Trust as a Strategic Asset: Exploring Concierge Premium Services in Healthcare

Victoria Susanne Scheer

Dissertation written under the supervision of Peter V. Rajsingh, Ph.D.

Dissertation submitted in partial fulfilment of requirements for the MSc in Management with a focus on Strategy, Entrepreneurship, and Impact, at the Universidade Católica Portuguesa, *04. January 2026.*

Abstract

This dissertation explores how concierge and premium healthcare services impact patient trust, emphasizing the service design elements that facilitate trust development in increasingly fragmented healthcare systems. Amid rising patient empowerment and choice, capacity limitations, and growing patient demand for control, the study considers trust not only as a relational outcome but also as a strategic asset integral to service structures.

An exploratory sequential mixed-methods approach was employed. First, twelve expert interviews with clinicians and managers identified key trust-building mechanisms. These insights guided a quantitative survey with 208 respondents, which was analyzed using multiple regression and group comparisons. The results show a clear hierarchy of trust drivers. Personalization - defined by the "decommodification of time" - was the strongest predictor of patient trust, confirming time as a rare, inimitable resource. Accessibility served not only as a convenience but also as a reliable "signal of competence," indicating a psychological process of attribute substitution among patients.

The study identified a Citizen-Consumer Gap: although concerns about societal fairness remain, they do not significantly reduce trust at the individual level. Instead, participants view the membership fee inherent to concierge models not as a barrier, but as a means to restore autonomy - a concept this research terms the *Dignity Premium*. This study links medical sociology to strategic management, offering practical guidance for providers on fostering trust through human-centered access and ongoing relationships.

Keywords: Patient Trust, Concierge Medicine, Resource-Based Theory, Signaling Theory, Citizen-Consumer Gap, Healthcare Management

Title: Trust as a Strategic Asset: Exploring Concierge Premium Services in Healthcare

Author: Victoria Scheer

Resumo

Esta dissertação explora o impacto dos serviços de saúde *concierge* e *premium* na confiança do paciente, enfatizando os elementos de design de serviço que facilitam o desenvolvimento da confiança em sistemas cada vez mais fragmentados. Num contexto de crescente empoderamento, limitações de capacidade e procura por controlo, o estudo considera a confiança não apenas como um resultado relacional, mas também como um ativo estratégico integrado nas estruturas de serviço.

Foi empregada uma abordagem exploratória sequencial de métodos mistos. Primeiramente, doze entrevistas com especialistas (médicos e gestores) identificaram mecanismos-chave, orientando um inquérito quantitativo com 208 participantes, analisado por meio de regressão múltipla e de comparações entre grupos. Os resultados demonstram uma hierarquia clara: a Personalização - definida pela "desmercantilização do tempo" - foi o preditor mais forte, confirmando o tempo como um recurso raro e inimitável. A acessibilidade serviu não apenas como conveniência, mas também como um "sinal de competência" fiável, indicando um processo psicológico de substituição de atributos.

O estudo identificou uma importante *Citizen-Consumer Gap*: embora permaneçam preocupações com a justiça social, estas não reduzem significativamente a confiança individual. Em vez disso, os participantes veem a taxa de adesão inerente aos modelos de *concierge* não como uma barreira, mas como um meio de restaurar a autonomia, conceito que esta investigação denomina *Dignity Premium*. Este estudo liga a sociologia médica à gestão estratégica, oferecendo orientações práticas para fomentar a confiança por meio de acesso centrado no ser humano e de relações contínuas.

Palavras-chave: Confiança do Paciente, Medicina Concierge, Visão Baseada em Recursos, Teoria da Sinalização, Discrepância Cidadão-Consumidor, Gestão em Saúde.

Título: A Confiança como Ativo Estratégico: Explorar Serviços Premium de Concierge na

Saúde Autora: Victoria Scheer

Acknowledgments

I want to express my deepest gratitude to my supervisor, Professor Peter Rajsingh. His guidance was invaluable in helping me shape a research direction that genuinely interests and challenges me. I am sincerely thankful for his patience and his belief in my ability to bring this topic to life, offering wisdom and steady support even as the work evolved.

I am also profoundly thankful to all the medical professionals, healthcare executives, and patients who participated in this study. Special thanks go to the experts who generously shared their time and deep industry insights during the interviews, as well as to the 208 individuals who completed the survey. Given the limited time available to both physicians and patients in today's healthcare landscape, I sincerely appreciate the contributions of everyone who participated in this work.

Also, I would like to acknowledge that selected AI tools were used to enhance the efficiency of this research, specifically for language refinement, stylistic suggestions, and initial transcript summarization. However, the core analytical tasks - conceptual development, critical interpretation, and hypothesis formation - were conducted exclusively by the author. All AI-generated outputs were critically reviewed to ensure accuracy.

My heartfelt gratitude goes to everyone who has accompanied me on the path to this significant milestone. To my sisters and my stepfather, thank you for being such important companions on this journey. I am also deeply grateful to my American family, whom I was fortunate enough to meet along the way.

A very special thank you goes to my mum, Susanne, who has not doubted me for a single minute. Thank you for helping me navigate the right paths and for never leaving my side. I am equally grateful to my father, Oliver, and my stepmother, Susanne. Without you, my chapter in Lisbon would not have been possible. Thank you for your unwavering support - from connecting me with experts to patiently listening as I dissected the same topics for the tenth time. Finally, I want to thank my partner, Jan, whom I was lucky to meet in Lisbon this past year. Thank you for always putting a smile on my face, for your unwavering belief in me, and for challenging me to grow.

Table of Contents

List of Figures

List of Tables

List of Abbreviations

Abbreviation	Full Meaning
AI	Artificial Intelligence
CF	Conceptual Framework
CMS	Centers for Medicare & Medicaid Services
CQC	Care Quality Commission
DPC	Direct Primary Care
GDPR	General Data Protection Regulation
HIPAA	Health Insurance Portability and Accountability Act
IGeL	Individual Health Services (GER: *Individuelle Gesundheitsleistungen*)
KMV	Key Mediating Variable
M	Mean
MSc	Master of Science
n	Number
NHS	National Health Service
Ph.D.	Doctor of Philosophy
RBT	Resource-Based Theory
RBV	Resource-Based View
SD	Standard Deviation
SPSS	Statistical Package for the Social Sciences
UK	United Kingdom
US / U.S.	United States
VIF	Variance Inflation Factor
WFPTS	Wake Forest Physician Trust Scale

1. Introduction

Despite investment exceeding $4.9 trillion in the U.S. alone (CMS, 2024), healthcare systems in high-income regions face crises of efficiency and fragmentation. Demographic pressures and the prevalence of chronic disease have created a volume-based environment in which time is scarce. Consequently, patients often experience the system not as a place of care, but as an industrial process marked by rushed consultations and administrative barriers.

This creates a tension. As Berry and Bendapudi (2007) observe, "health care is a rare service that people need but do not necessarily want." Yet, it remains "arguably the most personal and important service that consumers buy." When this deeply personal need collides with an impersonal, volume-driven system, a critical shift occurs: Patients transition from passive recipients of treatment to active health consumers seeking agency, personalization, and responsiveness.

In this context, Concierge and Direct Primary Care (DPC) models have emerged not merely as luxury trends but as strategic market responses to the limitations of standard care. By charging an annual retainer fee in exchange for limited panel sizes, these models promise to restore the traditional doctor-patient dyad. They effectively commodify access while decommodifying time, offering 24/7 availability and extended visits as their core value proposition. What began in the mid-1990s as a niche service for the ultra-wealthy is now expanding globally, driven by a growing willingness among patients to pay out-of-pocket for what this dissertation defines as the *Intimacy Premium* - the relational certainty that public systems increasingly struggle to provide.

However, the impact of these models on *Patient Trust* - the psychological core of medicine - remains a paradox. Introducing a direct financial transaction creates tension. Advocates argue that fees foster trust by allocating time for benevolence; critics warn that commercializing access creates a two-tier system, potentially eroding trust by replacing moral obligations with contractual ones.

This dissertation addresses this tension. It moves beyond the ethical debate to empirically examine *how* premium service features - especially time, accessibility, and personalization - translate into *Patient Trust.* Specifically, the research aims to:

- Identify the strategic service levers (e.g., personalization, accessibility) that differentiate concierge models from standard care.
- Analyze how these features act as credible signals of competence, benevolence, and integrity, utilizing Signaling Theory and the Trust Model by Mayer et al. (1995).
- Investigate the tension between the "Citizen" (concerned with fairness) and the "Consumer" (seeking access) in the formation of trust.
- Provide managerial implications for healthcare providers on how to operationalize trust not merely as sentiment but as a strategic asset.

Accordingly, this dissertation is guided by the following Research Question: ***How do factors associated with concierge premium services influence patient trust in healthcare?***

This study bridges medical sociology and strategic management. It links established trust theories to concierge practices, applying Resource-Based Theory (RBT) and Signaling Theory to view trust as a capability that depends on the decommodification of time. It also shifts the patient's sociological perspective from passive recipient to active bearer of a *"mandate of trust"* (Skirbekk et al., 2023), providing empirical data on the "Willingness-to-Pay" for relational certainty.

2. Literature Review

Trust is the fundamental glue of social cooperation and a critical determinant of organizational success. In its most widely accepted definition, Mayer et al. (1995) describe it as

> "one party's willingness to be vulnerable to another, based on the expectation that the other will act in the trustor's best interests, regardless of the trustor's ability to oversee or control that party."

From this perspective, trust is not merely a calculated risk but a psychological readiness to rely on a trustee's perceived ability, benevolence, and integrity. Complementing this view, trust development is dynamic, evolving from rational "calculus-based" assessments to deeper, relational bonds formed through repeated interaction (Rousseau et al., 1998).

In the healthcare context, these dimensions are uniquely amplified by the inherent knowledge gap between patient and provider. Trust serves as a necessary bridge, enabling patients to accept the risks of treatment even when they cannot technically evaluate the physician's skills (Hall et al., 2001). Beyond reducing complexity, Mechanic (1998) posits that trust provides the essential context for cooperation, enabling doctors and patients to work together to set care objectives and seek reasonable ways to achieve them, acting as a buffer against systemic friction.

Recent scholarship has refined this understanding, moving away from trust as a static trait toward viewing it as an active authorization. Trust is also conceptualized as a negotiated "mandate" - a permission given by the patient that allows the physician to exercise professional judgment (Skirbekk et al., 2023). Crucially, this mandate is not a static attribute that physicians automatically possess; rather, it is a dynamic authorization granted by the patient, with scope that varies with the depth of the relationship. Consequently, the central question in modern healthcare - and particularly in premium services - is not just *whether* patients trust, but specifically *what* drives them to grant this mandate. The following section examines the specific dimensions of ability, benevolence, and integrity to build a theoretical foundation for understanding how this mandate is constructed.

2.1 Operationalizing Trust in Service Relationships

To move beyond abstract ideas, trust must be turned into measurable factors that influence perceived trustworthiness. As Mechanic (1998) notes, "trust is multidimensional, and some

aspects are more easily tested than others." Consequently, to empirically capture its influence, scholars rely on established frameworks that decompose this complexity into specific drivers. The most widely accepted framework identifies three key dimensions: ability, benevolence, and integrity (Mayer et al., 1995). *Ability* refers to specific skills and competence in each area. *Benevolence* indicates the extent to which a trustee acts for the benefit of the trustor rather than for selfish profit. *Integrity* involves adhering to principles that the trustor values, such as honesty and fairness.

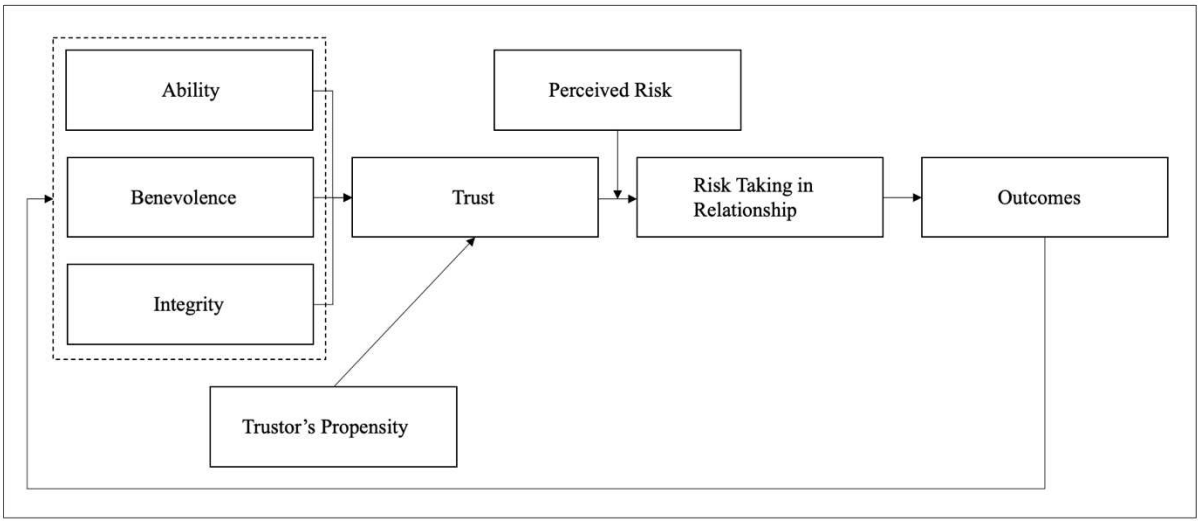


Figure 1: Proposed Model of Trust (Mayer et al., 1995)

As shown in Figure 1, these three factors determine the level of trust, which is influenced by the trustor's inherent trustworthiness. Significantly, this model differentiates trust from confidence. While confidence involves relying on predictable systems or results that require no decision, trust entails a deliberate willingness to be vulnerable amid uncertainty about another's actions (Mayer et al., 1995).

McKnight and Chervany (2001) introduce a topology relevant to complex service environments. Their framework distinguishes between disposition to trust (a general psychological tendency) and institution-based trust (a belief in structural safeguards such as regulations or guarantees), which, in turn, precede specific trusting beliefs (competence, benevolence, and integrity) and trusting intentions.

In the healthcare setting, these general dimensions translate into specific operational qualities described by Mechanic (1998). *Ability* equates to technical competence and clinical

judgment. *Benevolence* is operationalized as *Agency* - the assurance that the physician is acting solely in the patient's best interest rather than maximizing financial returns for stockholders. *Integrity* manifests as openness and the absence of conflicting incentives, ensuring that care decisions remain insulated from commercial pressures. This operationalization links theoretical ideas of vulnerability to observable actions in concierge medicine, where structural elements (such as membership models) and interpersonal interactions (such as extended time) interact to shape patients' trust.

2.1.1 Trust as a Strategic and Dynamic Resource

Beyond its behavioral definitions, trust serves as a vital strategic instrument. As relationships evolve from isolated transactions to continuous interactions, trust replaces rigid controls, lowering transaction costs and enhancing predictability (Berry, 1995; Rousseau et al., 1998). Within the Resource-Based View (RBV), now termed Resource-Based Theory, trust is a socially complex, path-dependent resource. Unlike physical assets, which are perfectly imitable, their "imperfect imitability" confers a sustainable competitive advantage, enabling organizations to differentiate through authentic relationships rather than price (Barney, 1991). Notwithstanding critiques of the RBV for being tautological and for factors being knowable only ex post facto (Priem and Butler, 2001), the framework is applied as a useful heuristic in our analysis.

Complementing the RBT, the Dynamic Capabilities framework explains how organizations mobilize this resource. Barreto (2010) offers a comprehensive conceptualization, defining dynamic capabilities as

> "[...] the firm's potential to systematically solve problems, formed by its propensity to sense opportunities and threats, to make timely and market-oriented decisions, and to change its resource base."

In the context of concierge medicine, trust acts as the operational catalyst for each of these dimensions:

1. **Sensing:** High-trust relationships facilitate transparent dialogue, allowing providers to accurately "sense" subtle health risks before they escalate.
2. **Seizing:** Trust removes the friction of skepticism. Patients act on recommendations immediately, enabling critical speed in high-velocity environments.

3. **Transforming:** Trust ensures that patients accept new care strategies (e.g., shifting from preventive to acute care) without hesitation, thereby allowing providers to reconfigure services effectively.

Empirical research confirms the strategic value. Trust mediates the link between communication quality and loyalty (Diouri et al., 2025; Pokhilenko et al., 2021) and boosts treatment adherence (Rao et al., 2025). Consequently, the systematic operationalization of trust is a core driver of sustainable value creation.

2.1.2 Theoretical Frameworks of Trust Formation

Three main theoretical perspectives explain the formation, signaling, and maintenance of trust in service relationships: Signaling Theory, Social Exchange Theory, and Relational Marketing Theory.

Signaling Theory addresses how trust forms in the absence of direct experience and amid information asymmetry. To reduce uncertainty, people rely on observable signals to infer unobservable qualities. For a signal to be convincing, it must be credible and costly to imitate (Spence, 1973). In high-end healthcare, credentials, exclusivity, and transparent communication serve as signals that help patients assess competence and integrity before engaging in clinical care.

Social Exchange Theory holds that trust develops through repeated, mutually beneficial interactions. Unlike economic exchange, which depends on formal contracts, social exchange hinges on future commitments that are not specified in advance, making trust crucial for stability (Blau, 1964). In healthcare, this reciprocity manifests as patients trusting professional expertise, while providers reciprocate with care. Successful exchanges build expectations of reliability and fairness, reducing uncertainty and aligning with the dimensions of ability, benevolence, and integrity (Mayer et al., 1995).

Once established, Relational Marketing Theory explains how trust is maintained. Rather than focusing on individual transactions, this approach emphasizes long-term engagement (Berry, 1995). Central to this is the Commitment-Trust Theory, which holds that successful relationship marketing requires both trust and commitment. In this Key Mediating Variable

(KMV) model, trust serves as a primary mediator linking relational antecedents, such as shared values and communication, to cooperative outcomes (Morgan & Hunt, 1994).

As shown in Figure 2, trust enhances commitment, boosting cooperation and reducing conflict. This is critical for intangible services where pre-purchase assessment is impossible. Collectively, these frameworks map the trust dynamic: Signaling Theory explains initiation, Social Exchange accounts for development, and Relational Marketing ensures endurance. In concierge medicine, these processes function simultaneously to sustain the patient-provider bond.

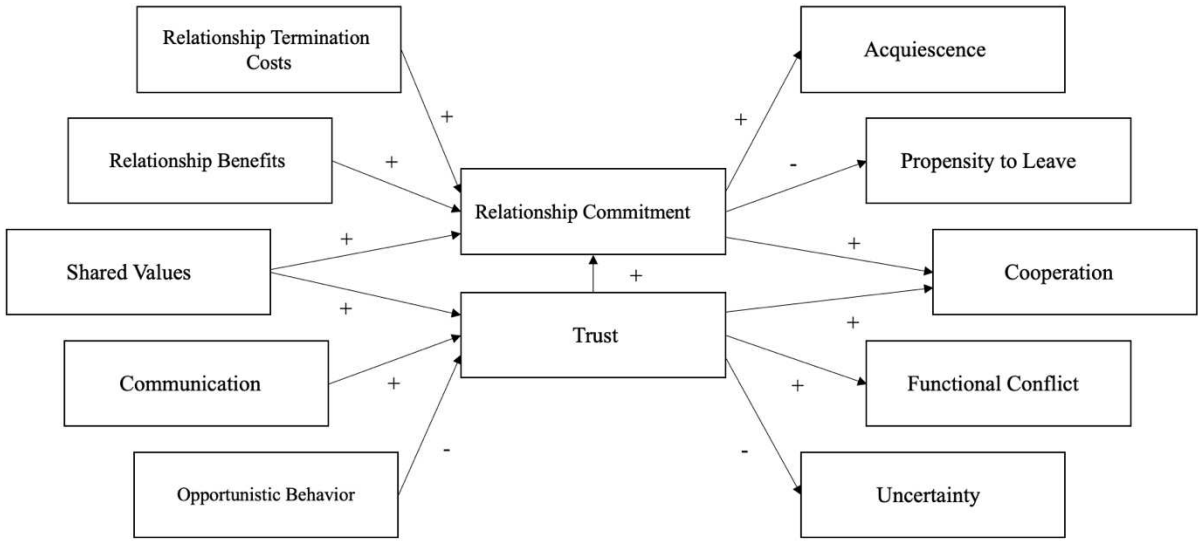


Figure 2: The Commitment-Trust Theory (Morgan & Hunt, 1994)

2.2 The Ecosystem of Healthcare Trust: Foundations and Determinants

Healthcare trust operates on interdependent levels: interpersonal trust in clinicians and institutional trust in the system (Campos-Castillo et al., 2015). These levels reinforce one another; confidence in the system buttresses trust in individual providers. To capture these dynamics, Hall et al. (2001) adapted Mayer et al.'s (1995) framework to develop the Wake Forest Physician Trust Scale (WFPTS). This model operationalizes trust through four core clinical behaviors: fidelity, competence, honesty, and confidentiality.

To sustain these dimensions - especially fidelity and competence - trust relies equally on relational quality and organizational structure. While communication and empathy facilitate shared decision-making (Whitney et al., 2021), continuity of care is essential to the structure.

Consistent interactions build strong relationships, correlating with higher adherence and efficiency (Wiedermann, 2025). Skirbekk et al. (2023) reframe trust as a dynamic "mandate." While episodic care implies a "narrow mandate," premium care supports a "wide mandate," granting physicians latitude to manage complex needs. This creates a buffer against conflict, establishing the context for cooperation (Mechanic, 1998).

However, market structures can undermine this bond. High trust reduces the need for second opinions (Hall et al., 2001). Conversely, if for-profit motives prioritize commercial interests over patient welfare, patients are forced to act as vigilant consumers rather than trusting recipients (Mechanic, 1998). Consequently, trust serves as the vital mechanism linking human interaction with institutional reliability.

2.3 The Rise of Healthcare Consumerism

Healthcare has shifted from a hierarchical model to an autonomy-based model, positioning patients as informed evaluators who integrate medical logic with consumer expectations. This evolution has driven the emergence of Concierge and Premium Models, blending clinical excellence with responsiveness to redefine access and trust (Lawlor, 2025).

2.3.1 From Patients to Consumers

The transition from "patient" to "consumer" is complex, shaped by layered motivations and systemic changes. Iliffe and Manthorpe (2020) outline three developmental stages: a pushback against medical paternalism, market-driven self-optimization, and systemic efforts to shift responsibility and costs to individuals. Furthermore, trust is complicated by commodification, as the emotional vulnerability inherent in illness often precludes patients from acting as purely rational evaluators (Lupton, 1997).

Psychologically, this shift aligns with Self-Determination Theory (Ryan & Deci, 2000). Patient motivation focuses not on total control - often unattainable - but on fulfilling fundamental needs for autonomy (experiencing actions as voluntary) and competence (feeling capable of handling challenges). Clarke et al. (2007) describe the "Citizen-Consumer" as a hybrid identity: the patient supports public equity in their role as a *citizen*, but simultaneously seeks efficiency and personal choice as a *consumer*. Thus, while supporting universal solidarity in theory, the

practical pursuit of responsiveness leads patients towards exclusive solutions that, in practice, endorse the fragmentation they oppose in principle.

However, applying marketing principles requires caution. Berry and Bendapudi (2007) emphasize that healthcare consumers differ from typical customers: they are "sick," "reluctant," and "at risk." Patients, unlike voluntary shoppers (and except for elective procedures such as plastic surgery), often undergo unwanted services that involve a loss of privacy and autonomy. Consequently, patients oscillate between seeking control when stable and requiring protective care when vulnerable (Lupton, 1997).

In this context, trust evolves from assumed authority to knowledge-based validation. Patients use acquired information not to challenge doctors but to simplify processes and restore control in an intimidating system (Conradsen et al., 2023).

Regarding digital tools, evidence suggests they do not distance patients from providers but significantly strengthen trust (François et al., 2024). The use of digital tools is primarily mediated by increased trust, suggesting that consumer-oriented tools serve as a bridge to physicians rather than a barrier.

2.3.2 Dimensions of Concierge and Direct Primary Care Models

To address the demands of evolving consumers, Concierge and Premium Models have emerged as strategic responses to fragmented, high-volume systems (Stange et al., 2023). These models reshape the physician-patient relationship by valuing time and attention, resources often limited in standard care.

While meeting similar market needs, their financial models differ. Concierge Medicine typically requires an annual retainer fee alongside insurance billing, offering 24/7 availability and extended consultations (Serna, 2019). Conversely, DPC charges a single flat membership fee, avoids insurance billing, and emphasizes transparent pricing (Lawlor, 2025). Despite the operational differences, both models incorporate what this dissertation calls an *Intimacy Premium*. This concept highlights highly personalized attention as the primary value driver (De Santiago et al., 2021). By reducing panel sizes - typically to 300-600 patients - physicians reintroduce deep familiarity as a service quality. However, this commodification

creates a paradox: while boosting trust among payers, it risks reframing relational care as a luxury, thereby eroding the solidarity underpinning the system (Sorell, 1997).

Crucially, since both models share the core values of access, time, and personalization, this dissertation refers to them collectively as "Concierge and Premium Services" (or, for brevity, "Concierge Models"). The psychological process of trust formation - driven by purchased access and relational continuity - remains consistent across both formats.

2.3.3 Market Drivers and Systemic Implications

The expansion of these Concierge Models is not a fleeting trend but a structural response to systemic failure. On the supply side, traditional private practices are financially unsustainable due to reimbursement constraints, prompting physicians to seek alternative delivery models (Johnsonwall et al., 2021). On the demand side, patients facing growing fragmentation and excessive wait times seek models that promise reliable access (Hoffman & Ganguli, 2026).

However, satisfying this demand through privatization carries significant structural risks, most notably the creation of a two-tiered system. Evidence from the UK indicates that as the private sector develops, it can exacerbate geographic disparities and waiting-time inequalities among those remaining in the public system, effectively segregating access by financial capacity rather than clinical need (Kirkwood & Pollock, 2025; McCann et al., 2024).

Beyond structural inequality, this poses a profound ethical challenge. As market norms increasingly govern the doctor-patient relationship, care risks commodification, resembling a consumer product rather than a moral obligation, thereby shifting the interaction to a private transaction (Neczypor, 2025; Wildes, 1999). In this context, the attentiveness central to healing is reframed not as a professional duty but as a purchasable privilege, questioning the equity and social contract of medicine (Sandel, 2012).

2.4 Trust Dynamics in Concierge and Premium Models

In this commodified landscape, trust shifts from an implicit institutional assumption to an explicit value proposition. In concierge models, trust is no longer granted solely by medical authority; instead, it is actively engineered through deliberate continuity, enhanced

accessibility, and proactive engagement. By leveraging personalized service to mitigate the impersonality of standard systems, these models transform trust from a strategic trait into a carefully crafted outcome of the service encounter.

2.4.1 Mechanisms of Trust Cultivation

In relationship-based models, time serves as the essential moderator linking financial investment to patient trust. Unlike high-volume settings where time is scarce, concierge models intentionally reframe it as a resource for continuity. While fragmented systems threaten relationship-based care, the concierge model restores conditions for continuity, allowing physicians to accumulate personal knowledge through repeated interactions rather than treating patients as isolated cases (Rudebeck, 2019). Viewed through Social Exchange Theory, this reciprocity transforms the interaction from a spot contract into a continuous commitment, where trust grows through repeated, mutually beneficial exchanges (Blau, 1964). This temporal luxury enables deeper trust formation. Patients evaluate healthcare settings through a multi-dimensional process: emotional cues (feeling welcome), cognitive efforts (obtaining an environmental overview), and normative assessments (judging if it is a "good place to be") (Conradsen et al., 2023). In the unhurried context of concierge care, these dimensions are positively reinforced, allowing the patient to reduce complexity and engage fully in the treatment process.

Furthermore, interaction quality is enhanced by prioritizing relational depth. The Senses Framework (Nolan et al., 2006) posits that effective care relationships must go beyond medical tasks to create a sense of security, belonging, and significance, qualities often lost in unidirectional, paternalistic encounters (Hutchison et al., 2021). This focus aligns with "interactional fairness": when patients perceive they are treated with politeness, respect, and adequate explanation, satisfaction and loyalty increase significantly (Dwidienawati et al., 2018).

2.4.2 Access, Transparency, and Perceived Fairness

Complementing the temporal dimension, the mechanics of access fundamentally shape trust. Visible coordination and procedural clarity are essential for establishing institutional

credibility (Elbers et al., 2016). However, linking payment directly to access introduces ethical friction.

While prompt responsiveness strengthens the doctor-patient dyad, risks arise when the relationship shifts from an ethical commitment to a contractual entitlement. This commercialization reframes patient expectations from traditional gratitude to consumerist demand (Sorell, 1997).

Empirically, the advantage of these models lies in superior accessibility. Private coverage provides significantly better access than safety-net programs (Wray et al., 2021). This parallels concierge settings, in which immediate availability is central (De Santiago et al., 2021). However, this selectivity reinforces structural disparity. While responsiveness strengthens bonds within the privileged group, the resulting inequality erodes perceptions of fairness among those with limited access, who view the market-driven system as inequitable (Lakhan et al., 2020). Consequently, the emerging two-tier system (McCann et al., 2025) challenges the universality of trust, creating pockets of high relational security amid a broader landscape of systemic skepticism.

2.4.3 Risks to Authentic Trust

The monetization of access introduces a distinct psychological risk: a threat to the authenticity of trust. When membership fees define interaction, the nature of the relationship is brought into question (Wildes, 1999). While concierge models structure the conditions for continuity, genuine relationship-based care relies on organic bonding, which cannot be manufactured through administrative design (Rudebeck, 2019).

If the encounter is perceived as purely transactional, it triggers an attributional dilemma. The patient may question whether the physician's attentiveness stems from genuine benevolence (a core dimension of trust) or merely contractual compliance. Consequently, the bond risks erosion, as the Intimacy Premium may be interpreted not as a sign of professional altruism, but as a purchased performance (Sandel, 2012).

2.4.4 Comparative Trust Paradigms

Despite these authenticity risks, comparative analysis reveals a clear bifurcation in trust logic. Concierge medicine fosters trust through proximity, rapid responses, and personalized care, driven by the Intimacy Premium. From a Signaling Theory (Spence, 1973) perspective, high membership fees serve not merely as barriers but as credible signals of a commitment to low patient volume, thereby structurally ensuring the capacity to deliver this premium experience.

In contrast, conventional systems derive legitimacy from standardization and broad inclusivity. While concierge care relies on exclusivity to guarantee responsiveness, traditional models rely on institutional stability to ensure equity. This creates a fundamental divergence: the former sells certainty through access, while the latter sells safety through system-wide standards.
The distinguishing feature of private models is not necessarily superior *clinical outcomes* but rather the rigorous prioritization of *access* (Wray et al. 2021). Consequently, their advantage lies in effectively operationalizing accessibility and relational continuity. By transforming these abstract values into tangible service features, they establish a distinct trust paradigm that serves as a strategic asset.

2.5 Conclusion: Trust as the Relational Foundation of Concierge Care

In concierge and DPC models, trust functions not merely as sentiment but as the central relational mechanism that bridges commercial exchange and a genuine care partnership. The literature shows that operationalizing accessibility, continuity, and personalization fundamentally transforms physician-patient interactions. Specifically, these features extend the "narrow mandate" of episodic care into a "wide mandate of trust" (Skirbekk et al., 2023), granting physicians the discretion to manage complex needs. This relational depth establishes a resilient context for cooperation, insulated from systemic friction (Mechanic, 1998).

Beyond its clinical utility, this accumulated trust is a critical intangible asset. Consistent with the RBT, cultivating deep, high-trust relationships is a rare, socially complex resource that is imperfectly imitable (Barney, 2021). Consequently, trust serves as a dynamic capability, enabling providers to sense needs and reconfigure care resources effectively (Barreto, 2010).

However, a specific theoretical and empirical gap persists. While research links trust to downstream outcomes such as loyalty (Morgan & Hunt, 1994), the particular precursors in this premium context remain unclear. Existing literature often conflates high service levels with high trust, failing to isolate the underlying mechanisms. A critical lacuna remains regarding how tangible features, such as 24/7 access, specifically activate the psychological antecedents of ability, benevolence, and integrity (Mayer et al., 1995), especially given the risk that commercial motives may undermine the moral neutrality of care (Sandel, 2012).

Therefore, this dissertation addresses this gap by shifting the analytical focus from outcomes to determinants. It seeks to explain *how* concierge premium services influence patient trust by identifying the specific service design features that drive this effect. By clarifying these causal links, this research provides the empirical foundation for understanding how concierge models operationalize trust not only as a service outcome but also as a resilient strategic asset.

3. Methodology

3.1 Conceptual Framework

This conceptual framework (CF) positions the dependent variable - *Patient Trust* - as the central outcome of specific service design features within concierge care (Figure 3). Building on established trust theory, it examines how interpersonal and organizational characteristics shape perceptions of trustworthiness. Trust is understood as a multidimensional construct, following the definition proposed by Mayer et al. (1995), who describe it as a willingness to accept vulnerability based on expectations of ability, benevolence, and integrity. In healthcare, these dimensions manifest through professional competence, empathetic engagement, and structural transparency. Trust is formed through psychological mechanisms associated with expectations of competence and goodwill, through relational processes grounded in repeated interactions, continuity, and empathetic communication, and through organizational features such as accessibility, availability, and coordinated care.

The proposed model links key elements of concierge service design - personalization, accessibility, empathy, and continuity - directly to the formation of patient trust. Unlike broader strategic models, this study focuses on identifying the antecedents of trust rather than exploring downstream outcomes such as loyalty or retention. To account for the socioeconomic context inherent in premium healthcare services, perceptions of fairness and insurance status are included as moderating factors that may strengthen or weaken these relationships.

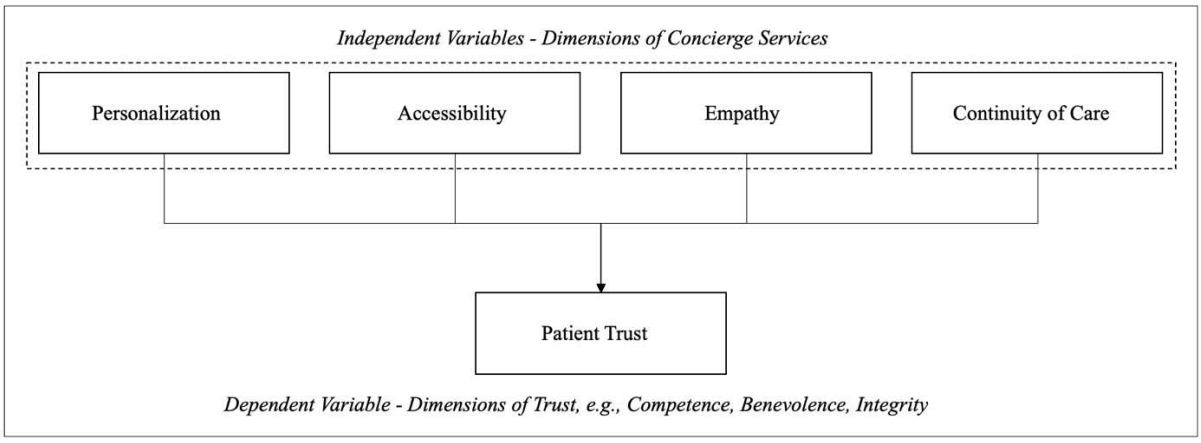


Figure 3: Conceptual Model

This framework provides the theoretical foundation for the empirical analysis. Given the complexity of trust formation in premium care settings, a mixed-methods approach is used to capture both the depth of professional insights and the scope of patient perspectives.

3.2 Hypotheses Development

To empirically test the CF, seven hypotheses were formulated regarding the impact of concierge service features on patient trust. While H_1-H_5 examine the direct effects of service attributes and fairness concerns, H_6 and H_7 address the moderating influence of contextual factors such as insurance status and decision confidence.

- **H_1:** Personalization positively affects patient trust in healthcare providers.
- **H_2:** Accessibility positively affects patient trust in healthcare providers.
- **H_{3a}:** Empathy shown by nursing staff positively affects patient trust.
- **H_{3b}:** Empathy shown by reception staff positively affects patient trust.
- **H_4:** Continuity of care positively affects patient trust in healthcare providers.
- **H_5:** Fairness concerns regarding concierge care negatively affect patient trust in healthcare providers.
- **H_6:** The positive effect of accessibility on patient trust is stronger among publicly insured patients than among privately insured patients.
- **H_7:** Patients who choose the premium care model report higher confidence in their choice than patients who choose standard care.

3.3 Research Design

This study employs an exploratory sequential mixed-methods design. As illustrated in Figure 4, the research follows an abductive approach, integrating inductive insights from expert interviews (Phase 1) to inform the deductive quantitative analysis of a patient survey (Phase 2). This combination balances the exploration of complex social dynamics with the statistical generalizability required to test specific trust drivers (Mayring, 1991; Röbken & Wetzel, 2016).

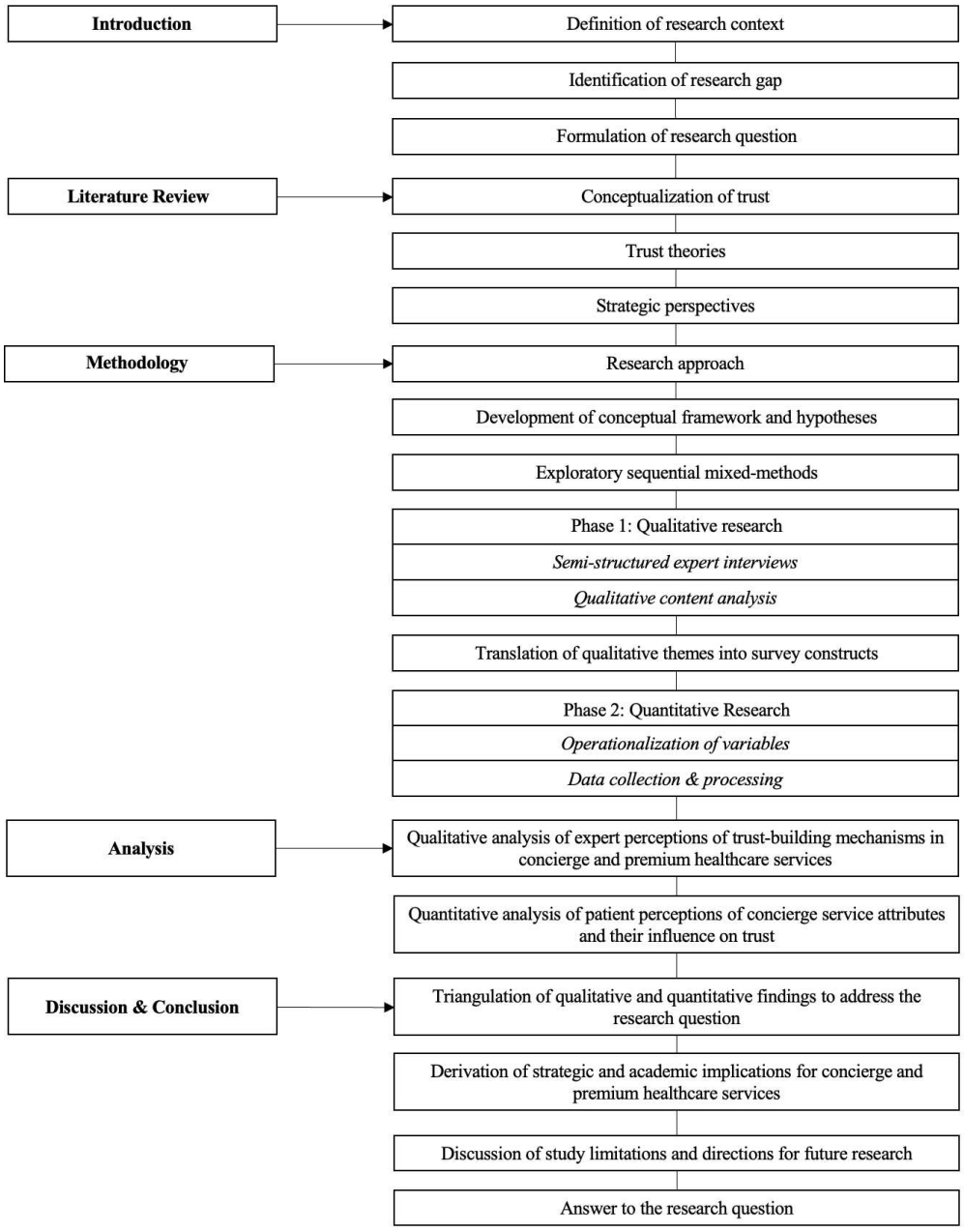


Figure 4: Research Design (Exploratory Sequential)

3.4 Phase 1: Qualitative Research (Expert Interviews)

3.4.1 Data Collection

To capture nuanced insights into professional reasoning, semi-structured interviews were conducted with twelve experts from clinical practice, healthcare management, and premium services (Table 1).

Table 1: Overview of Interview Participants and Professional Backgrounds

Code	Professional Role & Expertise	Sector / Domain
E01	Case manager in a clinical environment with experience in patient coordination, waiting-list management, and privately financed healthcare services.	Clinical operations
E02	Senior Director of Operations at a U.S. healthcare revenue management organization with expertise in operational efficiency, cost management, and patient satisfaction.	Healthcare management/revenue cycle
E03	Entrepreneur and former senior executive with international experience in strategic management and premium service operations.	Business/premium services
E04	Board-certified physician with clinical experience across inpatient and outpatient settings, including diagnostics and long-term disease management.	Clinical practice
E05	General practitioner with experience in preventive care, outpatient diagnostics, and long-term patient management.	Primary care
E06	Senior director in U.S. healthcare revenue cycle management, overseeing patient experience and operational planning; personally uses concierge medicine.	Healthcare consulting/revenue cycle
E07	Clinical lead in geriatric care and Chief Medical Officer at a digital health institute, with expertise in medical technology and pharmaceutical innovation.	Digital health / clinical leadership
E08	Executive leader in a regional hospital group in Germany, responsible for financial steering, digitalization, and clinical governance.	Hospital management
E09	Director of a concierge medical practice in the United Kingdom, specializing in personalized primary care and continuity-based patient relationships.	Concierge medicine / primary care
E10	Executive in the cooperative banking sector with expertise in healthcare financing structures and cost models; oversaw financial integration in a hospital merger.	Healthcare financing/governance
E11	Medical director at a German university hospital specializing in cardiac and vascular surgery and clinical innovation.	Clinical leadership/surgery
E12	Care coordinator in a U.S. concierge medicine program, responsible for patient navigation, membership services, and ensuring quick, personalized access to physicians.	Concierge Care Coordination

The interview guide employed open-ended questions grounded in the theoretical background (Appendix A). Interviews were conducted in person or via Microsoft Teams; both methods are acceptable for expert research when a professional setting is maintained (Von Soest, 2023). Data collection concluded when theoretical saturation was reached at the twelfth interview, as

no new themes emerged. The insights from the interviews shaped the subsequent patient survey, ensuring that professional perspectives and empirical measurement were aligned.

3.4.2 Qualitative Data Analysis

The interview transcripts were analyzed using qualitative content analysis, following Mayring (2015). This systematic, rule-guided procedure enabled the identification of central themes in trust-building and fairness. The analysis proceeded in three steps:

- **Summary:** Interview statements were condensed to their essential content to highlight recurring themes and eliminate irrelevant details.
- **Explanation:** Ambiguous passages were clarified by adding contextual information to ensure accurate interpretation.
- **Structuring:** Categories were inductively developed from the text, organizing data into a clear system of trust drivers and service attributes.

The final coding structure and the resulting themes derived from this process are presented in detail in Chapter 4 (Findings). An overview of the coding tree is provided in Appendix B.

3.5 Phase 2: Quantitative Research (Patient Survey)

Complementing the qualitative phase, a cross-sectional patient survey was conducted to confirm findings on a broader scale. The survey was administered online through Qualtrics, enabling efficient, geographically diverse data collection with minimal researcher involvement (Creswell & Hirose, 2019). The questionnaire primarily employed closed-ended items (Likert scales, matrix questions) to assess service attributes, trust dimensions, and behavioral intentions.

3.5.1 Instrument Development

The instrument was developed by translating the qualitative themes identified in Phase 1 into quantitative constructs (see Appendix C for the whole survey instrument).

- **Operationalization:** Core themes (*Personalization, Accessibility, Continuity, Empathy,* and *Fairness*) were connected to specific survey variables and assessed using 5-point Likert scales.

- **Scenario-Based Items:** To understand decision-making processes, the survey included hypothetical scenarios in which respondents had to weigh options across cost, availability, and continuity. These scenarios directly mirrored the real-world dilemmas discussed by experts in the interviews.

3.5.2 Operationalization of Variables

Variables were constructed from survey items to measure the research model's main dimensions. Unless otherwise noted, items were rated on 5-point Likert scales (1 = "strongly disagree" to 5 = "strongly agree"). Multi-item constructs were calculated as average scores. Internal consistency was evaluated using Cronbach's Alpha. According to Hair et al. (2010), while values above .70 are usually preferred, values between .60 and .70 are acceptable in exploratory research. Constructs below this threshold were carefully examined for their theoretical significance.

- **Personalization:** Reflects perceptions of the consultation as individualized, precise, and attentive. It was assessed through four items: time investment, explanation quality, attentiveness, and alignment with patient interests. These items formed a cohesive measure (Cronbach's $\alpha = .460$). Despite its lower internal consistency, this construct was retained because it reflects a core multidimensional feature of concierge care identified in the qualitative phase. Given the novelty of research on trust in patient healthcare systems and the exploratory nature of this study, this level of consistency was deemed acceptable.
- **Accessibility:** Assessed using two indicators: perceived appointment promptness and waiting-time category (recoded to an ordinal scale). An average score was calculated to represent overall accessibility **(**Cronbach's $\alpha = .605$).
- **Empathy (Reception Staff):** Assesses politeness and respect during the first interaction. Doctor interactions were intentionally excluded to prevent overlap with personalization and trust (Single-item measure).
- **Empathy (Nursing Staff):** Assesses politeness and competence during the pre-consultation/vital signs phase. Similar to the reception variable, this focuses exclusively on specific staff interactions to test H_{3a}/H_{3b} separately (Single-item measure).
- **Patient Trust:** The dependent variable, measured using two items assessing perceived professional competence and overall trust in the physician or practice (Cronbach's $\alpha = .627$).

- **Choice Confidence:** For H7, respondents were categorized based on their choice in the scenario-based question (Standard vs. Premium). Confidence was assessed using a combined score of four items: intention to continue, likelihood to recommend, perceived benefit, and "Willingness-to-Pay" (Cronbach's α = .628).
- **Continuity of Care:** Assessed by a question asking if respondents are usually cared for by the same doctor or medical team, indicating consistency in the care relationship.
- **Fairness Concerns:** A single indicator assessing whether respondents view the limited affordability of premium services as problematic.

An item-level overview of all constructs is provided in Appendix D.

3.5.3 Data Collection and Processing

Data cleaning was performed on the initial dataset of 258 responses to improve reliability and consistency. A total of 50 cases were excluded based on three strict criteria:

- **Incompleteness and Irrelevance ($n = 6$):** Responses with missing key data or participants reporting no healthcare visits in the past 12 months.
- **Attention Check Failure ($n = 5$):** Participants who failed the embedded quality control item.
- **Insufficient Completion Time ($n = 39$):** A minimum threshold of 120 seconds was set for proper processing. Responses below this limit were discarded.

After applying these exclusion criteria, the final sample for quantitative analysis consisted of $n = 208$ valid responses.

3.5.4 Sample Description

The final dataset shows a nearly equal gender distribution (51.0% male, 49.0% female) with an average age of 35 years ($\mathrm{SD} = 7.81$).

A key feature of the sample is the high rate of private insurance coverage (66.8%), which substantially exceeds that of the publicly insured group (32.7%). This imbalance suggests that the sample has a higher socioeconomic status, which is relevant to the analysis of premium services. Geographically, most respondents live in urban areas (68.3%). Income levels are

predominantly in the middle-to-upper ranges, with more than 60% earning between €25,000 and €75,000 annually.

Regarding health status, 39.4% of respondents reported at least one chronic condition. Healthcare utilization was high, with 88.0% of participants visiting a provider at least three times in the past 12 months. An overview of all variables, including absolute numbers and percentages, is provided in Table 2.

Table 2: Sample Characteristics and Descriptive Statistics

Variable	Category	n	%
Gender	Male	106	51.0
	Female	102	49.0
Age	Mean (SD)	34.99 (7.81)	-
	Range	20–65	-
Insurance Type	Public	68	32.7
	Private	139	66.8
	Other/None	1	0.5
Chronic Conditions	Yes	82	39.4
	No	118	56.7
	Prefer not to say	8	3.8
Income	Under €25,000	11	5.3
	€25,000–€49,999	62	29.8
	€50,000–€74,999	66	31.7
	€75,000–€99,999	53	25.5
	€100,000 or more	12	5.8
	Prefer not to say	4	1.9
Healthcare Usage	1–2 times	19	9.1
	3–5 times	111	53.4
	6–10 times	72	34.6
	>10 times	6	2.9
Living Area	Rural	66	31.7
	Urban	142	68.3

3.6 Validity, Reliability, and Ethical Standards

- **Quality Criteria:** To ensure qualitative reliability, interviews were fully transcribed and analyzed using a rule-guided, transparent coding process. Researcher bias was minimized through post-interview reflections and peer debriefing, while acknowledging the inherent subjectivity of qualitative interpretation. Construct validity was supported by the study's mixed-methods design. The quantitative survey was grounded in themes derived from the qualitative findings, ensuring an alignment between theoretical concepts and the empirical variables tested (Saunders et al., 2023).
- **Ethical Considerations:** Ethical standards were meticulously upheld throughout the study. Participants were informed of the research objectives and their right to withdraw at any time. Informed consent was obtained before data collection. To protect privacy, all personal identifiers were removed from transcripts, and data were stored securely with limited access (Saunders et al., 2023).

4. Results

4.1 Introduction to the Qualitative Analysis

This chapter presents the descriptive findings derived from the qualitative content analysis of the expert interviews (see Appendix E for detailed summaries). The structure follows the inductively identified themes, ranging from trust foundations and access barriers to future developments in healthcare. Theoretical interpretation and integration are addressed in the discussion (Chapter 5).

4.2 Thematic Findings from the Expert Interviews

4.2.1 Foundations of Trust in Healthcare Encounters

Experts described trust as a relational construct shaped mainly through interpersonal interactions. A recurring theme was the importance of time, attentiveness, and clear communication, which several experts considered essential for trust in clinical settings. Experts stressed that patients monitor whether professionals listen carefully, allow space for concerns, and remain calm despite time pressures. One expert noted, "Patients feel it immediately when you are not fully present with them" (E01). This focus on presence and attentiveness was often echoed, especially among clinical practitioners. E03 similarly emphasized that many patients rely on subtle emotional cues to feel understood, underscoring the importance of personal presence in trust building.

Another key element was professional competence, both perceived and demonstrated. Many clinicians noted that patients rely on visible signs of expertise, such as confident explanations, structured procedures, and smooth teamwork. E11 said, "Competence is not just about making the right decision; it is about showing that the patient is in safe hands." Clinicians in surgical and emergency settings (e.g., E04, E05, E11) emphasized that clear, consistent procedures reinforce this trust, especially in uncertain situations.

Continuity of care was considered vital to trust. Experts working with patients over long periods (E09, E12) described how familiarity, repeated contact, and stable relationships help patients feel understood and taken seriously. Maintaining this continuity is more difficult in fast-paced, fragmented healthcare environments, where patients often see multiple providers in a short time.

Experts identified factors that erode trust, often stemming from systemic issues. Rushed appointments, limited availability, and visible overload were repeatedly cited as indicators of reduced patient confidence (E01, E02, E06). Administrative problems, such as conflicting information, lost documents, or unclear roles, were also perceived as damaging, creating an impression of a disjointed system (E02, E06). Some experts noted that misinformation and online self-diagnosis can also undermine trust, as patients may bring conflicting expectations or skepticism (E04, E05).

Several interviewees observed a shift in how trust is built, driven by societal and technological changes. Patients are now seen as more informed and assertive, with higher expectations for transparency, shared decision-making, and quality of care (E05, E11, E12). A few experts also reported a general decline in institutional trust, which necessitates that professionals place greater emphasis on personal reassurance (E07, E08).

Overall, interviews indicated that trust arises from interpersonal behaviors, perceived competence, and systemic conditions. While there was general agreement on the key trust-building elements, experts noted that contemporary healthcare environments increasingly challenge the consistent delivery of these elements.

4.2.2 Structural Access Barriers and Perceived Inequality

Experts consistently highlighted systemic constraints in healthcare that influence patient access and, at times, lead to perceived inequalities. A common theme was the limited availability of healthcare professionals, resulting in long waits, shorter consultations, and scheduling difficulties. Several experts linked these issues to workforce shortages and increased patient demand. E06 noted, "The system is simply overstretched. Patients feel the pressure long before they even reach the consultation room." Similar comments from E01, E02, and E08 indicated that delays and capacity issues are visible to patients and undermine their sense of support.

Fragmentation of care and unclear responsibilities were identified as barriers to timely, coordinated access. Leaders such as E07 and E08 observed that patients often struggle to navigate among specialties, referrals, and institutions. This fragmentation creates uncertainty about whom to approach, especially for those with complex or chronic conditions relying on multiple providers.

Several interviewees pointed out regional disparities in service availability. Access to specialists, diagnostic services, and timely appointments varies widely across regions, with rural areas facing greater staffing shortages and infrastructure constraints. E11 describes cases in which patients must travel long distances for specialized treatment, leading to delays and logistical challenges.

Another recurring theme was the impact of socioeconomic and personal resources on patients' ability to navigate the system effectively. While experts avoided framing the system as deliberately unequal, many recognized that individuals with better confidence, health literacy, or social networks often succeed more in securing appointments or understanding next steps (E01, E02, E03, E09, E12). As one expert said, "not everyone has the same ability to push through the system" (E02). These subtle but influential dynamics shape perceptions of fairness. E03 noted that some patients also have difficulty articulating their concerns clearly, which can disadvantage them in a system that often values assertiveness.

Lastly, experts highlighted operational pressures, such as administrative tasks, documentation, and high patient volumes, that indirectly limit access by reducing flexibility and time for coordination (E02, E06, E07). Although these pressures stem from systemic issues, several interviewees noted that patients often interpret delays or brief interactions as personal rather than structural.

Finally, interviews indicated that organizational and systemic constraints primarily cause access barriers, though their effects vary across patient groups. These disparities may lead to perceptions of inequality, even if the underlying causes are not intentionally discriminatory.

4.2.3 Expert Perceptions of Concierge and Premium Healthcare Models

Several experts noted that the growing interest in concierge models highlights structural gaps in standard care, especially regarding time and coordination. These healthcare models were described as service arrangements designed to provide patients with accessibility, continuity, and coordination that are increasingly difficult to achieve in typical healthcare systems. Experts generally agreed that their main features are not about superior medical expertise but about the service environment that enables more time, proactive communication, and personalized navigation.

A central theme was that concierge care reorganizes the patient journey rather than the clinical content. Experts with direct experience (E09, E12) emphasized that patients value having a consistent point of contact who manages referrals, anticipates needs, and reduces delays. One expert described it as "removing the uncertainty between steps," noting that the benefit lies in smoothing transitions rather than altering medical decisions. This sense of structured guidance was often associated with greater reassurance for patients, especially those with chronic or complex conditions.

Many experts also highlighted the importance of relational continuity within concierge settings. Unlike traditional settings where patients often see multiple providers, concierge models enable more stable, ongoing relationships. Several interviewees noted that familiarity enables a deeper understanding of patient histories, personal preferences, and contextual factors that influence care. As E09 observed, "continuity creates a different kind of conversation," suggesting that relational depth can alter the dynamic of clinical encounters.

Extended time and greater availability were also seen as defining traits. Experts noted that longer appointments, flexible scheduling, and direct communication channels provide patients with a level of attention that is rarely available in standard care. E12 noted that patients appreciate having "room to talk through everything without feeling rushed," a sentiment supported by clinicians, who said such conditions enable more thorough assessments and fewer unresolved questions. The consistent focus on time suggests that concierge models address a structural gap rather than creating an entirely new form of medicine.

Despite these advantages, experts expressed concerns about cost and fairness. Interviewees in leadership roles (E01, E07, E08) noted that concierge services create a distinction based on financial ability, offering access to enhanced services that are not universally available. These concerns were framed less around clinical inequality and more about disparities in comfort, convenience, and responsiveness. One expert remarked that concierge care "does not change the quality of medical decisions, but it changes the experience around them," highlighting the tension between equitable treatment standards and differentiated service environments.

Some experts also discussed the reliance on organizational and individual expertise within concierge systems. Service value depends on the competence of those managing coordination, the strength of their professional networks, and their ability to navigate system constraints

effectively (E06, E09, E12). Several interviewees emphasized that concierge care operates within the same structural limitations as the broader system (e.g., shortages of specialists, regional capacity constraints), even if it mitigates these limitations for individual patients. As E08 explained, the model "helps people move through the system, but it cannot expand the system itself."

Additionally, several experts reflected on patient expectations in concierge care. Some observed that patients paying for enhanced service might expect faster problem-solving, highly personalized attention, or immediate access to specialists. While experts agreed that many of these expectations can be met through structured coordination, they also stressed the importance of managing unrealistic assumptions, especially when external constraints limit what can be achieved (E06, E11).

Overall, experts described concierge models as service architectures that offer patients greater navigation support, relational continuity, and time. These benefits were widely recognized, yet interviewees also highlighted ethical and structural tensions related to affordability, expectations, and system capacity. The descriptions suggest that concierge care is valued not for changing medical decisions but for shaping the overall experience in ways that standard healthcare settings often cannot.

4.2.4 Digital Care, Technology Use, and Their Influence on Trust

Experts described digital tools as increasingly integrated into practice, yet consistently distinguished between their functional benefits and their limited role in building trust. Several interviewees noted that digital channels often streamline administrative tasks, support documentation, and facilitate follow-up steps (E02, E06, E10). However, these improvements were mainly seen as operational rather than relational. As E10 emphasized, digital systems "move faster than the structures meant to support them," underscoring the concern that technological advances often outpace organizational capacity.

A common theme was the loss of personalized care in digital formats. Clinicians stressed that trust depends heavily on nonverbal cues, contextual understanding, and a sense of being heard, elements difficult to replicate through screens. E04 and E05, who often handle complex diagnostic cases, noted that subtle visual or emotional cues typically guide decisions, thereby

limiting digital interactions in certain situations. This concern was echoed by E03, who pointed out that some patients gain confidence only when they can "read" the clinician's reactions directly, a capability that digital appointments cannot provide.

Several experts also pointed out that digital readiness varies significantly across patient groups. Younger or more technologically familiar patients typically navigate portal systems and teleconsultation more easily, whereas older adults may feel overwhelmed by technical demands (E01, E03, E09). In such cases, digital tools can create obstacles rather than support, potentially weakening trust when patients feel uncertain or excluded.

Misinformation was another common theme. Clinicians described the increasing influence of online symptom searches, social media content, and AI-driven self-diagnoses. E05 noted that technology "helps with information, but not with understanding the person behind it [...]" underscoring that digital knowledge often lacks context. Patients arriving with preconceived digital interpretations can disrupt the consultation process, requiring clinicians to spend additional time refuting incorrect assumptions (E04, E11). At the same time, experts acknowledged the value of digital communication for clarifying steps, sharing updates, and reducing uncertainty. E10 observed that prompt confirmations or structured information exchanges can reinforce reliability, even if they do not replace personal relationships. Several interviewees emphasized that digital tools are most effective when they support, rather than replace, personal interaction.

Overall, the interviews indicated that digital care improves efficiency and convenience but does not fundamentally alter the process by which trust is built. Trust remains rooted in human connection, professional competence, and the ability to respond to individual needs. Digital tools play a growing supportive role, but their effectiveness depends heavily on patient expectations, literacy, and the extent to which technological processes align with clinical realities.

4.2.5 Expectations for Future Healthcare Delivery

Experts described healthcare systems as becoming increasingly complex due to demographic changes, rising demand, and increasing specialization. There was widespread agreement that future care models will need to adapt to this complexity by developing more differentiated

structures and clearer role distributions (E02, E06, E10). Several interviewees expected the responsibilities of non-physician professionals to expand and for new coordination-focused roles to emerge, reflecting workforce shortages and administrative pressures (E01, E02, E07).

Consequently, experts forecast that coordination and navigation functions will become increasingly crucial as care becomes more fragmented and specialized (E07, E08, E10). While not necessarily termed "concierge care," these roles share features such as continuity, guidance, and structured oversight, and are understood as responses to broader system needs rather than as niche innovations.

Overall, experts expected future healthcare delivery to feature stronger collaboration, more precise coordination mechanisms, and more personalized support, driven by rising complexity and changing patient expectations. These upcoming developments indicate that the system is evolving toward greater flexibility and integration while maintaining the interpersonal foundations essential to delivering high-quality care.

4.3 Summary of Interview Findings

The interviews revealed consistent themes indicating that trust, service structures, and system conditions shape patient experiences in modern healthcare. Trust was seen as fundamentally relational, grounded in interpersonal presence, competence, and continuity, yet heavily influenced by systemic pressures such as time constraints and fragmented processes. Experts discussed significant access challenges, often rooted in structural limitations and unequal patient resources, which can create perceptions of inequality despite uniform clinical standards. The discussions of concierge models highlighted their role in providing extended time, coordination, and stability within an overstretched system, as well as ethical concerns regarding affordability and fairness. Digital tools were viewed as applicable for efficiency and communication, but were limited in their ability to support the interpersonal factors essential to trust. Looking ahead, experts anticipate a healthcare environment characterized by greater complexity, diverse care models, and a growing need for coordination and personalized support. These findings offer a comprehensive overview of the professional perspectives that inform the following quantitative analysis.

4.4 Quantitative Analysis

This chapter presents the empirical findings from the quantitative survey data, starting with preliminary data checks and descriptive insights, followed by hypothesis testing (H_1–H_7).

4.4.1 Preliminary Data Checks

Assumption Checks

Before conducting the hypothesis tests, the main variables were examined to ensure they met the basic distributional requirements for the subsequent parametric analyses. Histograms with overlaid standard curves and descriptive statistics were reviewed for all constructs. The distributions showed no significant deviations from normality across the variables. Skewness values were within acceptable limits, with only the Trust variable showing a slightly left-skewed distribution, which is typical in healthcare-related assessments and does not pose a problem for the planned analyses (Figure 5). The data were also screened for potential outliers or irregularities. No extreme values or implausible responses were identified, and all observations were retained. Overall, the initial review indicated that the dataset met the conditions for the regression and group-comparison procedures used in subsequent sections.

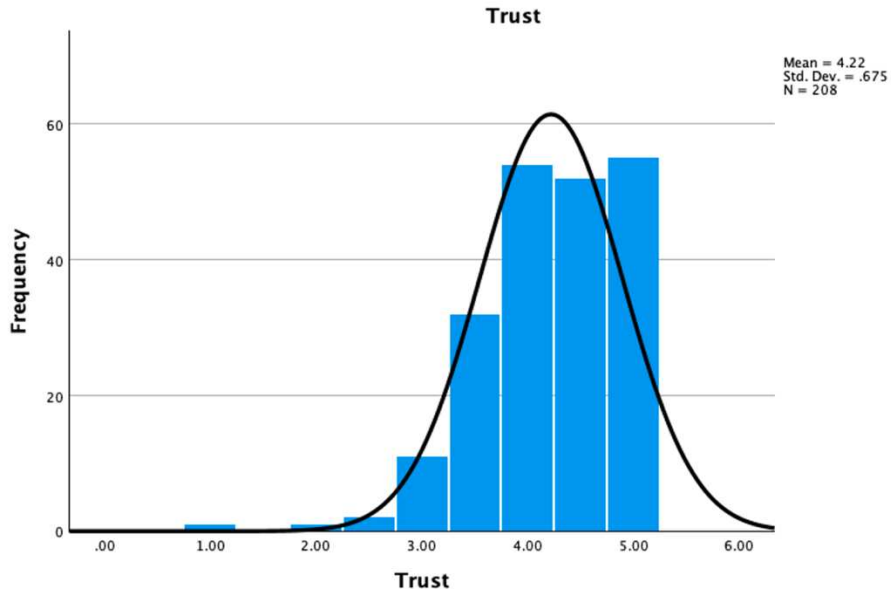


Figure 5: Distribution of Trust Scores with Normal Curve

4.4.2 Descriptive Statistics

Sample Characteristics

The descriptive analysis first examines key sample characteristics relevant to the study's context (Table 3). Most participants chose the Premium Care model over the Standard Care option in the choice scenario, indicating a general preference for premium-service features among the sample. Additionally, 53.4% of respondents reported being familiar with concierge or premium care models.

Table 3: Descriptive Statistics for Concierge Model Familiarity and Scenario Selection

Variable	**Category**	**n**	**%**
Concierge Model Familiarity	Yes	111	53.4
	No	97	46.6
Scenario Choice	Standard Care (A)	80	38.5
	Premium Care (B)	128	61.5

Main Construct Statistics

Descriptive statistics for all key constructs are shown in Table 4. Average scores across the constructs ranged from 3.19 to 4.22, indicating generally positive perceptions of the healthcare dimensions. The *Patient Trust* construct had the highest average score ($\bar{x} = 4.22$, $SD = 0.68$). In contrast, *Accessibility* ($\bar{x} = 3.19$) received the lowest rating. Scores for *Personalization* ($\bar{x} = 3.94$) and *Continuity of Care* ($\bar{x} = 3.92$) were also relatively high.

Table 4: Means and Standard Deviations of the Key Constructs

Construct	**Mean**	**SD**
Continuity of Care	3.92	0.87
Empathy: Receptionists	3.77	0.76
Empathy: Nurses	3.90	0.78
Fairness Concerns	3.52	1.06
Personalization	3.94	0.57
Accessibility	3.19	0.72
Patient Trust	4.22	0.68
Choice Confidence (Scenario)	4.05	0.59

4.5 Hypothesis Testing

The following section presents the quantitative findings, beginning with the multiple regression analysis for Hypotheses H_1-H_7.

4.5.1 Regression Procedure and Evaluation (H_1-H_5)

To test Hypotheses H_1 to H_5, a multiple linear regression analysis with backward elimination was conducted. All theoretically relevant predictors were initially included simultaneously. The backward process repeatedly removed the least significant predictors ($p < .10$) according to predefined criteria, thereby identifying the subset of variables that best explained the variance in *Patient Trust*.

Notably, backward selection was not used to exclude individual predictors. Each predictor was assessed based on the coefficient from the final model step in which it appeared. Essentially, this means the effects of *Fairness Concerns* are presented in Model 1, *Continuity of care* in Model 2, *Empathy of Reception Staff* in Model 3, and *Personalization, Accessibility*, and *Nursing Empathy* in Model 4. This method guarantees that each predictor is evaluated under consistent conditions.

Table 5 presents the backward regression results, coefficients, and collinearity diagnostics. The corresponding model summary statistics, including R^2 and $adjusted R^2$ values for each step of the backward elimination procedure, are presented in Table 6.

Since all hypotheses were formulated directionally, one-tailed significance tests were used. One-tailed significance levels were calculated by dividing the reported two-tailed p-value by two, as long as the effect was in the expected direction. A p-value of less than .05 for one-tailed tests was considered statistically significant.

Regression assumptions were checked before interpretation. Visual inspection of the histogram of standardized residuals (Appendix F) confirmed that the residuals were approximately normally distributed, satisfying the normality assumption. Furthermore, the scatterplot of standardized residuals against standardized predicted values (Appendix G) showed that normality, linearity, and homoscedasticity were adequately met. Collinearity diagnostics (VIF) did not indicate problematic multicollinearity among the predictors.

Table 5: Backward Multiple Linear Regression Results Predicting Patient Trust

Coefficients[a]

Model		Unstandardized Coefficients		Standardized Coefficients	t	Sig.	Collinearity Statistics	
		B	Std. Error	Beta			Tolerance	VIF
1	(Constant)	1.245	.395		3.149	.002		
	Personalization	.529	.081	.443	6.545	.000	.772	1.296
	Accessibility	.101	.062	.108	1.635	.104	.805	1.242
	Empathy, receptionists	.080	.055	.091	1.465	.145	.923	1.083
	Empathy, nurses	.097	.052	.113	1.875	.062	.980	1.021
	Continuity	-.017	.050	-.022	-.350	.727	.864	1.157
	Fairness concerns	-.012	.038	-.019	-.318	.751	.976	1.025
2	(Constant)	1.205	.374		3.220	.001		
	Personalization	.530	.081	.444	6.570	.000	.772	1.295
	Accessibility	.102	.061	.110	1.663	.098	.809	1.236
	Empathy, receptionists	.080	.055	.091	1.468	.144	.923	1.083
	Empathy, nurses	.097	.052	.112	1.873	.062	.980	1.020
	Continuity	-.020	.049	-.025	-.400	.690	.882	1.134
3	(Constant)	1.174	.365		3.213	.002		
	Personalization	.521	.077	.436	6.729	.000	.834	1.199
	Accessibility	.102	.061	.109	1.657	.099	.809	1.236
	Empathy, receptionists	.078	.054	.088	1.434	.153	.936	1.069
	Empathy, nurses	.097	.052	.112	1.880	.061	.980	1.020
4	(Constant)	1.361	.342		3.977	.000		
	Personalization	.533	.077	.447	6.917	.000	.845	1.184
	Accessibility	.116	.061	.124	1.910	.058	.831	1.203
	Empathy, nurses	.100	.052	.116	1.931	.055	.982	1.019

[a.] Dependent Variable: Trust

Table 6: Model Summary of Backward Elimination Steps

Model	R	R2	Adjusted R2	Std. Error of the Estimate	Change in R2
1	.537	.289	.268	.57770	-
2	.537	.288	.271	.57641	-.001
3	.537	.288	.274	.57522	.000
4	.530	.281	.270	.57670	-.007

Note: Predictors included in each step: Model 1: (Constant), Fairness, Empathy (Rec), Empathy (Nurse), Personalization, Continuity, Accessibility. Model 2: Fairness removed. Model 3: Continuity removed. Model 4 (Final): Empathy (Rec) removed. Included: Personalization, Accessibility, Empathy (Nurse).

H_1: Personalization positively affects patient trust in healthcare providers.

Personalization had a significant positive effect on trust. In the final model (Model 4), *Personalization* showed a strong standardized coefficient (β = .447, p <.001). The one-tailed significance criterion for the directional hypothesis was fully met.

Conclusion: H_1 is supported.

H_2: Accessibility positively affects patient trust in healthcare providers.

Accessibility maintained a consistently positive coefficient throughout the regression steps and remained in the final model (Model 4). The effect was moderate but significant ($\beta = .124$). The two-tailed p-value of .058 yields a one-tailed p-value of .029.

Conclusion: H_2 is supported

H_{3a}: Empathy shown by nursing staff positively affects patient trust.

Empathy demonstrated by *Nursing Staff* remained in the model until the final step (Model 4), where it showed a small but consistently positive effect ($\beta = .116$). The two-tailed p-value of .055 yields a one-tailed p-value of .028.

Conclusion: H_{3a} is supported.

H_{3b}: Empathy shown by reception staff positively affects patient trust.

Empathy demonstrated by the *Reception Staff* was omitted from the final model iteration and is evaluated based on the last step at which it appeared (Model 3). At that step, the coefficient did not approach statistical significance, and the effect size was small ($\beta = .088$). The two-tailed p-value of .153 yields a one-tailed p-value of .077.

Conclusion: H_{3b} is not supported.

H_4: Continuity of care positively affects patient trust in healthcare providers.

Continuity was removed earlier in the retrospective process and is evaluated based on its last occurrence (Model 2). At this stage, the coefficient ($\beta = -0.025$) pointed in the opposite direction from the hypothesis (negative rather than positive). The effect was not statistically significant, providing no evidence of a directional impact on trust. The two-tailed p-value of .690 indicates that the hypothesis is not supported.

Conclusion: H_4 is not supported.

H_5: Fairness concerns regarding concierge care negatively affect patient trust.

Fairness Concerns were addressed early in the model and evaluated using the coefficients from Model 1. Although the coefficient's sign was consistent with the expected negative direction, the effect was not statistically significant ($\beta = -0.019$). The two-tailed p-value of .751 corresponds to a one-tailed p-value of .376.

Conclusion: H_5 is not supported.

4.5.2 H_6: Insurance Type as Moderator of the Accessibility-Trust Relationship

Hypothesis 6 anticipated a moderating effect of insurance type on the relationship between *Accessibility* and *Patient Trust*. To examine this moderation, the analysis was performed separately for respondents with public insurance (n = 68) and those with private insurance (n = 139). As with the procedures for testing other hypotheses, all statistical tests for this directional hypothesis used one-tailed significance levels (α = .05).

Simple Correlations and Formal Comparison

Table 7: Correlations between Accessibility and Patient Trust by Insurance Type

Insurance Group	n	Pearson's r	Sig. (1-tailed)
Public Insurance	68	.114	.088*
Private Insurance	139	.430	< .001

*Note: The 2-tailed significance was .176

Initially, Pearson correlations between *Accessibility* and *Trust* were calculated separately for both insurance groups. The correlation for publicly insured patients was small and not statistically significant (r = .114, p = .176). In contrast, the association was substantial and statistically significant among privately insured patients (r = .430, p< .001).

To formally test the moderation hypothesis and the observed difference, the two Pearson correlation coefficients were compared using Fisher's z-transformation. This method assesses whether the strength of the linear relationship in one independent sample differs significantly from that in another. The comparison showed that the unadjusted correlation for the private group was substantially stronger than that for the public group (z = 2.291, $p_{(one\text{-}tailed)}$ = .011). This result formally confirms the visual pattern but contradicts the predicted direction of H_6.

Regression Analyses by Insurance Type

To assess whether this pattern generalizes to other predictors, the multiple regression model used for H_1-H_5 was re-estimated separately for each insurance group. Among publicly insured respondents, the backward procedure sequentially eliminated most variables, including *Accessibility* (Model 5). In the final step (Model 6), only *Personalization* remained

as a predictor of trust. The relatively small subsample size (n = 68) limits the ability to detect smaller effects. Therefore, the lack of significance for *Accessibility* should be interpreted cautiously; the results indicate that the effect is, at best, weak and highly dependent on the model specification. The corresponding model summary statistics are reported in Table 6. The final model for the public-insurance group explained a relatively small proportion of the variance in trust ($R^2 \approx .18$; $adjusted R^2 \approx .17$).

For respondents with private insurance, the backward procedure revealed a more complex pattern. *Personalization*, *Accessibility*, and both *Empathy* measures remained in the final step (Model 3). In this model, *Accessibility* continued to show a small but statistically significant positive effect ($\beta \approx .154$). The two-tailed p-value of .070 corresponds to a one-tailed p-value of approximately .035, accounting for the other predictors. The final model for this group explained considerably more variance in trust ($R^2 \approx .35$, $adjusted R^2 \approx .33$).

Table 8: Regression Model Summary for Patient Trust by Insurance Type

Insurance type	Model	R	R Square	Adjusted R Square	Std. Error of the Estimate
Public	1	.443[a]	.196	.117	.62148
	2	.443[b]	.196	.131	.61651
	3	.442[c]	.195	.144	.61175
	4	.440[d]	.193	.156	.60770
	5	.437[e]	.191	.166	.60394
	6	.429[f]	.184	.171	.60198
Private	1	.597[h]	.356	.327	.55939
	2	.596[i]	.355	.331	.55772
	3	.594[j]	.353	.334	.55675

Note: See Appendix H for predictor details

Robustness Check: Partial Correlations and Final Comparison

Because *Personalization* emerged as the strongest predictor in both groups, a further robustness check was conducted using partial correlations to pinpoint the unique relationship between *Accessibility* and *Trust*, while controlling for the effect of *Personalization*. The partial correlation for publicly insured patients was minimal and non-significant (r_{partial} =.057, p = .323). The partial correlation for privately insured patients remained positive and statistically significant (r_{partial} = .207, p = .007).

To provide final confirmation of the group difference under controlled conditions, these partial correlations were formally compared using Fisher's z-transformation. The results of this comparison are reported in Table 7. This test revealed that the difference between the partial correlations (r_{private} = .207 vs. r_{public} = .057) was no longer statistically significant (z = 1.014, $p_{(one\text{-}tailed)}$ = .155). Thus, there is no robust evidence that the insurance type moderates the relation between accessibility and trust when controlling for the influence of *Personalization*.

Conclusion: H_6 is not supported.

Table 9: Fisher's z-Test Results (Lenhard & Lenhard, 2014)

	n	r
Correlation 1	139	.207
Correlation 2	68	.057
Test statistic (z)	1.014	
Probability (p)	0.155	

4.5.3 H_7: Premium vs. Standard Care and Confidence in Choice

Hypothesis H_7 predicted that patients who selected the premium care scenario would report greater confidence in their decision than those who selected the standard care scenario. To test this, an independent-samples t-test was conducted to compare respondents' mean conviction scores. Conviction was measured as the average of four items assessing respondents' confidence in their chosen scenario. Table 9 presents the descriptive statistics for both groups.

Table 10: Comparison of Decision Conviction between Standard and Premium Care

Scenario Choice	n	Mean (M)	Std. Deviation (SD)	Std. Error Mean
Standard Care	80	3.98	.65	.073
Premium Care	128	4.09	.55	.049

Levene's test indicated that the assumption of equal variances was satisfied (p = .463). The direction of the difference ($M_{Premium} > M_{Standard}$) was consistent with the hypothesis. However,

the independent-samples t-test showed no statistically significant difference in conviction between the two groups ($t(206) = -1.222$, $p_{(\text{two-tailed})} = .223$). The corresponding one-tailed p-value of .112 exceeds the significance cutoff of $\alpha = .05$. Effect size estimates (Cohen's d = -0.174) indicate only a minimal difference.

Conclusion: H_7 is not supported.

5. Discussion

5.1 Interpretation of Key Findings

Combining quantitative survey data (n = 208) with expert insights (n = 12), the findings provide justification for the proposed CF (Chapter 3.1). The data indicate that concierge models do not merely sell "better medicine"; they effect a strategic shift from institutional legitimacy to interpersonal trust through specific service design strategies.

The following sections examine this transformation across four strategic dimensions: the decommodification of time, the signaling of safety, the systemic role of the human trust broker, and the Willingness-to-Pay for relational certainty.

5.1.1 Operationalizing Benevolence: Time as a Strategic Resource

In a market focused on efficiency, the results show that time is more than just an operational limit; it functions as a strategic asset - considered "valuable, rare, and difficult to imitate" (RBT; Barney, 2021). The quantitative data reinforce this, with *Personalization* (the skillful management of time) being the strongest indicator of *Trust* (β = .447, p < .001). This provides empirical support for Mayer et al.'s (1995) model, illustrating that trustworthiness is not abstract but depends on tangible service features. However, viewing time merely as a static asset is insufficient. Reflecting the Dynamic Capabilities framework discussed in Chapter 2.2.2, time serves as the operational prerequisite for "sensing" (Barreto, 2010), enabling the provider to detect subtle health risks before they escalate, a capability structurally suppressed in volume-based care.

While the survey scale showed only moderate reliability (α = .460), the qualitative insights strongly support a perspective aligned with Social Exchange Theory (Blau, 1964). Interviews (such as E04, E05) indicate that patients see the financial exchange not just as a purchase but as an investment in maintaining the relationship. Rudebeck (2019) emphasizes that genuine care depends on this continuity. Our results imply that decommodifying time enables a shift from a transactional approach (characterized by a narrow mandate) to the wider "mandate of trust" outlined by Skirbekk et al. (2023). Removing the constraints of the "industrial clock" provides physicians with the authority to focus on the patient's overall needs, strengthening the doctor-patient bond.

Additionally, the findings extend Signaling Theory (Spence, 1973). In typical care settings, physicians often lack the capacity to signal their benevolence convincingly. Concierge models address this gap by creating the structural conditions that make benevolence observable. By providing protected time slots, the model reduces patient vulnerability (Hall et al., 2001) and serves as a high-fidelity signal that the provider's integrity is not compromised by systemic churn.

Strategic Implication: Management must view *Time* not as a cost to minimize but as the core value proposition that fuels the Intimacy Premium (De Santiago et al., 2021). Consistent with Berry's (1995) relationship marketing, lasting trust requires service designs that explicitly decommodify time, thereby transforming the encounter from a standardized commodity into a resilient partnership.

5.1.2 Accessibility as a High-Fidelity Signal of Competence

The findings differ from those of traditional medical sociology regarding competence-based trust. While previous research primarily associates the *Ability* dimension with technical clinical skills (Mayer et al., 1995), this study's triangulation suggests that, in the premium segment, *Accessibility* serves as a reliable proxy for competence.

The quantitative analysis identifies *Accessibility* as a statistically significant, albeit moderate, predictor of *Trust* ($\beta = .124$, $p < .05$). This finding operationalizes Hutchison et al.'s (2021) call for a shift from unidirectional encounters toward models in which relationships serve as critical facilitators of health. In this context, immediate availability is the tangible mechanism that facilitates this relationship. Qualitative data (E01, E09) confirm this psychological link: for premium patients, being unreachable symbolizes a loss of control, intensifying the inherent vulnerability of the patient role (Hall et al., 2001). Consequently, *Accessibility* is interpreted not only as service speed but also as a fundamental signal of safety.

Crucially, this creates a distinct psychological mechanism. Because patients lack the medical expertise to directly verify the ability dimension (Mayer et al., 1995), they rely on observable proxies. Faced with information asymmetry about medical quality, they engage in attribute substitution, interpreting organizational efficiency - such as immediate callbacks - as a heuristic for clinical skill. This operational efficiency creates the context for cooperation described

by Mechanic (1998). By guaranteeing rapid access, the concierge model establishes a buffer that insulates the patient from systemic friction, signaling that the provider can manage the environment effectively. This reinforces Wray et al.'s (2021) finding that premium models foster trust by reducing access barriers, even when clinical outcomes remain comparable. Unlike benevolence, which depends on physical presence, competence is thus conveyed through consistent, frictionless processes.

This mechanism, however, is intensified by insurance status. Contrary to H_6, privately insured patients exhibited a significantly stronger link between *Accessibility* and *Trust*. This suggests a divergence in baseline expectations: public patients often exhibit "systemic resignation," accepting delays as inevitable structural flaws. Conversely, for premium patients, *Accessibility* functions as a non-negotiable prerequisite: higher fees establish an implicit contract of immediacy, in which any delay is interpreted not as a systemic issue but as a specific breach of professional competence.

Strategic Implication: *Accessibility* serves as a risk-reduction mechanism, transforming the front office from administrative support into a vital trust builder. Applying Berry's (1995) service marketing principles, a missed call in a concierge context is not merely a service error but a signal of incompetence that can directly undermine confidence in the provider's capacity to handle medical emergencies.

5.1.3 The Human Trust Broker: Systemic Empathy vs. Digital Efficiency

Alongside the dimensions of *Time* and *Accessibility*, the framework emphasizes *Staff Empathy* as a crucial factor in building trust. Despite the common focus on digital transformation, this study identifies a phenomenon called the "Human-Touch Paradox" as a key insight.

Survey data indicate that *Staff Empathy*, especially among *Nursing Staff*, significantly predicts *Trust* ($\beta = .116$, $p < .05$; H_{3a}). However, qualitative insights from E09 and E10 reveal a vital nuance: support staff serve as "Trust Brokers." They manage not only administrative entry but also the initial authorization of the relationship. In doing so, they fulfill the core requirements of the Senses Framework (Nolan et al., 2006). By transforming a sterile administrative process into a momentary sense of belonging and significance, they lay the

emotional groundwork for the clinical encounter. Consequently, by ensuring seamless access and emotional reception, they signal that the practice is capable of fulfilling the "wide mandate" of comprehensive care defined by Skirbekk et al. (2023), distinguishing it from the "narrow mandate" of episodic standard care.

These findings are consonant with those of François et al. (2024) discussed in the literature review. While digital tools can indeed serve as a bridge to physicians, the data suggests that, in the premium segment, this bridge must be secured by a human intermediary. Technology underpins efficiency, but the human element remains the key driver of value (Berry and Bendapudi, 2007).

However, a critical distinction emerges regarding the depth of clinical interaction. While literature frames digital health as an access enabler, the qualitative findings highlight the limits of digital trust. Experts (E03, E04, E05) emphasized that deep trust relies on nonverbal cues and the ability to "read" the patient, elements that are lost in digital formats. This contradiction suggests that trust is not monolithic: while digital tools enhance administrative trust (reliability), they risk eroding interpersonal trust (sensing). Thus, the Intimacy Premium requires physical presence in complex moments when the "human sensor" cannot be replaced by a screen; digital tools serve as complements to efficiency, not substitutes for the core therapeutic relationship.

Strategic Implication: This finding fundamentally reconfigures the locus of trust. It shifts the focus from a purely dyadic view to a systemic model in which support staff serve as clinical preconditioners. Drawing on Mechanic (1998), these Human Trust Brokers do not simply schedule appointments; they architect the context for cooperation. Without this initial emotional calibration, the physician - regardless of technical expertise - faces friction rather than openness. Consequently, management must elevate staff emotional intelligence from a soft skill to a core strategic asset, recognizing that the Intimacy Premium is often secured or lost before the medical encounter even begins.

5.1.4 The "Paradox of Paid Trust": Willingness-to-Pay and the Irrelevance of Fairness Concerns

Finally, the results address the ethical tensions of the two-tier system. Skeptics and ethicists, such as Sandel (2012), have long warned that the commodification of care risks eroding its moral neutrality, potentially reframing professional altruism as a mere contractual obligation. However, the empirical data reveal a striking divergence between these theoretical concerns and patients' actual behavior.

The Irrelevance of Fairness Concerns: H_5 proposed that patients with significant concerns about systemic fairness would trust concierge providers less. Unexpectedly, the regression analysis revealed no substantial adverse effect of *Fairness Concerns* on *Patient Trust* (β = -0.019, *n.s.*). This empirically validates the Citizen-Consumer Gap discussed in Chapter 2.4.1 (Clarke et al., 2007). While respondents, acting as "Citizens," criticize the inequality of a two-class system (E02), this moral stance collapses when they act as "Consumers." The theoretical explanation for this gap lies in the nature of the service itself. As Berry and Bendapudi (2007) emphasize, healthcare consumers are "sick," "reluctant," and "at risk." Faced with personal vulnerability, the abstract desire for societal equity is superseded by the immediate need for security. Consequently, patients compartmentalize their political beliefs to prioritize responsiveness. In the context of health, individual pragmatism overrides collective ideology.

High Willingness-to-Pay as a Signal: This pragmatic shift is reinforced by the scenario analysis (see Survey Scenario, Appendix C), where 61% of respondents found the fee-based premium model *more* trustworthy. Furthermore, 71% indicated that they would be willing to adopt or pay for this model if given the opportunity. This directly contradicts the fear that market norms crowd out trust. Instead, viewed through Signaling Theory, the fee functions as a credible signal of the provider's capacity to deliver the Intimacy Premium. It assures the patient that the physician is not subject to the resource constraints of the standard system.

Synthesis: Patients act as rational agents willing to trade financial resources for relational certainty. Contrary to Sandel's critique, the fee is not perceived as a bribe that corrupts the relationship, but as a mechanism to restore autonomy and competence, the core psychological needs defined by Self-Determination Theory (Ryan & Deci, 2000). By paying for access, patients transition from passive recipients in a rationing system to active partners who have

secured the necessary resources for their care - a transition here defined as the *Dignity Premium*. While the Intimacy Premium ensures the *quality of the relationship* (Benevolence), the Dignity Premium secures *the patient's status* (Agency). It is the cost paid not for luxury, but to escape the anonymity of standardized care and regain a sense of control.

Strategic Implication: The lack of adverse effects related to *Fairness Concerns* suggests that the moral stigma of concierge medicine is primarily a theoretical construct rather than a market barrier. For providers, this implies that openly charging for access does not delegitimize their practice; on the contrary, if it guarantees safety and timeliness, it reinforces their reputation by signaling a robust capacity for care.

5.2 Theoretical Implications

This dissertation advances strategic management within the context of healthcare consumerism.

5.2.1 Refining RBT: Time as a Strategic Asset

This study extends the Resource-Based Theory (J. B. Barney, 2021) by redefining *Patient Trust* as a strategic asset contingent on the decommodification of time. Bridging RBT with Dynamic Capabilities (Barreto, 2010; Teece, 2007), the findings identify structural time availability as the essential prerequisite for "sensing" patient risks. Consequently, the Intimacy Premium emerges not as a luxury byproduct but as a replicable resource created by explicitly decoupling care from the industrial clock.

5.2.2 Extending Signaling Theory: Responsiveness as a Proxy for Competence

Applying Signaling Theory (Spence, 1973), this research reveals that patients engage in attribute substitution, interpreting responsiveness as a high-fidelity proxy for medical competence. In systems marked by perceived failure, administrative efficiency establishes the context for cooperation (Mechanic, 1998). Thus, friction-free access transcends convenience; it precedes clinical signals in the trust hierarchy, effectively insulating the provider against systemic skepticism.

5.2.3 From Organic to Engineered Trust

Finally, this research challenges the notion of trust as a purely organic bond, instead supporting a functionalist view in which trust is architected through specific design choices (e.g., staff empathy). Linking findings to Self-Determination Theory (Ryan & Deci, 2000), the Willingness-to-Pay is driven not by luxury consumption but by a fundamental desire to regain autonomy and competence within an opaque system. This insight reframes the theoretical discourse on the Citizen-Consumer Gap: the fee is not a step toward the "Commodification of Care" but rather a mechanism for the "Restoration of Agency." The membership fee covers the Dignity Premium, transforming the passive patient into an empowered agent.

5.3 Social and Ethical Implications

The study identifies a critical tension around the "Commodification of Trust." Although the findings in Section 5.1.4 show that individual patients prioritize personal agency over systemic fairness, this pragmatic behavior creates a significant societal externality. Although concierge services foster strong trust among their users, they risk undermining the institutional legitimacy of the broader healthcare system.

- **The Two-Tier Trust Paradox:** As interviewees (E02, E11) observed, when high-quality relational care becomes a purchasable luxury, the public system is increasingly perceived not as a standard but as a residual safety net. This exacerbates the Citizen-Consumer Gap (Clarke et al., 2007): as the most resourceful patients exit the standard system to buy the Intimacy Premium, the public sector loses its most vocal advocates for improvement. The paradox is that while the fee restores trust for the individual, it accelerates the erosion of confidence in the collective system.

- **Social Risk:** When trust-building resources - specifically *Time* and *Accessibility* - are commodified, ethical concerns about universality arise. This research warns that while privatization may solve the "trust crisis" for the affluent, it risks branding the standard model as inherently unsafe. Consequently, the "Restoration of Agency" (described in 5.2.3) remains a privilege, potentially cementing a structural divide in which trust is no longer a public good but a private asset.

5.4 Limitations and Future Research

Although this study clarifies trust dynamics in premium healthcare, the following limitations suggest avenues for future scholarship.

5.4.1 Sample Composition and Bias

A critical limitation is the sample's composition, predominantly young, digitally literate, and privately insured (66.8%). This wealth bias constrains the interpretation of Hypothesis 5: the "Irrelevance of Fairness Concerns" likely reflects a privileged perspective in which the Dignity Premium is an affordable restoration of agency rather than an exclusionary barrier. Additionally, the younger demographic may obscure the trust dynamics of older adults, who typically prioritize physical continuity over hybrid accessibility. Consequently, these findings cannot be fully generalized to lower-income or older populations.

5.4.2 Construct Complexity

While *Patient Trust* showed acceptable reliability with a Cronbach's alpha of .627, *Personalization* indicated lower internal consistency ($\alpha = .460$). Theoretically, this supports the Dynamic Capabilities framework (Chapter 2.2.2), suggesting that "sensing" is a complex, multidimensional capability rather than a single variable. Thus, regression results for *Personalization* should be interpreted as exploratory signals rather than confirmatory evidence. Future research should prioritize refining this scale to establish more standardized metrics with higher internal consistency.

5.4.3 Causal Ambiguity

The cross-sectional design prevents determining causality. It is unclear whether concierge services build trust or simply attract patients who are already predisposed to trust (selection bias). This "Reverse Causality" issue limits the ability to establish an apparent directional effect.

5.4.4 Contextual Generalizability

By synthesizing insights across diverse health systems (DE, U.S., UK), the study simplified specific regulatory nuances. Findings on "Willingness-to-Pay" may therefore vary between single-payer and multi-payer systems with higher out-of-pocket exposure.

5.5 Directions for Future Research

To advance the field, future research should focus on three strategic areas.

1. **Comparative Analysis:** Investigate how different regulatory frameworks influence the effectiveness of the Intimacy Premium.
2. **Refined Measurement:** Develop granular scales to distinguish quantitative time from the qualitative depth of "sensing" and to measure the Dignity Premium empirically.
3. **Longitudinal Dynamics:** Track the Citizen-Consumer Gap over time to determine whether the tension between societal fairness and personal utility persists, or whether patients develop permanent coping mechanisms for the two-tier reality.

6. Conclusion

This dissertation set out to answer the central research question: ***How do factors associated with concierge premium services influence patient trust in healthcare?***

The empirical evidence points to a clear conclusion: Concierge services influence trust not merely by promising better medical outcomes, but by decommodifying time and commodifying access. At a time when the public sector is marked by fragmentation and efficiency pressures, concierge models succeed because they create the structural conditions necessary for the "wide mandate of trust" (Skirbekk et al., 2023) to develop. Specifically, they foster trust through three strategic mechanisms:

- **Personalization as a Dynamic Capability:** By shielding the encounter from the industrial clock, time is transformed from a cost factor into a strategic asset. This enables *"sensing"* (Barreto, 2010) - the proactive detection of risks - thereby signaling deep benevolence and securing the Intimacy Premium.
- **Accessibility as a Proxy for Competence:** Through the psychological process of attribute substitution, patients interpret immediate responsiveness as a high-fidelity signal of competence and safety. This establishes the "context for cooperation" (Mechanic, 1998) that insulates the relationship from systemic friction.
- **The Human Trust Broker:** Instead of digital interfaces, empathetic support staff serve as clinical pre-conditioners. They manage the emotional entry into the system, ensuring the interface remains human despite digital advances.

The study reveals a critical shift. While public discourse debates the ethics of two-tier medicine, individual behavior confirms the existence of a distinct Citizen-Consumer Gap. Faced with vulnerability, societal idealism yields to the need for security. The high adaptation willingness (71%) indicates that patients reinterpret the fee not as an exclusionary barrier but as a necessary investment to restore autonomy - a Dignity Premium paid to escape the anonymity of standardized care.

For the future of healthcare management, this study challenges the current emphasis on volume and efficiency. It demonstrates that while technology can scale *processes*, only human attention can scale *trust*. The industry's ultimate challenge lies not in securing this model for the few but in finding scalable innovations that reintroduce time and empathy into the care of the many.

Bibliography

Barney, J. (1991). Firm Resources and Sustained Competitive Advantage. *Journal of Management*, *17*(1).

Barney, J. B. (2021). The emergence of Resource-Based Theory: a personal journey. In *Journal of Management* (Vols. 47–47, Issue 7, pp. 1663–1676). https://doi.org/10.1177/01492063211015272

Barreto, I. (2010). Dynamic Capabilities: a review of past research and an agenda for the future. *Journal of Management*, *36*(1), 256–280. https://doi.org/10.1177/0149206309350776

Berry, L. L. (1995). Relationship Marketing of Services-Growing interest, emerging Perspectives. In *Journal of the Academy of Marketing Science* (Vols. 23–23, Issue 4, pp. 236–245) [Journal-article]. Academy of Marketing Science.

Berry, L. L., & Bendapudi, N. (2007). Health care: a fertile field for service research. *Journal of Service Research*, 111–122. https://doi.org/10.1177/1094670507306682

Blau, P. M. (1964). Justice in social exchange. *Sociological Inquiry*. https://doi.org/10.1111/j.1475-682X.1964.tb00583.x

Campos-Castillo, C., Woodson, B. W., Theiss-Morse, E., Sacks, T., Fleig-Palmer, M. M., & Peek, M. E. (2015). Examining the Relationship Between Interpersonal and Institutional Trust in Political and Health Care Contexts. In *Interdisciplinary Perspectives on Trust* (pp. 99–115). https://doi.org/10.1007/978-3-319-22261-5_6

Clarke, J., Newman, J., Smith, N., Vidler, E., & Westmarland, L. (2007). *Creating Citizen-Consumers: Changing Publics and Changing Public Services*. SAGE Publications Limited. https://doi.org/10.4135/9781446213551

Conradsen, S., Vardinghus-Nielsen, H., & Skirbekk, H. (2023). Patient knowledge and trust in health care. A theoretical discussion on the relationship between patients'

knowledge and their trust in health care personnel in high modernity. *Health Care Analysis*, *32*(2), 73–87. https://doi.org/10.1007/s10728-023-00467-7

Creswell, J. W., & Hirose, M. (2019). Mixed methods and survey research in family medicine and community health. *Family Medicine and Community Health*, *7*(2), e000086. https://doi.org/10.1136/fmch-2018-000086

De Santiago, A., Bingham, J. M., Vaffis, S., Scovis, N., McGlamery, E., Boesen, K., Warholak, T., & Dhatt, H. (2021). Evaluating the role and value of a clinical pharmacist in a concierge primary care clinic. *Journal of the American Pharmacists Association*, *61*(3), 240-247.e1. https://doi.org/10.1016/j.japh.2020.12.014

Diouri, L., Ecarnot, F., Berjot, S., Popiolek, A., Bouché, O., Botsen, D., Lemoine, A., Vignot, S., & Barbe, C. (2025). Towards a better understanding of patient expectations: ONCOPREMs-1 study—a qualitative study. *Aging Clinical and Experimental Research*, *37*(1), 256. https://doi.org/10.1007/s40520-025-03148-8

Dwidienawati, D., Arief, M., & Abdinagoro, S. B. (2018). Is service fairness influencing customers' satisfaction and intention to pay insurance premium? A case in BPJS Kesehatan Indonesia. *Journal of Business & Retail Management Research*, *13*(01). https://doi.org/10.24052/jbrmr/v13is01/art-04

Elbers, N. A., Collie, A., Hogg-Johnson, S., Lippel, K., Lockwood, K., & Cameron, I. D. (2016). Differences in perceived fairness and health outcomes in two injury compensation systems: a comparative study. *BMC Public Health*, *16*(1), 658. https://doi.org/10.1186/s12889-016-3331-3

François, J., Audrain-Pontevia, A., Boudhraâ, S., & Vial, S. (2023). Assessing the influence of patient empowerment gained through mental health apps on patient trust in the health care provider and patient compliance with the recommended treatment: cross-sectional study. *Journal of Medical Internet Research*, *26*, e48182. https://doi.org/10.2196/48182

Hair, J. F., Black, W. C., Babin, B. J., & Anderson, R. E. (2010). *Multivariate Data Analysis*. Pearson.

Hall, M. A., Dugan, E., Zheng, B., & Mishra, A. K. (2001). Trust in physicians and medical institutions: what is it, can it be measured, and does it matter? *Milbank Quarterly*, *79*(4), 613–639. https://doi.org/10.1111/1468-0009.00223

Hoffman, S., & Ganguli, I. (2026). Access to primary care and health care fragmentation. *Faculty Publications*. https://scholarlycommons.law.case.edu/faculty_publications/2327

Hutchison, K. N., Sweeney, J., Bechtel, C., & Park, B. (2021). Reimagining Relationship-Based health care in a Post-COVID world. *Journal of Patient Experience*, *8*, 2374373521998622. https://doi.org/10.1177/2374373521998622

Iliffe, S., & Manthorpe, J. (2020). Medical consumerism and the modern patient: successful ageing, self-management and the 'fantastic prosumer.' *Journal of the Royal Society of Medicine*, *113*(9), 339–345. https://doi.org/10.1177/0141076820911574

Johnsonwall, J. M., Southeastern University, & Classical Conversations. (2021). THE FUTURE OF AMERICAN PRIMARY CARE. In *Classical Conversations*. https://firescholars.seu.edu/ccplus/16

Kirkwood, G., & Pollock, A. M. (2025). Outsourcing national health service surgery to the private sector: waiting time inequality and the making of a Two-Tier system for Hip and Knee replacement in England. *International Journal of Social Determinants of Health and Health Services*, *55*(4), 455–464. https://doi.org/10.1177/27551938251336949

Lakhan, R., Gillette, S. Y., Lee, S., & Sharma, M. (2020). Satisfaction with health care system: A comparative study between market-based insurance model of the United States and "out-of-pocket" model in developing and low-income countries. *International Journal of Healthcare*, *6*(1), 41. https://doi.org/10.5430/ijh.v6n1p41

Lawlor, J., MBA. (2025). *The Semi-Concierge Medicine® model: innovation that bridges the gap between Fee-for-Service and concierge care*. https://ssrn.com/abstract=5362443

Lenhard, W., & Lenhard, A. (2014). *Signifikanztests bei Korrelationen*. Psychometrica. Retrieved December 28, 2025, from https://www.psychometrica.de/korrelation.html

Lupton, D. (1997). CONSUMERISM, REFLEXIVITY A n d THE MEDICAL ENCOUNTER. In *Soc. Sci. Med.* (Vol. 45, Issue 3, pp. 373–381) [Journal-article]. Pergamon.

Mayer, R. C., Davis, J. H., & Schoorman, F. D. (1995). An integrative model of organizational trust. In *The Academy of Management Review* (Vols. 20–20, Issue 3, pp. 709–734). Academy of Management. http://www.jstor.org/stable/258792

Mayring, P. (1991). Qualitative Inhaltsanalyse. In U. Flick, E. v. Kardoff, H. Keupp, L. v. Rosenstiel, & S. Wolff (Ed.), *Handbuch qualitative Forschung: Grundlagen, Konzepte, Methoden und Anwendungen* (pp. 209–213). Beltz - Psychologie Verl. Union. https://www.ssoar.info/ssoar/bitstream/handle/document/3727/ssoar-1991-mayring-qualitative_inhaltsanalyse.pdf

Mayring, P. (2015). *Qualitative Inhaltsanalyse: Grundlagen und Techniken* (12th ed.). Beltz Verlagsgruppe.

McCann, L., Holdroyd, I., Emberson, R., Painter, H., & Ford, J. (2024). Analysis of orthopaedic private healthcare patterns in England: A potential emerging two-tier system. *Public Health in Practice*, *9*, 100578. https://doi.org/10.1016/j.puhip.2024.100578

McKnight, D. H., & Chervany, N. L. (2001). Trust and Distrust Definitions: One Bite at a Time. In *Trust in Cyber-societies* (pp. 27–54). Springer.

Mechanic, D. (1996). Changing medical organization and the erosion of trust. In *The Milbank Quarterly* (Vols. 74–74, Issue 2, pp. 171–174). Blackwell Publishers.

Morgan, R. M., & Hunt, S. (1994). The Commitment-Trust theory of relationship Marketing. *Journal of Marketing*. https://doi.org/10.2307/1252308

Neczypor, J. E. (2025). The rise of commodity care. *Frontiers in Health Services*, *5*, 1611746. https://doi.org/10.3389/frhs.2025.1611746

NHE Fact Sheet | CMS. (2024). https://www.cms.gov/data-research/statistics-trends-and-reports/national-health-expenditure-data/nhe-fact-sheet

Nolan, M., Brown, J., Davies, S., Nolan, J., & Keady, J. (2006). *The Senses Framework: Improving care for Older People through a Relationship-Centred Approach* [Report].

Pokhilenko, I., Van Esch, T. E. M., Brabers, A. E. M., & De Jong, J. D. (2021). Relationship between trust and patient involvement in medical decision-making: A cross-sectional study. *PLoS ONE*, *16*(8), e0256698. https://doi.org/10.1371/journal.pone.0256698

Priem, R. L., & Butler, J. E. (2001). Tautology in the Resource-Based View and the Implications of Externally Determined Resource Value: Further Comments. *Academy of Management Review*, *26*(1), 57–65. https://doi.org/10.5465/amr.2001.4011946

Rao, X., Luo, L., Xiang, J., & Wang, X. (2025). The impact of perceived value, customer expectations, and patient experience on the satisfaction of contracted patients in hospitals. *BMC Health Services Research*, *25*(1), 7. https://doi.org/10.1186/s12913-024-12118-1

Röbken, H., & Wetzel, K. (2016). *Qualitative und quantitative Forschungsmethoden*. https://www.bba.uni-oldenburg.de/download/leseprobe_quantitativ_analytische_methoden.pdf

Rousseau, D. M., M., Sitkin, S. B., B., Burt, R. S., S., Camerer, C., Carnegie Mellon University, Duke University, University of Chicago, & California Institute of Technology. (1998). NOT SO DIFFERENT AFTER ALL: a CROSS-DISCIPLINE VIEW OF TRUST. In *Academy of Management Review* (Vol. 23, Issue 3, pp. 393–404).

Rudebeck, C. E. (2019). Relationship based care – how general practice developed and why it is undermined within contemporary healthcare systems. *Scandinavian Journal of Primary Health Care*, *37*(3), 335–344. https://doi.org/10.1080/02813432.2019.1639909

Ryan, R. M., & Deci, E. L. (2000). Self-Determination Theory and the Facilitation of Intrinsic Motivation, Social Development, and Well-Being. In *American Psychologist* (Vols. 55–55, pp. 68–78). https://doi.org/10.1037//0003-066X.55.1.68

Sandel, M. J. (2012). *What Money Can't Buy: The Moral Limits of Markets*. Farrar Straus & Giroux.

Saunders, M. N. K., Lewis, P., & Thornhill, A. (2023). *Saunders Research Methods* (9th edition). Pearson Higher Education.

Serna, D. C. (2019). Lifestyle Medicine in a Concierge Practice: My Journey. *American Journal of Lifestyle Medicine*, *13*(4), 367–370. https://doi.org/10.1177/1559827618821865

Skirbekk, H., 1,2,3, Magelssen, M., 4,5, & Conradsen, S., 6. (2023). Trust in healthcare before and during the COVID-19 pandemic. *BMC Public Health*, *23*, 2–12. https://doi.org/10.1186/s12889-023-15716-6

Sorell, T. (1997). Morality, consumerism and the internal market in health care. *Journal of Medical Ethics*, *23*(2), 71–76. https://doi.org/10.1136/jme.23.2.71

Spence, M. (1973). Job Market Signaling. *The Quarterly Journal of Economics*, *87*(3), 355–374. https://www.sfu.ca/~allen/Spence.pdf

Stange, K. C., Miller, W. L., Etz, R. S., Center for Community Health Integration, Lehigh Valley Health System and University of South Florida Morsani College of Medicine, & Virginia Commonwealth University. (2023). The role of primary care in improving population health. In *The Milbank Quarterly* (Vols. 101–101, Issue S1, pp. 795–840).

Wiley Periodicals LLC. https://pmc.ncbi.nlm.nih.gov/articles/PMC10126984/pdf/MILQ-101-795.pdf

Teece, D. J., Pisano, G., & Shuen, A. (1997). DYNAMIC CAPABILITIES AND STRATEGIC MANAGEMENT. In *Strategic Management Journal* (Vols. 18–7, pp. 509–533).

Von Soest, C. (2023). Why Do We Speak to Experts? Reviving the Strength of the Expert Interview Method. *Perspectives on Politics*, *21*(1). https://doi.org/10.1017/S1537592722001116

Whitney, R. L., Clark White, A. E., Rosenberg, A. S., Kravitz, R. L., Kim, K. K., & The Authors. (2021). Trust and shared decision-making among individuals with multiple myeloma: A qualitative study. *Cancer Medicine*, *10*, 8040–8057. https://wileyonlinelibrary.com/journal/cam4

Wiedermann, C. J. (2025). Preserving continuity and trust in primary Care: Strategies for Implementing Team-Based Models in South Tyrol, Italy. *International Journal of Environmental Research and Public Health*, *22*(4), 477. https://doi.org/10.3390/ijerph22040477

Wildes, K. W., SJ. (1999). More Questions than Answers: The Commodification of Health Care. *The Journal of Medicine and Philosophy: A Forum for Bioethics and Philosophy of Medicine*, *24*(3), 307–311. https://doi.org/10.1076/jmep.24.3.307.2526

Wray, C. M., Khare, M., & Keyhani, S. (2021). Access to care, cost of care, and satisfaction with care among adults with private and public health insurance in the US. *JAMA Network Open*, *4*(6), e2110275. https://doi.org/10.1001/jamanetworkopen.2021.10275

Appendices

Appendix A: Expert Interview Question Guide

1. Introduction & Information

Good afternoon, Mr./Ms. …,

And thank you very much for taking the time to speak with me today. This interview is part of my master's thesis, in which I explore how different healthcare delivery models – particularly concierge or premium healthcare – influence patient trust. The interview is semi-structured, meaning that I have prepared a set of guiding questions. Still, the focus is entirely on your personal perspective, your individual assessments, and your professional experience. There are no right or wrong answers.

The interview will take approximately 30 minutes. With your permission, I would like to record our conversation so I can accurately transcribe it later and avoid relying solely on memory. All recordings and transcripts will be treated confidentially and processed in accordance with applicable data protection laws, including the GDPR. Any information that could reveal your identity will be anonymized during transcription. No personal data will be published or shared with third parties, and the final thesis will include only anonymized statements, excluding names, organizations, or other identifying details. You may skip any question or pause the interview at any time.

Are you comfortable with the recording?

2. Warm-up & Context Questions

1. *To begin, I would like to understand your current professional role.* What field do you work in now, and what are your primary responsibilities?

2. *And, to better understand how you came into this position,* what has your career path looked like so far? Were there particular experiences or roles that shaped your work today?

3. Main Section

A) Understanding Trust in Healthcare

1. What does trust mean in a medical or healthcare context, from your perspective?
2. Which factors or behaviours strengthen patient trust in healthcare providers or institutions?
3. And what can weaken or damage trust?

4. *(If relevant)* Has the meaning of trust changed in recent years? If yes, what influenced this change

B) Concierge & Premium Healthcare Models

1. Are you familiar with Concierge & Premium Healthcare?
2. Concierge or premium healthcare models are those in which patients pay a fee to access enhanced services (e.g., extended appointment times, direct access, personalized coordination). Would you define it the same way, or differently?
3. Have you had direct or indirect contact with concierge or premium models?
    - If yes: In what context?
    - If no: How do you perceive these models through media, research, or public discussion?

C) Trust in Concierge and Premium Care Models (Link to the Conceptual Framework)

1. When you think of concierge or premium healthcare, what do you believe makes patients feel they can truly trust these services or feel particularly well cared for?

    1.1 *If not mentioned yet:* How important are the factors
    – personalization,
    – accessibility,
    – empathy, and
    – continuity of care
    ... in this context?
    1.2 *How do these factors influence the perceived*
    – competence,
    – benevolence, and
    – integrity
    ... of the physician or medical organization?
2. Which aspects of concierge or premium care might raise skepticism or erode trust?
3. Are there patient groups that you believe benefit particularly strongly from these models - or approach them more critically? Why?

D) Comparison: Regular vs. Concierge Care

1. When considering trust, are there aspects where regular healthcare has advantages, and others where concierge or premium care builds trust more effectively? How would you describe these differences?
2. In your opinion, which care model builds long-term trust more effectively, and why?

3. Do you see risks or unintended consequences of concierge models - for individual patients or for the healthcare system as a whole?

E) Society & System-Level Implications

1. If such models become more common, what impact could this have on public trust in the healthcare system as a whole?
2. What might be the influence on trust?
3. Some argue that concierge medicine contributes to a two-tier healthcare system. How do you view this debate?
4. Which political, ethical, or regulatory measures could help ensure fairness, access, and trust?

F) Future of Healthcare & Trust

1. Looking ahead, do you expect care to become more personalized and service-oriented, more digital, or both?
2. Which developments could strengthen trust in the future - and why?
3. What role do concierge or premium elements play going forward - marginal, complementary, or central?

4. Closing Questions

1. If you could change one thing to strengthen patient trust in healthcare (or physicians, hospitals, or new care models) - what would it be?
2. Is there anything we have not discussed that you feel is essential?
3. May I contact you again if any questions arise during the analysis, or if I need your consent to quote specific statements?

Appendix B: Coding Manual

Category System

1. Dimensions of Trust (Ability - Benevolence - Integrity)

Category	Subcategory	Definition	Anchor Example	Coding Rule (Use when…)	Exclusion Rule (Use not when…)
A -Trust Dimensions	A1 - Ability	Statements referring to perceived medical competence, expertise, or reliability of clinicians or the organization.	"Patients must feel the doctor knows what he is doing."	Use when competence, skill, medical expertise, or correct procedural execution is emphasized.	Exclude when the emphasis is on empathy or emotional support –> code under Benevolence.
	A2 - Benevolence (Empathy & Relational Warmth)	Statements referring to emotional support, empathy, listening, or relational care.	"I sit lower than the patient so they feel in control."	Use when care, compassion, emotional presence, or relational connection is described.	Exclude when the focus is on structural/organizational availability –> code under B1–B7.
	A3 - Integrity (Honesty, Transparency, Reliability)	Statements about truthfulness, transparent communication, reliability, or trust built through honesty.	"What he tells me must be true."	Use when honesty, transparency, consistent information, or the avoidance of deception is discussed.	Exclude when discussion centers on competence (skills) → code under Ability.

2. Concierge Premium Service Features

Category	Subcategory	Definition	Anchor Example	Coding Rule (Use when…)	Exclusion Rule (Use not when…)
B - Concierge Premium Service Features	B1 - Access & General Availability	Statements referring to easier access, shorter waiting times, predictable availability.	"I could only get an appointment if I paid privately."	Use when general access, waiting times, or responsiveness (non-24/7) is mentioned.	Exclude when explicit 24/7 availability is mentioned → code under B7.
	B2 - Time & Attention	Statements indicating that clinicians have or take more time for patients.	"Does he have time or is he hectic?"	Use when consultation length, unrushed care, or thorough examinations are highlighted.	Exclude when emotional warmth is central → use A2.
	B3 - Personalization & Holistic Lifestyle Insight	Statements describing individualized care, tailored services, or holistic understanding of patients' lives.	"They tell us their entire lifestyle. You understand broader contributing factors."	Use when care is adapted to personal needs, lifestyle, preferences, or long-term patterns.	Exclude when the comment is purely about access/availability → B1/B7.
	B4 - Relationshio Continuity (Same Doctor Long Term)	Statements referring to stable, continuous doctor-patient relationships with minimal provider change.	"They want someone who knows their whole family."	Use when long-term continuity, one doctor, or stable relationships are emphasized.	Exclude when continuity is not about relationships but about responsiveness → B1/B7.
	B5 - Environmental & Staff Experience (Service Environment)	Statements concerning the physical environment, cleanliness, staff friendliness, or atmosphere.	"The front desk lady is a biatch […] makes you not want to come back."	Use when environment, reception experience, facility layout, or staff behavior is discussed.	Exclude when the comment refers to medical skill → A1.
	B6 - Financial Transparency & Fairness	Statements referring to clarity, fairness, or acceptability of fees, pricing, or payment structures.	"Pay 4000 euros and you can bring your child next week."	Use when pricing, fee models, fairness, or affordability concerns are mentioned.	Exclude when affordability is used to discuss societal inequalities → C1.
	B7 - 24/7 Accessibility & Immediate Responsiveness	Statements explicitly referring to round-the-clock service, immediate phone pickup, or urgent responsiveness.	"24/7 someone will pick up the phone."	Use when 24/7 availability, urgent response expectations, or out-of-hours service is referenced.	Exclude when only general availability is mentioned → B1.

3. Systemic & Ethical Tensions

Category	Subcategory	Definition	Anchor Example	Coding Rule (Use when…)	Exclusion Rule (Use not when…)
C - Systemic & Ethical Tensions	C1 - Equity & Two-Tier Debate (Fairness & Access Justice)	Statements reflecting concerns about inequality, two-tier healthcare, or ethical consequences of paid services.	"Who can even afford this anymore?"	Use when inequality, fairness, access justice, or political debates around paid care appear.	Exclude when the conversation is about individual costs rather than social fairness → B6.
	C2 - System Overload & Clinician Burnout	Statements highlighting structural system pressure, clinician burnout, limited time, or overload.	"Clinicians are taxed […] less time with my doctor."	Use when overloaded systems, staff shortages, burnout, or systemic inefficiencies are described.	Exclude when the critique is about institutions or politics → C3.
	C3 - Institutional Distrust (System, Government, Insurers)	Statements expressing distrust in the healthcare system, government, payers, or institutional actors.	"Our healthcare is treated like big business."	Use when trust in macro-level institutions (state, insurance, system) is questioned.	Exclude when it concerns micro-level trust (doctor-patient) → A Categories.
	C4 - Reputation, Social Capital & Community Influence	Statements about organizational reputation, word-of-mouth, influential patients, or "trust contagion" in communities.	If community leaders are unhappy, the blast radius is huge."	Use when reputation, influential patients, word-of-mouth, or social capital are discussed.	Exclude when the statement is about an individual experience with no broader reputational effect.

Coding Table

Participant ID	Professional Role	Theme Block	Extracted Quote	Subcategory	Analytical Interpretation
E01	Patient Coordination	A	"For me, trust means that a doctor takes the time to address my concerns and looks at my medical history."	A2 - Benevolence	Trust is strengthened when patients feel heard and taken seriously.
		B	"The reception is very important. Is the staff friendly, understanding, polite?"	B5 - Environment & Staff Experience	Reception-level interactions significantly influence the initial formation of trust.
		B	"If the doctor is rushed and has no time, you immediately feel like a second-class person."	B2 - Time & Attention	Insufficient time during encounters is perceived as devaluing and undermines trust.
		B	"You often don't get appointments at all [...] or you're told to pay privately."	B1 - Access & General Availability	Restricted access to care generates frustration and decreases trust in the system.
		B	"If you pay us 4,000 euros, you can bring your child next week."	B6 - Financial Transparency & Fainess	High out-of-pocket fees for urgent care are perceived as unfair and ethically problematic.
		C	"Who can even afford this anymore?"	C1 - Equilty & Two-Tier Debate	Growing inequality in access to healthcare is identified as a cause for concern.
		B	"Often no one even answers the phone. That is much worse."	B1 - Access & General Availability	Poor responsiveness signals organizational neglect and weakens trust.
		C	"I don't like online video diagnoses [...] I want to see the doctor personally."	C2 - System Overload & Digital Scepticism	Digital-only care formats may reduce trust when they diminish personal contact.
		B	"A premium service would only help if I actually get faster access to specialists."	B1 - Access & General Availability	The value of concierge models is largely associated with accelerated access to specialists.
		C	"Politically everything has gotten worse; you notice it when you can't get any appointments."	C3 - Institutial Distrust	Declining trust in healthcare is linked to broader political and systemic shortcomings.
E02	Healthcare Operations	B	"Understanding who I am and what my specific needs are [...] understanding my family situation and anticipating those needs."	B3 - Personalization & Holistic Insight	Personalization and anticipating patient needs are viewed as core drivers of trust.
		B	"Having trust means I'm going to have the same provider for years [...] treated consistently when I go there."	B4 - Relationship Continuity (Same Doctor Long Term)	Long-term continuity with the same provider is linked to stable trust formation.
		B	"The front desk lady is a biatch [...] makes you not want to come back."	B5 - Environment & Staff Experience	Negative staff interactions at reception can severely weaken trust.
		B	"They don't care about me. They don't take time for me. I'm constantly not seen on time."	B2 - Time & Attention	Perceived lack of time or emotional presence reduces trust in providers.
		A	"I switched doctors because I didn't feel like I was getting heard."	A2 - Benevolence	Feeling unheard is experienced as an indicator of low empathy and reduced trust.
		A	"Trust could mean you're keeping my data safe [...] mismanagement of data can also cause a problem with trust."	A3 - Integrity	Data protection and error-free information handling are essential to perceived integrity.
		C	"For me, concierge healthcare would be on-demand, on location [...] it comes with a fee the general population cannot afford."	C1 - Equity & Two-Tier Debate	Concierge care is viewed as financially exclusive and inaccessible to most people.
		B	"I have to know that I have immediate access to you [...] that you can get here today."	B7 - 24/7 Accessibility & Immediate Responsiveness	Immediate availability is perceived as a primary requirement for concierge services.
		A	"Concierge healthcare could only exist with highly credentialed and capable providers."	A1 - Ability	The concierge model is expected to be staffed by providers with high expertise.
		C	"When the highest payment wins [...] you can't have money be a driver."	C1 - Equity & Two-Tier Debate	High-price-driven prioritization is seen as detrimental to authentic trust-building.
		C	"Concierge setups may not have access to best practices and research that a network of physicians would have."	C2 - System Overload & Clinical Burnout	Lack of institutional knowledge-sharing in concierge models is viewed as a potential quality risk.
		C	"The increase of concierge healthcare will [...] contribute to the downturn of public healthcare."	C3 - Institutial Distrust	Expanded concierge care is expected to weaken public trust in the general healthcare system.
E03	Entrepreneur & Executive	A	"Trust in a medical context is the most important thing for a patient."	A2 - Benevolence	Trust is viewed as a fundamental emotional requirement in healthcare.
		A	"Competence is decisive for trust [...] in medicine, trust through competence is a key characteristic."	A1 - Ability	Medical expertise is perceived as a primary driver of trust-building.
		A	"During the accident, the analytical approach and the competence created extreme trust in a very short time."	A1 - Ability	Rapid, competent assessment in critical situations strengthens trust significantly.
		A	"When no one communicates in the emergency room, no trust is built."	A3 - Integrity	Lack of communication leads to uncertainty and undermines trust in care.
		B	"I was placed among all the other ambulatory cases and simply had to wait [...] the situation went completely wrong."	B1 - Access & Availability	Poor triage and long waiting undermine trust in the system's ability to provide appropriate care.
		B	"Good trust was created because someone took time, analyzed properly, and communicated clearly."	B2 - Time & Attention	Adequate time and clear explanation support trust formation in medical encounters.
		C	"Many people cannot afford such a concierge service even though they would want it."	C1 - Equity & Two-Tier Debate	Premium models are viewed as financially inaccessible for large parts of the population.
		C	"The system is moving toward a three-class society [...] those who cannot afford it will feel left behind."	C1 - Equity & Two-Tier Debate	Increasing socioeconomic divides are expected to worsen healthcare inequality.
		C	"The collapse of the traditional general practitioner system leaves people helpless in making decisions."	C2 - System Overload & Clinical Burnout	Structural shortages create uncertainty and reduce trust in the overall care system.
		C	"A concierge service would make sense, but the health insurers will not support it because they cannot afford it."	C3 - Institutional Distrust	Lack of institutional support is linked to financial constraints, leading to mistrust in policy decisions.
		B	"People search their personal network for someone with access to good doctors [...] that becomes an informal concierge."	B4 - Relationship Continuity (Same Doctor Long Term)	When systems fail, informal networks take over the concierge role for navigation and access.
		B	"The concierge service only works if digital solutions and personal consultation are connected and actually reachable."	B7 - 24/7 Accessibility & Immediate Responsiveness	Successful concierge models require both digital and personal availability to maintain trust.

E04	Physician	A	"Finding a healthcare provider who can still see you as a person is super important from a trust perspective."	A2 - Benevolence (Empathy & Relational Warmth)	Trust increases when patients feel personally acknowledged rather than treated impersonally
		A	"Handling patient information [...] making sure it stays private [...] should be standard."	A3 - Integrity (Honesty, Transparency, Reliability)	Strong information protection practices are expected as a baseline for trust.
		A	I alway make sure that I'm sitting lower than a patient so that they're kind of in the point of control."	A2 - Benevolence (Empathy & Relational Warmth)	Trust is reinforced when patients perceive autonomy and respectful communication during care.
		A	"Explained well and at a lay person level is important."	A3 - Integrity (Honesty, Transparency, Reliability)	Clear, understandable communication strengthens transparency and reliability perceptions.
		C	"There is less trust in the healthcare system now than there has been."	C3 - Institutinal Distrust	Public confidence in healthcare institutions is perceived as declining.
		C	"Patients [...] come to me who have already read stuff on TikTok or online."	C2 - System Overload & Clinical Burnout	Increasing digital self-diagnosis contributes to rising complexity and stress in clinical encounters.
		A	"You're basically being questioned about your knowledge base."	A1 - Ability	Provider competence is increasingly challenged due to digital information sources.
		B	"Probably as a patient you feel rushed because the provider [...] is on a time limit."	B2 - Time & Attention	Time pressure in standard care reduces perceived attentiveness and weakens trust.
		B	"You probably can develop a much more personal relationship [...] versus most healthcare systems."	B4 - Relationship Continuity (Same Doctor Long Term)	Concierge-like models are thought to enable stronger, long-term relational bonds.
		B	"You get to know people better [...] there's probably more trust in that system."	B3 - Personalization & Holistic Lifestyle Insight	Greater personal familiarity is linked to stronger trust in premium care settings.
		C	"If you're paying someone just to be kind of on call for you [...] you could worry about their amount of experience hours."	C2 - System Overload & Clinical Burnout	Reduced patient loads in concierge care raise concerns about maintaining clinical experience.
		C	"You might make decisions to make you feel more reassured that may not be in the patient's best interest."	C1 - Equity & Two-Tier Debate	Personalized over-testing in premium care could create unfair risks or unnecessary interventions.
		C	"In the U.S. [...] you would have no healthcare if you chose not to pay for it [...] which is very dangerous."	C1 - Equity & Two-Tier Debate	Lack of baseline coverage makes two-tier healthcare particularly problematic in certain systems.
		C	"We're going towards a convenience model of medicine, which means it's going to be less personable."	C2 - System Overload & Clinical Burnout	Structural shifts toward digital convenience reduce personal interaction in care.
		B	"If what you value is having one doctor that sees you for everything, concierge is super appealing."	B7 - 24/7 Accessibility & Immediate Responsiveness	Premium models promise consistent physician availability, appealing to patients prioritizing continuity.

E05	General Practitioner	A	"Trust means knowing that when I am sick, I enter a system that I can rely on."	A2 - Benevolence (Empathy & Relational Warmth)	Trust is associated with the feeling of being safely embedded in a dependable care environment.
		A	"The patient must have the feeling: this doctor can do it, this doctor is in control of the situation."	A1 - Ability	Perceived competence and confident demeanor are central to establishing trust.
		A	"A specialist is like a master craftsman [...] you can rely on at least a minimum standard of what has been learned."	A1 - Ability	Formal qualifications signal competence and strengthen trust in professional skill.
		A	"If a doctor appears insecure, patients often say they did not feel well taken care of."	A2 - Benevolence (Empathy & Relational Warmth)	An insecure appearance weakens relational trust and generates doubt.
		A	"A lack of communication in the emergency room creates no trust."	A3 - Integrity (Honesty, Transparency, Reliability)	Missing information reduces transparency and leads to uncertainty.
		C	"Because of online information, everything gets questioned [...] you must explain a lot more now."	C3 - Institutinal Distrust	Digital information availability increases skepticism toward medical decisions.
		C	"Unguided googling only causes insecurity and fear."	C2 - System Overload & Clinical Burnout	Information overload intensifies stress and complicates patient–provider interactions.
		B	"This is already almost a premium model [...] practices taking only private patients have more time and better availability."	B1 - Access & General Availability	Selective private care increases access and availability compared to standard practice.
		B	"For premium care, the decisive factor is the price. Trust is not the problem."	B6 - Financial Transparency & Fairness	Cost is viewed as the main barrier to concierge medicine rather than trustworthiness.
		C	"Many people cannot afford such a model [...] only valuable managers are sent to these special clinics."	C1 - Equity & Two-Tier Debate	Premium services are perceived as accessible only to socioeconomically privileged groups.
		B	"A hundred people giving a hundred euros for always being available [...] I once thought about that as a business model."	B7 - 24/7 Accessibility & Immediate Responsiveness	Constant personal availability is seen as a core differentiator of concierge-style models.
		B	"In regular care, everything is like a conveyor belt [...] in a private system, examinations are longer and more thorough."	B2 - Time & Attention	Time intensity and thoroughness are perceived advantages of premium models over standard care.
		C	"The classic general practitioner model is disappearing [...] young doctors want work-life balance."	C2 - System Overload & Clinical Burnout	Structural pressures and changing workforce expectations challenge continuity of traditional care models.
		C	"Premium models can create inequalities [...] normal people may be left behind if many doctors switch to them."	C1 - Equity & Two-Tier Debate	Expanding premium services risks reducing access for those reliant on standard care.
		A	"Healthcare must become more transparent so patients understand decisions and motives."	A3 - Integrity (Honesty, Transparency, Reliability)	Transparency about clinical and system decisions is viewed as essential for rebuilding trust.

E07	Geriatrics & E-Health Leadership	A	"Trust in medicine must be earned again and again."	A3 - Integrity (Honesty, Transparency, Reliability)	Trust is viewed as a dynamic process requiring continuous confirmation.
		A	"The basis of trust is always competence."	A1 - Ability	Perceived expertise is positioned as the foundational element of medical trust.
		A	"Patients sense very clearly whether someone knows what they are doing."	A1 - Ability	Patients evaluate competence intuitively, shaping trust perceptions.
		A	"Transparency is enormously important; people want to understand what is happening."	A3 - Integrity (Honesty, Transparency, Reliability)	Clear explanations and openness about decisions strengthen trust.
		B	"Time pressure destroys the interpersonal relationship."	B2 - Time & Attention	Overly rushed interactions weaken relational foundations of trust.
		C	"Good medicine needs time and that time is no longer available."	C2 - System Overload & Clinical Burnout	Structural time scarcity undermines quality care and trust-building.
		B	"Continuity of care no longer exists; patients see a different doctor every time."	B4 - Relationship Continuity (Same Doctor Long Term)	Fragmented care delivery disrupts stable doctor–patient relationships.
		C	The system is completely overloaded - everyone is working at their limit."	C2 - System Overload & Clinical Burnout	Excessive workloads contribute to deteriorating system performance and patient trust.
		C	"People feel the system no longer takes care of them."	C3 - Institutinal Distrust	Perceived institutional neglect fuels declining public trust.
		C	"We are heading toward a two-tier healthcare system."	C1 - Equity & Two-Tier Debate	Increasing inequality in access is seen as an emerging structural issue.
		B	"With money, one gets faster appointments and better access - that is the reality."	B1 - Access & General Availability	Financial resources are associated with preferential access to care.
		B	"Premium services can absolutely strengthen trust if the doctor truly has time."	B2 - Time & Attention	Extended consultation time in concierge models is linked to improved trust.
		C	"The danger is that normal patients will be left behind when doctors move to concierge medicine."	C1 - Equity & Two-Tier Debate	Expansion of premium models risks exacerbating inequities for the general population.
		B	"Trust is also influenced by the atmosphere. Is it clean, is it professional?"	B5 - Environmental & Staff Experience	The physical and professional environment contributes to perceived trustworthiness.

E08	Hospital Management	A	"Trust in the medical context has two facets for me: the competence of those treating and the availability of objective information."	A1 - Ability	Trust is grounded in professional expertise supported by reliable information structures.
		A	"The basis of trust is created by experienced specialists and good chief physicians."	A1 - Ability	Seniority and clinical experience are seen as foundational signals of competence.
		A	"Communication is one of the behavioral factors that significantly contribute to trust."	A3 - Integrity (Honesty, Transparency, Reliability)	Transparent and clear communication enhances predictability and reduces uncertainty.
		B	"If expectations are not met and after five attempts no one picks up the phone, trust is gone."	B1 - Access & General Availability	Missed or delayed responsiveness undermines trust through perceived inaccessibility.
		B	"Premium care involves aesthetics and preventive medicine and focuses on people seeking more proactive engagement with their health."	B3 - Personalization & Holistic Lifestyle Insight	Premium services emphasize individualized, forward-looking health strategies.
		B	"The professional appearance of a practice contributes to the feeling of being well taken care of."	B5 - Environmental & Staff Experience	Environmental quality and professional presentation support perceived trustworthiness.
		C	"Premium care does not apply to all situations; for acute care, people need the regular system."	C2 - System Overload & Clinical Burnout	Structural system functions cannot be fully substituted by premium models due to role limitations.
		C	"We are heading toward stronger two-class medicine."	C1 - Equity & Two-Tier Debate	Increasing inequality in access is foreseen as a societal challenge tied to premium services.
		B	"With money, people get faster appointments and better access - that is the reality."	B6 - Financial Transparency & Fairness	Payment-based preferential access contributes to perceived unfairness in the system.
		C	"We reject the concept of two-class medicine when it comes to acute care in our region."	C3 - Institutinal Distrust	Organizations attempt to counteract public mistrust by committing to equitable acute care.
		C	"Digitization has potential, but the healthcare system in Germany is far behind."	C3 - Institutinal Distrust	Systemic shortcomings in digital infrastructure contribute to skeptical perceptions.
		C	"The question is how medical knowledge and data can be made globally available in the future."	C4 - Reputation, Social Capital & Community Influence	Trust is also linked to broader questions of shared knowledge and responsible data governance.

		B	"Really look at someone's life holistically rather than just the symptoms itself."	B3 - Personalization & Holistic Lifestyle Insight	Trust is supported through understanding the patient's broader life context.
		A	"The average person sees a doctor [...] very differently now; that village doctor from the 1950s had a lot more respect."	A1 - Ability	Perceived professional authority has shifted over time, affecting baseline trust.
		C	"They can't go back to the NHS because it's a different doctor every time; the system is overloaded."	C2 - System Overload & Clinical Burnout	Systemic capacity issues reduce continuity and push patients toward premium models.
		C	"We are the centres of a lot of people's lives [...] people come to us for everything."	C4 - Reputation, Social Capital & Community Influence	Concierge providers often become trusted anchors far beyond medical care.
		C	"We have a lot of trust in the communities [...] it's a lot of reputation management."	C4 - Reputation, Social Capital & Community Influence	Maintaining organizational reputation is central to sustaining patient trust.
		B	"Continuity of care [...] they don't want a different doctor; they want someone who knows their family."	B4 - Relationship Continuity (Same Doctor Long Term)	Long-term relational consistency is perceived as essential to trust.
		B	"24/7 someone's gonna pick up the phone [...] that's a subcomponent of concierge."	B7 - 24/7 Accessibility & Immediate Responsiveness	Permanent availability is a defining expectation of concierge care.
		B	"Continuity is huge [...] and that's going to be one of the biggest problems every concierge company comes across."	B4 - Relationship Continuity (Same Doctor Long Term)	Ensuring continuity is both a trust driver and a persistent operational challenge.
E09	Concierge Healthcare Management	A	"You see that with our doctors [...] the subconscious is a powerful thing."	A2 - Benevolence (Empathy & Relational Warmth)	Trust dynamics often operate at an intuitive, emotional level.
		B	"I see it as very personalised [...] large language models getting heavily involved."	B3 - Personalization & Holistic Lifestyle Insight	The future of care is envisioned as highly personalized and technologically augmented.
		B	"When you've only got 10 minutes per appointment, it's very hard to do personalized medicine."	B3 - Personalization & Holistic Lifestyle Insight	Time constraints directly limit personalization in non-premium settings.
		A	"A big part of our relationship-based medicine is the follow-up [...] just remembering the patient."	A2 - Benevolence (Empathy & Relational Warmth)	Proactive, relational follow-up reinforces the sense of being cared for.
		B	"That would create a brilliant service [...] a huge competitive advantage."	B1 - Access & General Availability	Technology-enabled responsiveness strengthens both service quality and trustworthiness.
		B	"Doctors are hard to manage [...] I like robot doctors, that's the future."	B2 - Time & Attention	Managing clinicians' limited time is challenging, prompting interest in automation.
		A	"It could be this, could be this [...] AI can pull out hundreds of millions of data points."	A1 - Ability	AI is seen as enhancing clinical accuracy by offering broad differential insights.
		C	"It's very cyclical [...] private equity loads up debt [...] that might destroy trust."	C3 - Institutinal Distrust	Financial extraction by investors is viewed as a major threat to trust in healthcare.
		C	"Ultimately the distinction will just be price [...] who can afford who cannot."	C1 - Equity & Two-Tier Debate	Price becomes the defining access barrier as concierge models proliferate.

		A	"Trust means having the feeling that the doctor cares, even without knowing how good they are professionally."	A2 - Benevolence (Empathy & Relational Warmth)	Emotional care is valued more highly than medically assessable competence.
		A	"I've always got along best with doctors who communicate clearly."	A3 - Integrity (Honesty, Transparency, Reliability)	Clear communication increases transparency and strengthens trust.
		A	"When someone avoids saying things directly, you feel something is going on in the background."	A3 - Integrity (Honesty, Transparency, Reliability)	Indirect or evasive communication reduces perceived transparency.
		A	"I do not rely on self-diagnosis; that is the role of specialists."	A1 - Ability	Professional expertise is preferred over lay knowledge or online information.
		A	"Reliability means that what is said actually happens."	A3 - Integrity (Honesty, Transparency, Reliability)	Following through on commitments reinforces trust in professional reliability.
		B	"The practice environment is important [...] waiting long really annoys me."	B5 - Environmental & Staff Experience	Organizational environment and waiting times shape overall trust in care settings.
E10	Healthcare Finance	A	"I tell the doctor: you are the expert, we'll do whatever you say is best."	A1 - Ability	Deference to medical expertise signals high baseline trust in professional judgment.
		B	"Everyone who pays more gets more - that's simply the logic."	B6 - Financial Transparency & Fairness	Premium care is understood as a price-based differentiation of service levels.
		B	"The expectation is: I pay for an above-average service that sets me apart from normal patients."	B3 - Personalization & Holistic Lifestyle Insight	Premium patients expect enhanced, differentiated experiences as part of personalization.
		B	"Some patients are used to having people available whenever they want."	B7 - 24/7 Accessibility & Immediate Responsiveness	High-net-worth patients often expect immediate access as a baseline service standard.
		C	"Premium care already existed [...] private insurance used to offer very high standards without the concierge stuff."	C1 - Equity & Two-Tier Debate	Historical contrasts highlight how premium models amplify existing inequalities.
		C	"Concierge medicine kills the rest of the system [...] capacity is already scarce."	C2 - System Overload & Clinical Burnout	Additional premium layers are seen as draining capacity from an already strained system.
		C	"It's a three-class system [...] and the gap keeps widening."	C1 - Equity & Two-Tier Debate	Stratification is perceived as increasing, with significant implications for fairness in access.

E11		A	"I would look at the colleague's experience - how many procedures of a certain type they have performed and for how long they have done this."	A1 - Ability	Experience and procedure volume are key indicators of competence.
		A	"Heart surgery is never the work of one surgeon; it is performed by a whole team."	A1 - Ability	Trust depends on coordinated team competence rather than individual skill alone.
		A	"Trust is found directly in dialogue [...] I try to build a bond by responding to the patient's needs."	A2 - Benevolence (Empathy & Relational Warmth)	Trust forms through attentive communication and relational responsiveness.
		C	"Patients today are much more informed [...] second and third opinions are relatively new."	C2 - System Overload & Clinical Burnout	Increased information access shifts expectations and alters trust dynamics.
		B	"Time is an important trust-building factor [...] which is in short supply today."	B2 - Time & Attention	Limited consultation time undermines opportunities for trust formation.
		B	"You have to take the time to explain things so patients understand them."	B2 - Time & Attention	Adequate time is necessary for clear, trust-enhancing explanations.
		B	"Availability is very important - making an appointment with the doctor of choice when it fits your schedule."	B1 - Access & General Availability	Flexible and direct access increases perceived reliability.
		A	"Competence is not based on trust; it comes from elsewhere [...] there must be validation."	A3 - Integrity (Honesty, Transparency, Reliability)	Competence must be demonstrated through objective evidence, not assumed.
		C	"The private patient receives a somewhat different treatment [...] for example, being operated on by the most experienced surgeon."	C1 - Equity & Two-Tier Debate	Insurance status already results in unequal access to expertise.
		B	"If a fee is charged, then a truly special service must be provided."	B6 - Financial Transparency & Fairness	Premium care must justify costs with clear added value.
		A	"A concierge clinic must show a clear added value [...] the outcome must be at least as good as in the regular clinic."	A1 - Ability	Clinical outcomes must be equal or superior to standard care to warrant concierge fees.
		C	"If the clinic is overwhelmed, the entire process becomes stressful for the patient."	C2 - System Overload & Clinical Burnout	Overcapacity reduces perceived reliability and weakens trust.
		A	"Patients form a picture based on the first three minutes - how one appears, how one communicates."	A2 - Benevolence (Empathy & Relational Warmth)	Early-stage interpersonal cues strongly shape trust impressions.
		C	"Public perception does not distinguish between competence and availability."	C3 - Institutinal Distrust	Patients often misinterpret accessibility as expertise, complicating trust formation.
		C	"Patients often assume everything is free and included, but that is not how the system works."	C1 - Equity & Two-Tier Debate	Misaligned expectations contribute to perceived unfairness.
		A	"We must communicate honestly about what is realistically possible in the future."	A3 - Integrity (Honesty, Transparency, Reliability)	Transparency about system limitations is essential for maintaining trust.
		C	"Digitalization must come because fewer and fewer staff work in hospitals."	C2 - System Overload & Clinical Burnout	Workforce shortages drive the need for digital solutions.
		C	"There will fundamentally be a multi-tier healthcare system [...] even with a universal insurance model."	C3 - Institutinal Distrust	Structural inequality is expected to persist regardless of reforms.
E12	Concierge Care Coordination	A	"For me, trust comes from knowing the provider is competent, open about things, and actually follows through."	A3 - Integrity (Honesty, Transparency, Reliability)	Trust forms when communication is transparent and actions are reliable.
		A	"When communication is clear and you can reach someone easily, that really builds trust."	A2 - Benevolence (Empathy & Relational Warmth)	Transparent interaction and dependable access strengthen relational security.
		B	"Trust drops fast when appointments feel rushed or when messages get mixed."	B2 - Time & Attention	Insufficient time and inconsistent communication weaken trust.
		B	"People expect more personal attention now - they want care to fit their situation, not the other way around."	B3 - Personalization & Holistic Lifestyle Insight	Rising expectations increase the importance of personalized approaches.
		C	"Traditional clinics are so full that patients often feel like they're just one more number in line."	C2 - System Overload & Clinical Burnout	Overcapacity reduces perceived support and emotional safety.
		C	"Inequality mostly shows up in what people can afford - some can pay for quicker access, others can't."	C1 - Equity & Two-Tier Debate	Access differences arise primarily from financial capacity.
		B	"Concierge care basically means you pay for more time, 24/7 contact, and appointments when you need them."	B7 - 24/7 Accessibility & Immediate Responsiveness	Constant availability and speed are central trust-building features.
		B	"What helps people most is the continuity - talking to someone who really knows their story."	B4 - Relationship Continuity (Same Doctor Long Term)	Ongoing familiarity supports long-term trust.
		B	"If people pay extra, they want to see the value clearly - otherwise the trust just isn't there."	B6 - Financial Transparency & Fairness	Fee-based models require transparent and visible value to maintain trust.
		A	"Digital tools are great for efficiency, but they can't replace the personal side, especially when something serious is going on."	A2 - Benevolence (Empathy & Relational Warmth)	Technology supports logistics but cannot replace personal reassurance.
		B	"I think the future will mix both - digital efficiency on one side and the personal relationship on the other."	B4 - Relationship Continuity (Same Doctor Long Term)	Trust-building is expected to rely on hybrid care combining technology and continuity.

Appendix C: Patient survey

Introduction & Consent

Welcome! This survey explores current perspectives on healthcare services.

Duration: Approx. 5 minutes.

Anonymity: Your responses are anonymous.

By clicking “Next,” you agree to the use of your responses solely for research purposes.

Screening

S1. In the past 12 months, have you had at least one contact with a doctor (in a practice or clinic)?

☐ Yes ☐ No

Note on Logic:

- *If **Yes** → Proceed to Section A*
- *If **No** → Skip Section A & C, proceed to Section B and continue at D*

A) Most Recent Healthcare Experience *(Please answer based on your last visit to a doctor)*

Please indicate your agreement with the following statements.

(Scale: 1 = Strongly Disagree to 5 = Strongly Agree)

Statement	1	2	3	4	5
A1. I received an appointment promptly when I needed one.	☐	☐	☐	☐	☐
A2. The practice was easy to reach (by phone, online, or response time).	☐	☐	☐	☐	☐
A3. The reception staff treated me politely and with respect.	☐	☐	☐	☐	☐
A4. The nurse who took my vitals prior to seeing the doctor was polite and competent.	☐	☐	☐	☐	☐
A5. The doctor spent sufficient time with me.	☐	☐	☐	☐	☐
A6. The treatment prescribed was explained clearly to me.	☐	☐	☐	☐	☐
A7. I am usually treated by the same doctor or medical team.	☐	☐	☐	☐	☐

A8. How long was the waiting time for your last appointment?

☐ Less than 1 week ☐ 1–2 weeks ☐ 2–4 weeks ☐ More than 4 weeks ☐ Emergency / Immediate treatment

B) Service Attributes: Time, Access, Empathy, Continuity

Please indicate how important the following aspects are to your trust in healthcare providers.

(Scale: 1 = Strongly Disagree to 5 = Strongly Agree)

Statement	1	2	3	4	5
B1. Quick access to appointments greatly increases my trust.	☐	☐	☐	☐	☐
B2. Direct availability (e.g., same-day or next-day call-back) is very important to me.	☐	☐	☐	☐	☐
B3. When doctors take their time and explain calmly, my trust increases.	☐	☐	☐	☐	☐
B4. A friendly welcome at the front desk is important to me.	☐	☐	☐	☐	☐
B5. Seeing the same doctor repeatedly strengthens my trust.	☐	☐	☐	☐	☐
B6. Support with organizing care (e.g., referrals, specialist appointments, forwarding of results) is important to me.	☐	☐	☐	☐	☐
B7. I trust a doctor more when they appear confident and competent.	☐	☐	☐	☐	☐
B8. I value empathy more than confidence and competence.	☐	☐	☐	☐	☐

C) Trust in Healthcare Providers

(The following questions refer exclusively to your most recent doctor or practice visit)

Please indicate your agreement.

(Scale: 1 = Strongly Disagree to 5 = Strongly Agree)

Statement	1	2	3	4	5
C1. The doctor appeared professionally competent.	☐	☐	☐	☐	☐
C2. I felt taken seriously and received clear explanations.	☐	☐	☐	☐	☐
C3. Overall, I trusted this doctor or practice.	☐	☐	☐	☐	☐
C4. I felt that the doctor acted in my best interests.	☐	☐	☐	☐	☐

D) Digitalization & Communication Channels

Please indicate your agreement to the use of digital health services.

(Scale: 1 = Strongly Disagree to 5 = Strongly Agree)

Statement	1	2	3	4	5
D1. Video or phone consultations are a good addition to in-person visits.	☐	☐	☐	☐	☐
D2. I trust medical advice provided via video (when examination and diagnosis make this feasible).	☐	☐	☐	☐	☐
D3. Without a secure data channel (e.g., avoiding SMS or unsecured email), I would not use digital consultations.	☐	☐	☐	☐	☐
D4. I prefer face-to-face contact when receiving new diagnoses or discussing complex issues.	☐	☐	☐	☐	☐

E) Concierge / Premium Healthcare Models

Definition: *"Concierge" or "Premium" care refers to services that provide enhanced access, longer consultation time, direct availability, and personalized coordination in exchange for a membership fee.*

E1. Adoption and Perceptions

(Scale: 1 = Strongly Disagree to 5 = Strongly Agree)

Statement	1	2	3	4	5
E1a. Such an offer would likely increase my trust.	☐	☐	☐	☐	☐
E1b. Faster access (same- or next-day appointments) would be especially important to me.	☐	☐	☐	☐	☐
E1c. I would find it problematic if only some people could afford such offers.	☐	☐	☐	☐	☐
E1d. I would be willing to pay for reliable availability (e.g., same-day call-backs).	☐	☐	☐	☐	☐
E1e. More time per appointment is the most important aspect for me.	☐	☐	☐	☐	☐
E1f. I would trust such offers more if they connected me with proven doctors (verified quality/satisfied patients).	☐	☐	☐	☐	☐
E1g. I value other aspects of concierge services beyond just healthcare (e.g., premium hospital rooms, gourmet catering).	☐	☐	☐	☐	☐

E2. Comparison of Two Care Models

Please imagine that all your medical visits in the coming year follow one of the following two models. Read both carefully, then answer the questions below.

Scenario A: Standard Care	Scenario B: Premium Care (Concierge)
Appointment availability: 2–3 weeks waiting time	Appointment availability: Within 24–48 hours
Consultation length: Approx. 10–12 minutes	Consultation length: Approx. 30 minutes
Response to inquiries: Within 2 working days	Response to inquiries: 24/7 availability
Continuity: Care provided by different doctors	Continuity: Dedicated doctor with small patient panel
Coordination: No active follow-up on results	Coordination: Personal follow-up & specialist coordination
Cost: No additional costs	Cost: Annual membership fee: €3,000

E2a. Which of the two models would you consider more trustworthy?

☐ Scenario A – Standard Care ☐ Scenario B – Premium Care

E2b. If you had the choice, would you use Scenario B even with an annual fee of €3,000?

☐ Yes ☐ No

E2c. (If "No") What would need to change for you to consider Scenario B?

(Optional short answer)

E3. Willingness to Pay

Assuming the Premium Model (Scenario B) were available to you, what is the maximum annual fee you would be willing to pay for its benefits?

☐ €0 – I would not pay for such an offer ☐ Up to €1,000 ☐ Up to €2,000 ☐ Up to €3,000

☐ Up to €4,000 ☐ More than €4,000 (please specify: _____ €)

F) Behavioral Intentions & Perceived Value

(The following statements refer to the care model you preferred in Question E2a)

Please indicate to what extent you agree with each statement.

(Scale: 1 = Strongly Disagree to 5 = Strongly Agree)

Statement	1	2	3	4	5
F1. I would stay with this care model if I had the choice.	☐	☐	☐	☐	☐
F2. I would recommend this model to friends or family.	☐	☐	☐	☐	☐
F3. This care model provides me with the best personalized benefits.	☐	☐	☐	☐	☐
F4. I would be willing to pay the annual fee long-term, provided the quality remains consistent.	☐	☐	☐	☐	☐

G) Demographic Information

G1. Age: ☐ 18–29 ☐ 30–44 ☐ 45–59 ☐ 60+

G2. Gender: ☐ Female ☐ Male ☐ Non-binary / Diverse ☐ Prefer not to say

G3. Health Insurance Type: ☐ Public ☐ Private ☐ None / Other

G4. Place of Residence: ☐ Rural ☐ Urban

G5. Highest Educational Level: ☐ High school or below ☐ Vocational / Technical degree

☐ Bachelor's degree ☐ Master's degree ☐ Doctorate / PhD

☐ Other (please specify: _____)

G6. Gross Annual Income (optional): ☐ Less than €30,000 ☐ €30,000 – €50,000

☐ €50,001 – €80,000 ☐ €80,001 – €120,000 ☐ More than €120,000

G7. How often do you use healthcare services annually (approximate visits)? ☐ 0–1 times

☐ 2–4 times ☐ 5–10 times ☐ More than 10 times

G8. Do you have any chronic illnesses or conditions? ☐ Yes ☐ No

G9. Have you used a concierge or premium medical service before? ☐ Yes ☐ No

Appendix D: Overview of All Variables Used in the Quantitative Analysis

Construct	Survey Block	Item Wording	SPSS Variable Name
Personalization	A	The doctor spent sufficient time with me.	Pers_1
Personalization	A	Treatment was explained clearly to me.	Pers_2
Personalization	C	I felt taken seriously and received clear explanations.	Pers_3
Personalization	C	I felt that the doctor acted in my best interests.	Pers_4
Accessibility	A	I received an appointment promptly when I needed one.	Access_1
Accessibility	A	Waiting time category (recoded: higher = faster).	Access_2
Empathy (Reception Staff)	A	The reception staff treated me politely and with respect.	Empathy_1
Empathy (Nursing Staff)	A	The nurse who took my vitals was polite and competent.	Empathy_2
Continuity of Care	A	I am usually treated by the same doctor or medical team.	Cont
Fairness Concerns	E	I would find it problematic if only some people could afford such offers.	FC
Patient Trust	C	The doctor appeared professionally competent.	Trust_1
Patient Trust	C	Overall, I trusted this doctor or practice.	Trust_2
Choice Confidence	F	I would stay with this care model if I had the choice.	Scenario_4
Choice Confidence	F	I would recommend this model to friends or family.	Scenario_5
Choice Confidence	F	This care model provides me with the best personalized benefits.	Scenario_6
Choice Confidence	F	I would be willing to pay the annual fee in the long term, provided the quality remains consistent.	Scenario_7

Appendix E: Interview Summaries

E01: Patient Coordination | 05. November 2025

Foundations and Erosion of Trust in Care Delivery

Trust is grounded in sufficient time, calm interactions, and clear communication. First impressions at reception strongly shape the experience, while rushed consultations, limited attention, and poor responsiveness reduce confidence in care. Trust also depends on consistent communication across touchpoints, including phone availability and respectful treatment. The participant perceives an overall decline in trust due to long wait times, unanswered calls, and a sense of overload within the system, collectively creating a sense of being undervalued. This erosion is tied to broader political and institutional developments that have weakened access and service capacity.

Access Barriers, Perceived Inequality, and Ethical Concerns

Limited specialist availability, long waitlists, and frequent referrals to self-paid treatment options contribute to perceptions of structural unfairness. High out-of-pocket fees for urgent care are considered inappropriate, particularly for individuals who contribute to the system through taxation. Variations in insurance coverage, inconsistent reimbursement structures, and differences in medication costs further intensify frustration. These challenges are seen as signs of a system in which resource scarcity and income increasingly determine access to timely and adequate care.

Views on Concierge Medicine and Premium Care Models

Concierge care is primarily associated with faster access to specialists, which is regarded as the most relevant trust-enhancing element. While personalization, empathy, and continuity are valued, accelerated access remains the most decisive factor. At the same time, the participant raises concerns about fairness and questions who will be able to afford such services. Concierge care is often viewed as reinforcing a two-tiered system, but it may be used when conventional pathways no longer provide sufficient support.

Digital Care, Personal Contact, and Generational Dynamics

Digital-first care, such as video consultations or online diagnoses, is perceived as reducing the personal encounter that is essential for trust. Physical examinations, in-person communication, and personal interaction are considered indispensable for credible care. Generational differences influence attitudes toward digital models, with older patients favoring direct contact.

Expectations for Future Healthcare Delivery

Trust-building is seen as dependent on improved access to specialists, greater support from insurers, and better coordination across the system. Although further digitalization is expected, concerns persist regarding increasing privatization and unequal access. Concierge elements are expected to remain supplementary rather than central, valued primarily for efficiency rather than personal depth.

E02: Healthcare Operations | 05. November 2025

Foundations and Erosion of Trust in Care Delivery

Trust is described as emerging from personalized attention, clear communication, and sustained relationships. Consistent interactions with the same provider and an understanding of a patient's personal context contribute to a stable sense of reliability. Trust declines when encounters feel rushed or impersonal, when staff interactions lack professionalism, or when administrative processes are not running smoothly. Errors in digital systems (e.g., inaccurate records, misassigned information) further undermine trust by disrupting continuity. Fragmented experiences, high-workload environments, and operational inconsistencies in healthcare settings are considered broader factors that erode confidence in care delivery.

Access Barriers, Perceived Inequality, and Ethical Concerns

Access limitations arise from overextended staff, appointment delays, and time constraints, which create perceptions of unequal treatment. While inequality is not intentionally framed, differences in responsiveness, service quality, and reliability contribute to uneven patient experiences. Administrative mistakes and long waits intensify these perceptions. The participant notes that financial disparities affect access to timely attention but emphasizes system-level pressures over deliberate discrimination.

Views on Concierge Medicine and Premium Care Models

Concierge care is primarily associated with immediate access, convenience, and confidentiality. Trust in these models depends on providers' perceived expertise and their ability to respond quickly to patient needs. Personalization is viewed as helpful but secondary to rapid availability. Concerns include reduced exposure to peer consultation, limited connection to broader clinical networks, and potential gaps in knowledge updating. Financial incentives and on-demand expectations may influence provider behavior, raising questions about relationship quality and decision-making in cash-based environments.

Digital Care, Personal Contact, and Generational Dynamics

Digital tools such as portals, kiosks, and electronic records shape trust by influencing efficiency and accuracy. When functioning reliably, they complement care; however, technological errors or the replacement of personal interaction can reduce trust. Differences in digital confidence

affect how various patient groups engage with these tools. Despite digital expansion, relational contact and continuity remain central to trust building.

Expectations for Future Healthcare Delivery

Future care is expected to combine digital convenience with greater personalization. Elements associated with concierge medicine, such as proactive communication, clear scheduling support, and anticipatory guidance, are already emerging in standard healthcare. Trust improvements are viewed as contingent on expanded access, operational reliability, and sustainable continuity, whereas concierge models are expected to remain a niche yet influential complement.

E03: Entrepreneur & Executive | 06. November 2025

Foundations and Erosion of Trust in Care Delivery

Trust is vital in emergencies and non-urgent care, built through competence, analysis, and clear communication. In serious accidents and cardiac events, trust increased when clinicians provided accurate assessments, explained risks, and adhered to procedures. It declined when symptoms were misinterpreted, triage failed, or communication broke down. These experiences indicate that trust depends on medical expertise, attentiveness, and sound decision-making.

Access Barriers, Perceived Inequality, and Ethical Concerns

Access challenges appear in inconsistent emergency triage, shortages of general practitioners, and uneven specialist availability, particularly in rural areas. As a result, patients increasingly rely on informal networks (friends, personal contacts, or acquaintances) to obtain timely access or specialty referrals. The lack of transparency around healthcare costs in Germany contributes to limited awareness of the economic value of services. Demographic changes, staff shortages, and regional disparities are perceived as drivers of widening access gaps, creating the impression of an emerging multi-tier system.

Views on Concierge Medicine and Premium Care Models

Concierge models are viewed as a practical response to guidance gaps in the system, offering structured navigation, specialist preselection, and personal support. Their appeal lies in reducing patient uncertainty and quickly guiding them to the appropriate provider. However, high costs limit access to individuals with greater financial resources. The credibility of concierge models depends on their ability to identify competent specialists, stay up to date, and serve as a reliable coordination point. Their spread is expected to influence expectations toward service quality but may reinforce access differences if not supported by broader system measures.

Digital Care, Personal Contact, and Generational Dynamics

Digital tools and AI-based guidance are considered increasingly relevant, especially for individuals without a general practitioner. Digital pathways may support initial orientation, whereas personal dialogue remains necessary for complex decisions or situations that require reassurance. Preferences vary by income, age, and health literacy, leading to the coexistence of both digital-first and personal advisory approaches.

Expectations for Future Healthcare Delivery

Future care is expected to evolve in two directions: increased digital self-navigation for cost-sensitive groups and expanded personal advisory services for higher-income individuals. A sustainable model would combine centralized digital triage with human advisory support to enhance continuity and reduce inefficiencies. Structural adjustments, cost transparency, and insurer-supported coordination functions are described as essential for maintaining trust and improving system navigation. Concierge-style services are viewed as complementary components rather than replacements for core healthcare structures.

E04: Physician | 08. November 2025

Foundations and Erosion of Trust in Care Delivery

Trust is said to emerge when patients feel seen as individuals, particularly in vulnerable situations such as hospitalization. Preserving dignity, avoiding judgment, and maintaining respectful body language contribute to a sense of safety. Clear explanations, informed consent, and predictable procedural guidance strengthen reliability, especially when patients temporarily surrender control. Institutional safeguards, such as private messaging systems and secure communication channels, enhance integrity. Trust is perceived to have declined due to increased exposure to online information, AI-generated symptom interpretations, and stories of misdiagnosis, which lead patients to question professional expertise. A shift from paternalistic models toward shared decision-making also influences expectations and changes how patients evaluate care.

Access Barriers, Perceived Inequality, and Ethical Concerns

Access challenges are discussed mainly in relation to time pressure within standard care models. Appointment structures, productivity incentives, and brief consultation formats can reduce space for dialogue and diminish trust. Comparisons across healthcare systems highlight differences in baseline access; in systems without guaranteed care, socioeconomic status strongly shapes whether individuals can obtain services. Where a baseline exists, differences are framed more as trade-offs between waiting time and cost rather than outright inequity.

Views on Concierge Medicine and Premium Care Models

Concierge care is associated with longer duration, greater accessibility, and stronger relationships. These elements are expected to foster greater trust by allowing deeper explanation of clinical reasoning and a more consistent interpersonal connection. Potential concerns include reduced exposure to a wide variety of cases, limited connection to broader clinical networks, and the risk of unnecessary testing driven by reassurance rather than medical necessity. Payment structures and small patient panels may influence practice patterns and raise questions within the broader clinical community.

Digital Care, Personal Contact, and Generational Dynamics

Digital tools enhance convenience but reduce personal contact. While efficiency is recognized, digital-only communication is less suitable for complex decisions or ongoing relationships. Generational gaps influence comfort with digital care; some prefer traditional visits, others favor quick digital access.

Expectations for Future Healthcare Delivery

Future care is expected to become more digital and focused on convenience, driven by system pressures and changing work-life expectations among clinicians. Personal continuity may decrease in standard models, making concierge-style services appealing to those who value accessibility and a single, consistent provider. Concierge elements are considered complementary, not replacements, particularly in systems that still guarantee a baseline of care.

E05: General Practitioner | 10. November 2025

Foundations and Erosion of Trust in Care Delivery

Trust is defined as confidence in both the physician and the system. It develops when clinicians demonstrate competence, act confidently, communicate clearly, and handle situations reliably. Professional experience, visible confidence, and perceived maturity enhance trust, whereas uncertainty and hesitation diminish it. Formal training and the structured nature of medical specialization are seen as key foundations for trust. Over time, trust has evolved as patients increasingly question decisions, influenced by online information and digital symptom searches. This shift requires more explanation, guidance, and clarification during medical encounters.

Access Barriers, Perceived Inequality, and Ethical Concerns

Access challenges include high patient volumes, long wait times, and difficulty securing appointments, leading to frustration and disrupted care. Rural general practitioner shortages and systemic inefficiencies worsen access to care. Supplemental services, such as unnecessary cash-based treatments (IGeL), create parallel access, affecting the availability of standard care.

Patients have limited cost awareness, often unaware of service value or resource constraints. Inequality is seen as a system feature, not an exception.

Views on Concierge Medicine and Premium Care Models

Concierge care is understood as a paid service that provides enhanced access, availability, and personalized support. The participant acknowledges the model's potential appeal and suggests that trustworthy implementation would require transparency, patient feedback, and demonstrable value. Time and accessibility are considered the primary differentiators, whereas competence is expected to be equivalent across premium and standard care. Concerns center on the risk that widespread adoption could shift physicians' capacity toward paying groups, thereby reducing availability for others. The participant also identifies similarities between concierge models and existing private service add-ons, such as comprehensive executive checkups.

Digital Care, Personal Contact, and Generational Dynamics

Digital consultations, remote triage, and video-based practices are likely to grow, especially as staffing shortages worsen. Younger patients adapt more easily to digital formats, while older patients prefer in-person visits. Digital options may reduce personal contact but are considered a practical response to demographic and resource constraints.

Expectations for Future Healthcare Delivery

Future care is expected to become more digital, less personalized, and increasingly influenced by large medical centers rather than solo practices. Traditional house-doctor models are considered in decline. System-wide reforms, cost transparency, and honest communication about limitations are deemed essential to maintaining trust. Concierge services are expected to support, rather than replace, standard care, particularly for patients seeking greater availability and coordination.

E06: Healthcare Administration | 13. November 2025

Foundations and Erosion of Trust in Care Delivery

Trust develops when clinicians listen, incorporate patient input into care decisions, and maintain transparency from scheduling through billing. Kindness, clear expectations, and the involvement of family members also build trust. Trust erodes when staff do not listen, records are incorrect or incomplete, patients are asked the same questions repeatedly, facilities look unclean, or staff appear distressed. On a larger scale, rising healthcare costs, complex insurance processes, and perceptions of healthcare as "big business" erode trust and cause frustration. Clinician burnout and shorter visits also limit meaningful conversations and impact perceived quality of care.

Access Barriers, Perceived Inequality, and Ethical Concerns

Access challenges include long wait times, over-scheduled clinicians, and limited appointment availability, resulting in patients receiving only partial attention during brief visits. Variability in insurance rules, medication approvals, and billing practices creates inconsistency and opacity. While inequality is not framed as intentional, it arises from financial capacity, benefit structures, and the fragmented nature of U.S. healthcare, resulting in access that is highly dependent on insurance, geography, and personal resources.

Views on Concierge Medicine and Premium Care Models

The participant has used concierge care for several years and reports substantially better access, longer appointment times, more detailed examinations, and direct communication with the physician. The model offers rapid responses, continuity, and support in navigating insurance requirements. Limitations include affordability, the risk of overpricing by individual professionals, and reduced regulatory oversight in smaller practices, including gaps in HIPAA applicability. Potential disadvantages include dependence on a single provider and fewer built-in safeguards than those in larger group practices. Concierge care is seen as beneficial but accessible primarily to those with financial means.

Digital Care, Personal Contact, and Generational Dynamics

Digital care is expected to grow, especially for administrative tasks and routine communication. However, fully digital options are not considered sufficient to meet all patients' needs. Comfort with digital tools varies across generations, and personal interaction remains crucial for complex or emotional issues.

Expectations for Future Healthcare Delivery

Future developments are expected to include increased digitalization, efforts to reduce administrative burden, and a reconsideration of the relationships among providers, facilities, and insurers. Private equity involvement is viewed as shaping care delivery models. Concierge elements may be included in employer benefits and could operate alongside traditional insurance. Trust-building is considered to depend on more time, better access, and a greater emphasis on shared decision-making.

E07: Physician & Digital Health Expert | 14. November 2025

Foundations and Erosion of Trust in Care Delivery

Trust is primarily defined as truthfulness and reliability: what clinicians communicate must be accurate, even if not comprehensive. Trust also depends on consistency, professionalism, and patients' confidence in clinicians and institutions. The participant describes a significant decline in trust across all groups, including patients, physicians, nurses, and administrative staff, which

he attributes to political decisions perceived as broken promises over many decades. This decline includes distrust in the healthcare system, its structures, and the government.

Access Barriers, Perceived Inequality, and Ethical Concerns

Structural inequities are linked to policy frameworks that deliberately restrict private add-on services to prevent further inequality. At the same time, demographic pressures, rising costs, and strained social insurance funds limit individuals' ability to buy private services. The participant notes that existing regulatory boundaries serve as ethical safeguards but also limit consumer autonomy. Concerns are less about individual discrimination and more about systemic limitations shaped by political decisions, tightening budgets, and demographic shifts.

Views on Concierge Medicine and Premium Care Models

Concierge medicine is a recognized concept, but it is considered incompatible with the current German regulatory and financial systems. While features such as availability and flexible scheduling could benefit patients, the participant argues that political intervention would constrain such models if they led to increased inequalities. He distinguishes between perceived competence (where patients might equate availability with skill) and actual medical competence, which is unrelated to responsiveness. He considers concierge models financially impractical in Germany and only partially workable in the U.S., where costs remain structurally high. Benefits of regular care include adherence to evidence-based guidelines and the prevention of unnecessary services and patient-requested services that are not indicated.

Digital Care, Personal Contact, and Generational Dynamics

Digital and virtual care improve efficiency and enable remote monitoring, but are insufficient for diagnosis or comprehensive assessment. Participants highlight sensory limitations and the risk of misdiagnosis from incomplete information. Digital tools may boost demand, but cannot replace hands-on care for vulnerable or cognitively impaired patients. Human presence, empathy, and physical assessments are essential for trust.

Expectations for Future Healthcare Delivery

Future care is likely to shift toward more home-based treatment, expanded digital support, and efficiency-focused tools. However, primary medical roles will remain vital, particularly for populations with high care needs. Restoring trust requires political honesty, stabilizing the financial condition of social insurance funds, and clearly separating core healthcare funding from non-medical costs. Concierge models might remain limited unless systemic reforms create opportunities for broader adoption.

E08: Hospital Executive | 18. November 2025

Foundations and Erosion of Trust in Care Delivery

Trust is defined by two main components: interpersonal communication and measurable clinical quality. Communication is crucial because medicine is a "people business," and trust increases when clinicians engage empathetically, especially during serious situations. Structured communication training is a key component of cancer care. Trust also relies on quality outcomes, clinical expertise, the concentration of complex procedures in high-volume centers, and transparent benchmarking. Patients are increasingly researching providers and are willing to travel for reputable care. Trust diminishes when environmental cues, such as cleanliness, friendliness, or food quality, signal disorganization, because laypeople perceive them as indicators of overall reliability.

Access Barriers, Perceived Inequality, and Ethical Concerns

Access issues stem from system overload, staffing shortages, and the decline in local general practitioners and hospital services. As demand rises and supply stagnates or decreases, waiting times lengthen, prompting others to seek alternatives. Inequality is seen not mainly as discrimination but as a structural issue caused by demographic pressures, system capacity limits, and payment ability differences. The participant notes that Germany's "full-coverage mentality" creates expectations that all services should be included, making insured versus self-paid care contentious.

Views on Concierge Medicine and Premium Care Models

Concierge medicine is paid access to additional time, availability, service, and support beyond what public or private insurance covers. Its appeal lies in reducing waiting times, improving access to preventive care, and addressing increasing health awareness. Trust is shaped by professional appearance, empathetic interaction, and visible organizational competence (e.g., responsive scheduling, reliable processes). Skepticism arises when providers appear profit-driven, employ commercial branding, or fail to meet service expectations (e.g., unreachable phone lines, lack of follow-up). Concierge care is primarily considered suitable for preventive care, check-ups, and elective services, but not for acute or complex treatments.

Digital Care, Personal Contact, and Generational Dynamics

Digital offerings, telemedicine, automated diagnostics, teleradiology, and AI-supported triage are considered essential developments. Machines are viewed as effective for pattern recognition and monitoring, while human clinicians remain crucial for diagnosis, complex decision-making, and emotional reassurance. Adoption of digital tools varies among patient groups, and hybrid models such as walk-in telemedicine centers or physician-assistant-led practices are expected to grow.

Expectations for Future Healthcare Delivery

Future care is expected to become increasingly digital, efficiency-focused, and AI-supported, driven by rapid advances in medical knowledge and workforce shortages. Concierge-like elements are anticipated to complement, rather than replace, standard care by handling demand for preventive and elective services. Structural reforms, clearer regulatory frameworks, and more flexible delivery models are seen as necessary to maintain trust within an overstretched system.

E09: Concierge Healthcare Director | 22. November 2025

Foundations and Erosion of Trust in Care Delivery

Trust is described as originating from two sources: an intuitive form grounded in professional status and a deeper, relational trust developed through long-term familiarity. Home-based care encourages disclosure, as patients share more detailed lifestyle information that supports holistic assessments. Relationship-based medicine is central to the participant's model, with trust strengthened when physicians know a patient's family history and personal background. Trust may be strained when continuity is lacking, when reputational signals are misinterpreted, or when boundary management is challenging due to close personal contact during home visits. Reputation management is crucial for maintaining trust in small, subscription-based models.

Access Barriers, Perceived Inequality, and Ethical Concerns

Access barriers in the UK stem from National Health Service overload, long waiting times, and decreasing availability of general practitioners. This leads some patients to seek private or concierge care. Inequality is more related to cost than discrimination: membership fees determine access. Regulatory oversight (e.g., Care Quality Commission, equality policies) helps ensure non-discrimination in practice, but affordability remains the main obstacle. The participant views debates about two-tier care as fundamentally political and connected to broader societal issues, such as education, housing, and healthcare, which are essential social goods.

Views on Concierge Medicine and Premium Care Models

Concierge medicine is defined by improved continuity, accessibility, and extended consultation times, supported by 24/7 phone availability. Continuity is often considered the most crucial factor for most patients, while high-profile individuals may prioritize immediate access. Perceived competence frequently depends on administrative responsiveness rather than clinical skill. Concierge models benefit from smaller patient panels, but frequent doctor turnover can be a challenge. Traditional healthcare maintains advantages in structured clinical pathways (e.g., cancer care), whereas concierge services excel in navigation, relationship building, and

responsiveness. The growth of concierge care in the UK is expected, with price becoming the key factor differentiating competing models.

Digital Care, Personal Contact, and Generational Dynamics

Digital tools, large language models, and AI-supported diagnostics are expected to play significant roles in future healthcare. The participant anticipates improved follow-up systems, AI-assisted patient reminders, and enhanced diagnostic support once regulatory and data limitations are addressed to enable local deployment. Personal contact remains key in concierge care, but digital enhancements are seen as increasing efficiency and service quality.

Expectations for Future Healthcare Delivery

Future care is likely to become more personalized, technologically enhanced, and supported by AI-driven triage and diagnostic tools. A hybrid approach combining relationship-based medicine with advanced digital technology is expected. The participant predicts many concierge companies will emerge, offering similar services, mainly distinguished by price and service setting. Trust will rely on continuity, responsiveness, and the ability to incorporate digital features without sacrificing personal connection.

E10: Banking Executive | 20. November 2025

Foundations and Erosion of Trust in Care Delivery

Trust is said to form when clinicians communicate clearly, act reliably, and convey professional confidence. Directness, transparent explanations, and decisive guidance are valued more than extensive detail. Trust declines when communication is vague or when agreed-upon actions are not taken. Reliability and follow-through are seen as signs of competence. Waiting times, inefficient processes, and inconsistent administrative experiences also weaken trust. Personal encounters with highly structured specialist environments enhance trust, while disorganized or outdated settings cause discomfort.

Access Barriers, Perceived Inequality, and Ethical Concerns

Long wait times, staffing shortages, rural physician shortages, and overcrowded emergency departments create access constraints. These issues contribute to perceptions of declining system performance. Inequality is seen as a structural outcome of the current three-tier system (statutory insurance, private insurance, and concierge services). Financial ability influences treatment experiences both domestically and internationally, as evidenced by cases in which urgent care requires immediate payment. Inequity is a persistent feature of the healthcare system, exacerbated by demographic pressures and rising insurance costs.

Views on Concierge Medicine and Premium Care Models

Concierge care is associated with exclusivity, convenience, and enhanced service. Its appeal lies in the expectation of superior attention, quick access, and luxurious surroundings. However, these features are viewed as separate from clinical skill. The participant believes that skilled clinicians within the regular system do not need to be branded as concierge, and that a premium environment can give false impressions of medical quality. Concierge care is regarded as an additional privilege within existing private options, available only to a small portion of the population. Expanding such models is viewed as diverting resources from the standard system and possibly weakening it.

Digital Care, Personal Contact, and Generational Dynamics

Digital tools and self-diagnosis trends are personally rejected; reliance on professional medical judgment remains central. Digitalization is acknowledged as expanding, but not as a substitute for interpersonal communication. Generational differences may shape digital openness, but core expectations of clear guidance and reliability remain constant.

Expectations for Future Healthcare Delivery

Future care is expected to face increasing physician shortages, especially in rural regions. The decline in general practitioner availability is viewed as a significant structural risk. System strain, bureaucratic demands, and geographic disparities are likely to worsen. Concierge care is not considered a significant supplement but rather a luxury for a tiny population. Broader reforms, reduced bureaucracy, and structural stabilization are necessary to restore confidence in the system.

E11: Chief of Cardiothoracic Surgery | 02. December 2025

Foundations and Erosion of Trust in Care Delivery

Trust is built through adherence to evidence-based guidelines, proven experience, and transparent communication. Professional expertise is assessed by factors such as years in practice, procedure volume, and team competence, since major surgical procedures depend on coordinated teamwork rather than individual skill alone. Trust also develops through direct dialogue, where clinicians tailor their communication to patient groups and foster a sense of connection. The participant notes that patients today arrive more informed, often after researching clinicians online or seeking second and third opinions, which highlights the importance of relationship-building. Trust diminishes when competence is unclear, communication is lacking, or procedural expectations are not met.

Access Barriers, Perceived Inequality, and Ethical Concerns

Differences between statutory and private insurance already create a multi-tier system in Germany. Private patients may receive treatment from more experienced clinicians or benefit

from improved accommodations, whereas statutory patients may be treated by less experienced staff. Therefore, inequality is seen as an inherent feature of the system. As healthcare costs rise and patients remain unaware of actual service prices, financial barriers become more significant. Ethical concerns arise around high private billing multipliers, which could become disproportionate if not adequately regulated. However, inequality is mainly understood as a structural rather than an intentional issue.

Views on Concierge Medicine and Premium Care Models

The participant was initially unfamiliar with the term but associates concierge medicine with personalized navigation, more time, direct access, and individualized support. These features are expected to build trust, provided the model demonstrates clear added value and reliability. Competence cannot be assumed solely based on availability; it requires transparent validation, including publications, case volume, and outcome data. The participant notes that concierge services must deliver results at least as good as those of university medicine to justify their fees. While acknowledging the potential for further stratification, he notes that multi-level care is already in place in Germany and believes concierge models are viable if demand exists.

Digital Care, Personal Contact, and Generational Dynamics

Digitalization is essential due to staffing shortages and workflow inefficiencies. Automated documentation, AI-supported imaging, and digital scheduling are seen as practical solutions. However, diagnosis and complex interactions still require human involvement.

Expectations for Future Healthcare Delivery

Care is expected to become more digital and more stratified. Rising healthcare costs and limited resources may increase willingness to pay for enhanced services. A multi-tier system is likely to persist regardless of political reform. Digital tools will expand, but personalized and premium offerings will coexist for patients seeking additional support, convenience, or expertise.

E12: Concierge Care Coordination | 02. December 2025

Foundations and Erosion of Trust in Care Delivery

Trust is defined as relying on competence, transparency, responsiveness, and sincere investment in the patient's well-being. Clear communication, relational continuity, and dependable follow-through are key elements that build trust. Trust diminishes when interactions feel rushed, communication is inconsistent, or systemic inefficiencies result in long wait times and administrative errors. Patients are seen as more informed and more demanding than in previous years, which raises expectations for clarity, personalized guidance, and prompt support.

Access Barriers, Perceived Inequality, and Ethical Concerns

Access barriers in standard healthcare include long wait times, overloaded clinicians, and limited appointment availability. These issues shape perceptions of inefficiency and erode trust. Inequality primarily stems from financial constraints, as some patients can afford faster access while others cannot. Ethical concerns center on fairness, transparency of value, and the risk that cost-based prioritization may affect care. The participant views inequality as structural rather than intentional, stemming from time pressure, resource shortages, and systemic limitations.

Views on Concierge Medicine and Premium Care Models

Concierge medicine is defined as membership-based access to extended consultations, 24/7 communication channels, personalized navigation, and expedited appointments. These features are believed to enhance trust by providing continuity, reliable access, and unhurried interactions. Trust relies on perceived added value, as well as the provider's responsiveness and competence. Limitations include cost, reliance on a single physician, and the potential for decreased integration with larger healthcare networks. Patient groups with high time demands, complex needs, or a strong preference for personal guidance benefit most, while those sensitive to costs may remain skeptical.

Digital Care, Personal Contact, and Generational Dynamics

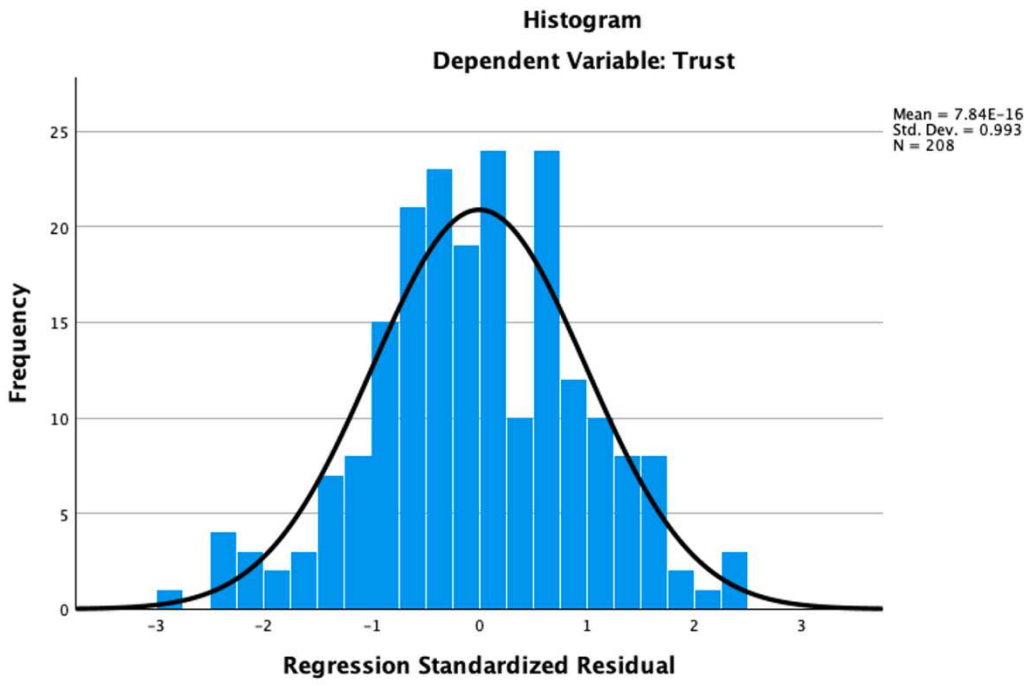
Digital tools are seen as supplements to personal interaction. Reliable digital communication and scheduling can build trust, but they do not replace face-to-face meetings, especially for complex decisions or emotional support. Generational differences affect how comfortable and reliant people are on digital methods.

Expectations for Future Healthcare Delivery

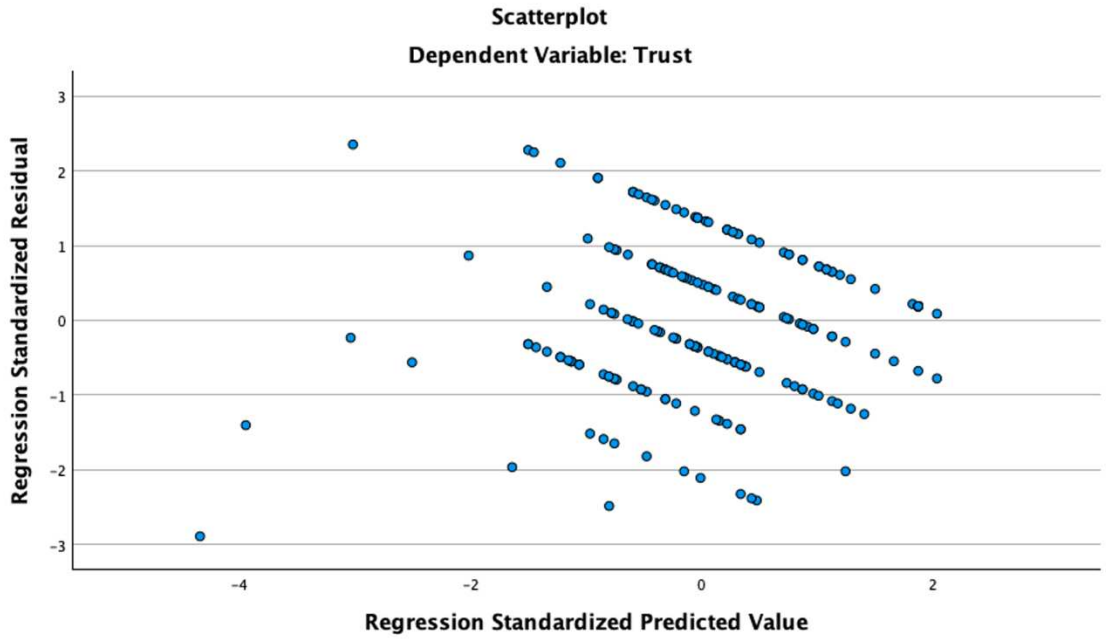
Future care is expected to combine digital efficiency with personal continuity. Concierge-like features, such as proactive outreach, quick access, and personalized guidance, may become part of broader healthcare models. Building trust will depend on improved communication, greater accessibility, and stronger coordination. Concierge services are likely to grow as a complementary option rather than replacing standard care.

Appendix F: Histogram of Regression Standardized Residuals for the Dependent Variable *Patient Trust*

Charts



Appendix G: Scatterplot of Standardized Residuals against Standardized Predicted Values for the Dependent Variable *Patient Trust*



Appendix H: Predictor Definitions and Model Specifications

[a]Predictors: (Constant), Fairness concerns, Empathy receptionists, Empathy nurses, Personalization, Accessibility, Continuity

[b]Predictors: (Constant), Fairness concerns, Empathy receptionists, Empathy nurses, Personalization, Accessibility

[c]Predictors: (Constant), Empathy receptionists, Empathy nurses, Personalization, Accessibility

[d]Predictors: (Constant), Empathy nurses, Personalization, Accessibility

[e]Predictors: (Constant), Empathy nurses, Personalization

[f]Predictors: (Constant), Personalization

[g]Dependent Variable: Trust

[h]Predictors: (Constant), Fairness concerns, Empathy receptionists, Empathy nurses, Continuity, Accessibility, Personalization

[i]Predictors: (Constant), Fairness concerns, Empathy receptionists, Empathy nurses, Accessibility, Personalization

[j]Predictors: (Constant), Empathy receptionists, Empathy nurses, Accessibility, Personalization