of internal challenges—including resource constraints, bureaucratic inefficiencies, and gaps in service delivery—which could explain their lower performance ratings. This interpretation aligns with the findings of prior studies demonstrating that specialized knowledge is often associated with more critical assessments (Litovtseva et al., 2022).

The survey likely captured general institutional trust, whereas those with insider experience may be more attuned to managerial or technical shortcomings. Thus, the absence of a trust gap does not necessarily indicate alignment or satisfaction, but may reflect a measurement gap (Greene & Wolfson, 2023; Kashefi et al., 2023).

The persistence of high trust despite more negative performance ratings supports previous findings suggesting that trust may stem from broader emotional or social frameworks—such as identity, moral alignment, or perceived legitimacy—rather than technical knowledge alone (Darden & Macis, 2024; Adams et al., 2025).

These findings also echo earlier work on the relationship between education and healthcare perceptions. Individuals with higher levels of education or health-related education may hold more critical views due to heightened expectations regarding access, equity, or service quality (Martirosov et al., 2023; Tarafder, 2024).

Interestingly, while individuals with private or supplementary insurance were more likely to rate the system positively, their levels of trust did not differ significantly. This may point to a pragmatic acceptance of service quality among those with enhanced access, without broader endorsement of system fairness or responsiveness. The finding raises important normative questions about equity in satisfaction and trust within mixed public-private healthcare models (Chernichovsky & Sharony, 2015).

Beyond the main explanatory variable, our findings highlight meaningful differences across demographic and health-related characteristics. Respondents from Arab and Haredi Jewish communities expressed greater trust and more favorable performance evaluations than non-Haredi Jews, even after full adjustment. This is consistent with earlier Israeli research suggesting that distinct cultural expectations, group identity, or past experiences may influence attitudes toward public institutions (Pinchas-Mizrachi et al., 2020).

Older adults, particularly those aged 65 and above, reported higher trust and satisfaction; these findings aligned with international literature linking age to more favorable perceptions of healthcare systems (Katz et al., 2024). Conversely, respondents in poor self-rated health reported significantly lower trust and satisfaction, potentially reflecting unmet needs or negative experiences (Saha, 2024).

Although the timing of the interview (pre- vs. post-October 7) was not significantly associated with trust or performance evaluations, this distinction remains important in times of national crisis. People may maintain institutional trust as a normative belief, even when short-term satisfaction declines. Future studies should further disentangle these dimensions of trust—belief versus reliance—particularly in contexts of prolonged emergency (Kashefi et al., 2023).

Limitations

This study has several limitations that should be acknowledged. First, its cross-sectional design limits the ability to infer causal relationships between having a health-related professional background and perceptions of trust or healthcare system performance. Second, both outcome variables—trust and perceived performance—were assessed using single-item self-report measures. While such measures are common in large-scale surveys, they may not fully capture the complexity of these constructs and are susceptible to response biases.

Third, the analysis of trust likely reflects a general sense of institutional trust rather than more specific dimensions such as managerial or professional trust, which may be particularly relevant for individuals with insider perspectives. As a result, subtle differences in trust may have been masked by the measurement approach.

Fourth, the main explanatory variable grouped all respondents with health-related education or training into a single category, without distinguishing among roles such as physicians, nurses, public health professionals, or allied health workers, each of which may entail different relationships with the healthcare system.

Finally, although the timing of the survey in relation to the October 7, 2023 war was statistically adjusted for, the broader societal disruptions may have introduced unmeasured contextual effects that influenced public attitudes in complex ways.

This study underscores the need to broaden the lens of evaluation beyond the patient perspective. Specifically, it calls for the development of assessment tools that also capture how healthcare professionals perceive the quality of care they help deliver. Exploring the determinants of such evaluations may reveal systemic gaps and opportunities for improvement. These insights align with previous research emphasizing the importance of integrating provider perspectives to complement patient-based measures of quality (Kashefi et al., 2023).

Moreover, the observed divergence between layperson and professional assessments highlights the value of structured dialogue between system users and providers. Bridging this experiential gap—through participatory mechanisms, joint feedback forums, or collaborative evaluation panels—may help align expectations and inform more inclusive quality improvement processes (Anderson, 2023; Kashefi et al., 2023).

Overall, the findings underscore the importance of differentiating between trust and performance evaluation in public health research. While these are related constructs, they reflect distinct domains of public perception. Trust may remain stable even in the presence of critical performance assessments, and performance ratings may vary according to individuals’ proximity to the health system. Policymakers should therefore consider the perspectives of both laypeople and health professionals when evaluating public confidence in healthcare institutions.

These conclusions should be interpreted in light of Israel’s universal healthcare system, which combines public insurance with private supplementary options and generally provides high-quality care by international standards. The generalizability of the findings to other contexts may be limited by structural and cultural differences.

Future studies could benefit from incorporating qualitative components to better understand the reasons behind critical evaluations despite sustained trust. In-depth interviews or focus groups with health professionals could provide insights into their complex relationships with the systems in which they operate. Longitudinal designs would also help determine whether continued exposure to systemic shortcomings diminishes trust over time, or whether trust, once formed, remains resilient despite criticism.

**Conclusion and Policy Implications**

The present findings offer a differentiated view of how professional background shapes healthcare attitudes. While trust in the healthcare system remained relatively stable across groups, individuals with health-related education were significantly more critical in their evaluation of system performance. These insights highlight perceptual divides between professionals and the general public and point to opportunities for more responsive, inclusive, and evidence-informed healthcare policy.

Several implications emerge for policy, practice, and future research:

First, healthcare systems should implement structured tools to assess how healthcare professionals perceive the quality of care they help deliver. These assessments can complement patient satisfaction metrics and provide a more comprehensive understanding of service performance.

Second, institutional evaluations should actively incorporate the perspectives of professionals. Their insider knowledge can illuminate operational inefficiencies and barriers that may not be visible to external stakeholders.

Third, health education programs should foster reflective practice among professionals, encouraging constructive critique and engagement with system-level challenges. Cultivating a culture of critical awareness may enhance both individual and organizational learning.

Fourth, future research would benefit from mixed-methods approaches that combine statistical analyses with qualitative insights. In-depth interviews and focus groups can enrich our understanding of the tensions between trust, satisfaction, and professional experience.

Fifth, researchers and policymakers should be mindful of contextual influences—such as national crises—on public attitudes. Monitoring the timing of data collection and its potential impact is essential for interpreting results accurately.

Finally, inclusive policy design should actively engage both healthcare users and providers. Bridging the experiential gap between those who use services and those who deliver them can support more equitable and effective reforms.

Together, these recommendations aim to enhance alignment between perceived and actual healthcare performance, while fostering mutual understanding across the system’s key constituencies. Such alignment is critical for maintaining public confidence and for promoting continuous improvement in health service delivery.

# References

Abd Hamid, H. S., Alwi, A., & Mustapha, W. F. M. W. (2018). Is Generalized Trust Related To Mistrust Of University Health Care Centre?. JURNAL PSIKOLOGI MALAYSIA, 32(1).‏

Adams, O. R., Holder-Dixon, A. R., Campbell, J. T., Bennett-Brown, M., Moscovici, Z., & Gesselman, A. N. (2025). Medical mistrust and healthcare seeking among women of color with chronic vulvovaginal pain. International Journal of Behavioral Medicine, 32(1), 21-33.‏

Beller, J., Schäfers, J., Haier, J., Geyer, S., & Epping, J. (2023). Trust in Healthcare during COVID-19 in Europe: vulnerable groups trust the least. Journal of Public Health, 31(9), 1495-1504.‏

Bie, F., Yan, X., Qiu, W., Mao, A., Meng, Y., Cai, M., ... & Zhang, Y. (2024). Does supplemental private health insurance impact health care utilization and seeking behavior of residents covered by social health insurance? Evidence from China National Health Services Survey. International Journal for Equity in Health, 23(1), 113.‏

Booysen, F., & Hongoro, C. (2018). Perceptions of and support for national health insurance in South Africa’s public and private healthcare sectors. Pan African Medical Journal, 30(1).‏

Campos-Castillo, C. (2018). Trust in Health Care: Understanding the Role of Gender and Racial Differences between Patients and Providers. In Gender, Women’s Health Care Concerns and Other Social Factors in Health and Health Care (pp. 151-174). Emerald Publishing Limited.‏

Carter, J. A. (2022). Trust as performance. Philosophical Issues, 32(1), 120-147.

Chen, L., & Cheng, M. (2022). Exploring Chinese elderly’s trust in the healthcare system: empirical evidence from a population-based survey in China. International journal of environmental research and public health, 19(24), 16461.‏

Darden, M., & Macis, M. (2024). Trust and Health Care-Seeking Behavior. https://doi.org/10.3386/w32028

Dave, U., Lewis, E. G., Patel, J. H., & Godbole, N. (2024). Private health insurance in the United States and Sweden: A comparative review. Health Science Reports, 7(3), e1979.‏

Dirindin, N. (2019). Fondi sanitari e nuovi livelli essenziali di assistenza: un intreccio potenzialmente pericoloso. Politiche sanitarie, 37.‏

Greene, J., & Wolfson, D. (2023). Physician perspectives on Building Trust with patients. Hastings Center Report, 53, S86-S90.‏

Haenssgen, M. J., Elliott, E. M., Phommachanh, S., Phomkong, S., Kounnavong, S., & Kubota, S. (2024). Trust in healthcare: methodological and conceptual insights from mixed-method research in Lao People’s Democratic Republic. BMJ Global Health, 9(5), e014640.‏

Kashefi, M. H., Bohlooli, N., Skandari, K., & Emari, H. (2023). Providing a Model of Organizational Trust with Professional Ethics Approach in the Health System: Grounded Theory. Depiction of Health, 14(1), 116-136.‏

Katz, E., Edelstein, B., & Turiano, N. A. (2024). Age as a moderator of health outcomes and trust in physicians. Journal of Aging and Health, 36(5-6), 308-319.‏

Litovtseva, V., Brychko, M., & Srovnalíková, P. (2022). Current Trends in Research on Confidence in the Healthcare System. 3(1), 62–75. https://doi.org/10.21272/hem.2022.1-07

Martirosov, A. V., Cherkasov, S. N., Fedyaeva, A. V., Karailanov, M. G., & Arutyunyan, G. B. (2023). The importance of the level of education as a social characteristic of the patient in the formation of his attitude to the organization of outpatient medical care. Bulletin of the Russian Military Medical Academy, 25(2), 211-218.‏

McKee, M., van Schalkwyk, M. C., Greenley, R., & Permanand, G. (2024). Placing trust at the heart of health policy and systems. International journal of health policy and management, 13, 8410.‏

Nikodem, K., Ćurković, M., & Borovečki, A. (2022). Trust in the healthcare system and physicians in Croatia: a survey of the general population. International journal of environmental research and public health, 19(2), 993.‏

Petrovici, D., Lassar, W., & Hertelendy, A. J. (2025). Patient perceptions of healthcare service quality in Romania: Public versus private hospitals–Implications for developed and developing healthcare systems. Journal of Hospital Administration, 13(1), 16-24.‏

Pinchas-Mizrachi, R., Zalcman, B. G., & Daoud, N. (2020). Trust in the Israeli healthcare system among Arabs, Jewish immigrants, and non-immigrants. International Journal of Behavioral Medicine, 27, 647-659.‏

Ray, M. K., Beach, M. C., Nicolaidis, C., Choi, D., Saha, S., & Korthuis, P. T. (2013). Patient and provider comfort discussing substance use. Family medicine, 45(2), 109.‏

Robles, B., Kwak, H., & Kuo, T. (2024). Associations Between Patient Comfort with a Primary Care Provider and Three Measures of Behavioral Health Services Utilization. International Journal of Behavioral Medicine, 1-13.‏

Saha, S. (2024). Navigating trust and health in India: the influence of social status and neighbourhood environment. BMC Public Health, 24(1), 2680.‏

Singh, G. K., Lee, H., Kim, L. H., & Daus, G. P. (2024). Promoting Health Literacy as an Important Initiative in Reducing Health Disparities and Advancing Health Equity. International Journal of Translational Medical Research and Public Health, 8.‏

Souvatzi, E., Katsikidou, M., Arvaniti, A., Plakias, S., Tsiakiri, A., & Samakouri, M. (2024). Trust in Healthcare, Medical Mistrust, and Health Outcomes in Times of Health Crisis: A Narrative Review. Societies, 14(12), 269.‏

Tarafder, M. (2024). Patients' Perceptions of Quality in Healthcare: A Review. ZH Sikder Women's Medical College Journal, 6(1), 36-39.‏

Wood, E. H., & Patel, M. I. (2024). The Role of Trust in Oncology Across Populations and Cultures: Implications for Health Inequities and Social Justice. In The Complex Role of Patient Trust in Oncology (pp. 71-92). Cham: Springer International Publishing.‏

Zhou, J., Guo, W., & Ren, H. (2023). Subjective social status and health among older adults in China: the longitudinal mediating role of social trust. BMC Public Health, 23(1), 630.‏

Zhu, Y., Li, Y., Wu, M., & Fu, H. (2022). How do Chinese people perceive their healthcare system? Trends and determinants of public satisfaction and perceived fairness, 2006–2019. BMC Health Services Research, 22(1), 22.‏