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Towards a Theory of Care Transition: From Medical Dominance to Managed Consumerism

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In this paper we outline a theory of care transition. Under conditions of demographic and epidemiologic transition, combined with rising costs, new forms of health care develop. This process is summarized as a shift from medical dominance to managed consumerism in an ageing society, involving significant changes in the nature of professionalism and professional practice. An emphasis on professional regulation and evidence-based practice, combined with partnership, shared decision-making and concordance is found in a range of policies aimed at altering the social relations of health care. Choice, self-management and active engagement in health become features of a restructured patient role. The paper concludes by suggesting that further work needs to be carried out to test whether these ideas for a theory of care transition can be applied more generally.

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I've heard it said that we (sociologists) should be glad to trade what we've so far produced for a few really good conceptual distinctions and a cold beer.
Irving Goffman (1982)

INTRODUCTION

In this paper we attempt to provide an outline of a theory of care transition.¹ We argue for a view that sees health care in England being transformed from a system characterized by medical dominance to one characterized by managed consumerism in an ageing society. The argument involves a number of conceptual distinctions that we hope will provide a better understanding of



current change, not only in the English National Health Service (NHS, see footnote 2), but in the international arena as well.² Given the historical and cultural peculiarities of health care systems, some of the processes discussed will be specific to the NHS, but our belief is that the dynamics at work have applicability across a wide range of health services. We hope that the distinctions we make will be at least as valuable as Goffman's cold beer.

The paper proceeds in three stages. In the first part we outline briefly the key drivers of change: demographic transition, epidemiologic transition and the rising social and economic pressures on health care systems. Second, we outline the main dimensions of care transition and some of the conceptual distinctions they contain. These refer to evidence and arguments about the end of medical dominance, the changing role of the professions, the changing social relations of health care and the place of the patient as consumer. We then consider the balance between rhetoric and reality in the formulation of change, especially in key ideas currently being promoted in policy circles. The paper concludes by offering a critical reflection on the development of a theory of care transition in the future.

THE DRIVERS OF CHANGE

Demographic transition

In 1989, Peter Laslett published *A Fresh Map of Life* in which he set out his approach to population ageing and especially the rise of the 'Third Age'. In this book Laslett argued that:

A country is really old, we can pronounce, when the proportion of its population aged sixty five and over is at least 12.5%, [16% today] that is about one man in every nine and one woman in every seven, and when its expectation of life at birth is seventy-five years or more for women and seventy years or more for men. In the last year of the 1980s the United Kingdom fits. (Laslett, 1989, p. 38)

This 'pronouncement' summarizes many of the changes that have taken place in developed societies over recent decades, and increasingly in developing countries as well. Life expectancy for females at birth is now 80 and for males 76. In 2007, in England (and Britain as a whole), those aged 60 and over constituted 20% of the population for the first time. In addition to this, the older population is itself ageing. Official figures published in the Department of Health's *National Service Framework for Older People* (2001) show that over the decades since the 1950s those sections of the population aged 75 and over, and especially 85 and over, have grown at a faster rate than



those in younger age groups, including those aged 60–74. The scale of the changes underway can be illustrated with respect to the rapid growth of centenarians in the population. Today these number some 9,000 in England and Wales, a marked growth compared with the last decades of the 20th century (Bury and Holme, 1991). As Roger Thatcher (1999) has shown, this situation can be explained by the steady and then (from the mid-1970s onwards) steep decline of the mortality rate at age 80. Improvements in survival, including those in their advance years, have added significantly to the upward pressure on population ageing.

The result is an ageing older population, bringing with it challenges to health care that were kept at the margins of the NHS in a period of age barriers to acute and expensive treatment. A largely separate geriatric service provided only basic care for older people. Today, by contrast, acute services have seen a steady rise in the average age of their patient base and the growth of more effective care, including pharmaceutical-based treatments. The cost implications will be discussed shortly, but the main point to underline is that health care structures, which were fashioned to meet the needs of a relatively young adult population, are having to undergo major revision. The idea, for example, of focussing on return to work as a main outcome of health care means little in a population where retirement may have taken place many years ago. Moreover, many health care systems now have to respond to the rising expectations of service provision (Garfield *et al.*, 2008), not only from older people themselves but also from their relatives, who may be more actively involved than in the past.

Epidemiologic transition

Linked to demographic transition is epidemiologic transition: the process whereby patterns of disease in the population are transformed from those dominated by infectious diseases in early life and adulthood, to those characteristic of an ageing population. In a number of papers, the influential epidemiologist Abdel Omran has explored this changing disease patterning in a historical context. His approach can best be seen in the following summary:

We can distinguish three major stages of the epidemiologic transition (a) the *age of pestilence and famine*, when mortality is high and fluctuating, thus precluding sustained population growth. In this stage, the average life expectancy is low and variable, swinging between 20 and 40 years. (b) The *age of receding pandemics*, when mortality declines progressively as epidemics decrease in frequency and magnitude. The average life expectancy at birth increases from about 30 to 55 years. Population growth is sustained at



high rates as the gap between birth rates and death rates widens. (c) The *age of degenerative and man made diseases*, when mortality continues to decline and eventually approaches stability at a relatively low level. The average life expectancy at birth rise gradually until it exceeds 70 year. It is during this stage that fertility becomes a crucial factor in population growth. (Omran, 1983, p. 306)

Again, it is worth emphasizing that the focus of the present discussion is on developed societies. Clearly, health priorities in many parts of the developing world remain involved with epidemic diseases, HIV/AIDS being the most recent in a line of persistent problems. Indeed, in much of sub-Saharan Africa where millions of people still live without clean or running water issues such as childhood diarrhoea persist. As Omran indicates, a secular, that is, persisting decline in fertility, characteristic of developed countries such as England (despite a small increase in the last few years), combined with low levels of childhood illness, provide further indicators of longer average life expectancy. With this, and as health improves in the middle years of the life course, illness and disability are confined increasingly to later life.

From this historical viewpoint, epidemiologic transition, alongside changing demographic patterns, can be seen as a major gain of development and public health measures. The postponement of illness (and death) until the later years of a long life has, after all, been the goal of societies through the ages. There is much to be celebrated as well as dispassionately recorded here. Many individuals as well as societal leaders in developing countries would happily trade their current health patterns for at least some of those evident in developed societies.

Even so, the problems that the 'success story' of epidemiologic transition has brought in its wake are considerable. Care transition expresses and is a response to many of the difficulties that long-term and degenerative illnesses create in later life. For example, attempts to estimate 'healthy life expectancy' arise from the common observation that 'living longer but feeling worse' represents at best a mixed picture of change. In fact, estimates show that although life expectancy at birth for females rose from 76.8 in 1981 to 80.5 in 2002, healthy life expectancy was some 10 years adrift, being 66.7 and 69.9 respectively for the years in question. 'Disability free expectancy' rose from 60.8 in 1981 to only 63.0 by the year 2002. Although some improvement in healthy life expectancy can be detected in these figures, it is clear that the struggle to match improved survival with improved health status is a constant one.

Of course, many degenerative diseases, by definition, show greater incidence and prevalence with age. Limiting self-reported, long-term health



problems also show steady increases across the life course. They range (for females in Great Britain in the year 2005) from about 11% in early adult life to 37% between the ages of 65–74 and 40% at age 75 and over (Social Trends 37, 2007, p. 89). Male rates are slightly less, except for those aged 75 and over. It might be argued that these figures also show that the majority of people, even in their later years, are living without long-term conditions, and this is reinforced by the more positive picture that can arise when questions about health rather than illness are asked (Bury, 2007). But, given the rise in the proportion of the population reaching very advanced years, the pressure on health care systems (as well as social care and on welfare) of epidemiologic transition is considerable.

Social and economic pressures

It is clear that demographic and epidemiologic transitions have a range of costs as well as benefits, both to individuals and societies as a whole. Much has been made of the financial costs of an ageing society, so much so that terms such as the demographic ‘time bomb’ have been used to express political alarm at what is assumed to be the implications of ever greater numbers of older people. Health care expenditure is often thought to be of particular concern (alongside, of course, that on pensions and social welfare payments). Some 2/5ths of total health expenditure on health (in England at present some £100 billion per annum) is absorbed by older people. The use of health care shows a clear association with age. At survey, reported attendance at out-patient or casualty departments in the previous three months shows a steady rise with age (once the use for those aged 0–4 are excluded) with some 10% of those aged 16–24 using the services compared to over 20% aged 75 and over (Social Trends 36, 2006, p. 123).

While the average level of expenditure on health was running at £708 per head in the year 2002/2003, ‘those aged 85 and over received some £4,147 per head, more than six times the average amount spent on the under 85s’ (Social Trends 35, 2005, p. 111). It is also worth noting that in the field of personal social services (costing some £15.2 billion in England in the same year) people aged 65 and over accounted for about half of the total. While writers such as Jefferys and Thane have argued that a ‘technologically innovative and ingenious society such as ours’ (Jefferys and Thane, 1989, p. 13) should be able to support the growth in numbers of old people, this may appear easier said than done, when viewed from a policy viewpoint. The use of terms such as ‘burden’ when referring to older people in public discussion carries unacceptable connotations. At the same time, mainstream health care has had relatively little experience of dealing with older people in such large numbers.



There are two caveats to be entered, however, before we proceed to examine the resulting features of 'care transition' that these pressures have helped to create. The first is that predictions of a negative impact of demographic and epidemiologic transition do not always specify which aspects are of particular concern. As Alastair Gray has put it: 'it is not clear exactly which demographic features have the strongest effect on health care spending: candidates include the number of people over a certain age, the number with given levels of disability or ill-health, and the number in the final years of their lives' (Gray, 2005, p. 15). Responding to an OECD projection that health and long-term care will account for 'about half of the increase in age related expenditures between 2000 and 2050' (*ibid.*), Gray goes on to argue that evidence suggests that proximity to death rather than the age of an individual is a greater predictor of health care costs. From this viewpoint, the ageing of the population may be more complex than is often recognized when considering drivers of growth in health care expenditure. Caution needs to be exercised in assuming a 'mechanistic' relationship between demographic change and health care costs, despite the clear association of utilization rates and age examined above.

Second, there is a widespread belief that because the incidence of many diseases rises with age, an ageing population must mean more ill health. As noted, much of the concern with an older population lies with the prevalence of limiting long-term disabilities, rather than with frank disease. As Martin Roland and colleagues have shown (Roland *et al.*, 2005), the fear held by older people of a 'revolving door' of readmission for acute care has to be tempered with the observation that many older people with serious illnesses die before they receive repeated hospitalization. More positively, in the case of long standing conditions, it may not be the case that an older population has to mean a worsening health profile. Although we have seen that healthy life expectancy is struggling to keep up with the increase in the growth of calendar years, there are some indications that successive age cohorts entering later life are bringing a healthier profile with them. In the US, for example, Manton and Gu (2001) have shown that disability levels among older age groups are showing some signs of declining. The relative contributions of age and cohort effects are also being examined in the English Longitudinal Study of Ageing. Already they have reported that 'many older people reported and showed no difficulties with physical and cognitive function' (Marmot *et al.*, 2002, p. 268). Education and occupational class were strong predictors of such functioning. Future reports from this study will provide evidence on the so-called 'morbidity compression' hypothesis. This may help clarify whether level of poor health and disability in older age are being offset by the arrival of more positive profiles of younger cohorts.



THE MAIN DIMENSIONS OF CARE TRANSITION

The ‘Kaiser triangle’

One way to consider care transition is provided by the so-called ‘Kaiser triangle’, found in many English Department of Health (DoH) documents on the future of health care (see for example *The NHS Improvement Plan, 2004*). This expresses the dynamics at the heart of current developments, and derives from a model of care pioneered by the Californian Health Maintenance Organisation, Kaiser Permanente (see Figure 1).

The model highlights the importance of self-care – a subject to which we will return to below. For the present, it is important to note that a ‘high percentage’ of professional care is confined to ‘high risk cases’. The remainder comprises a mixture of ‘shared care’ and ‘self care’, the latter especially for the vast majority of those with long-term conditions. In this way a clear signal is given that the future of health care is to move away from a professionally based system, to one based on a much greater role for the patient as an active participant. The emphasis found here and in other policy documents received strong support in the influential review of the future of the English NHS published in 2002: the so called Wanless Report. In that Report, Derek Wanless argued strongly for a vision of health care in the future in which the public would be ‘fully engaged’ in their health (Wanless, 2002). Only this could hope to meet the demands for services in the context of growing expectations in an ageing population. By extension, these signals indicate the limits of professionally driven provision, and especially that of doctors. This

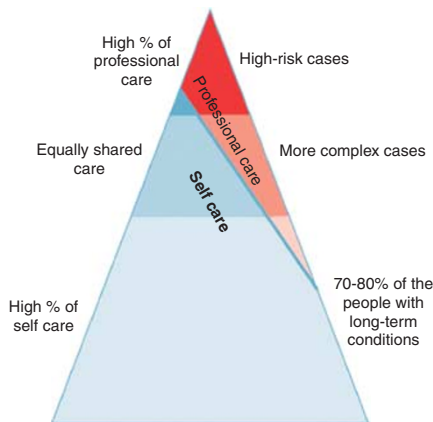


Figure 1: The Kaiser Triangle



feeds into one of the key long-term features of care transition: the decline of medical dominance.

The decline of medical dominance

The sociology of health care has frequently invoked the putative problem of medical dominance. Stemming particularly from Freidson's (1970/1988) formulation in his book *Profession of Medicine*, it has been widely accepted that the medical profession has held sway in defining and responding to health and illness. In so doing, it was argued, the profession effectively excluded all other influences on matters medical, including that of the suffering patients themselves. For Freidson (at least in the first edition of his book), medical dominance raised a range of political and human rights issues. The medical profession not only dominated the pattern and organization of health service provision. It also determined the way society thought about and understood the very nature of health and illness. Wider societal and lay interests could be seriously restricted. For Freidson, the technical business of doing medicine should be confined to treatment, with lay perspectives on illness definition, referral processes and the role of social networks given far more weight in research and policy formulation.

This critical shift in attention towards the deleterious effect of a dominant medical profession in silencing the patient became the stock in trade of medical sociology in the 1970s and 1980s. It was applied readily to the English NHS, as it was to the very different health care system in the US. Its echoes can still be heard today, for reasons that will be discussed below. For the present, however, it is the waning of the power of medicine that concerns us most. Perhaps the most cogent expression of this development lies in the exchange of views between Freidson and one of his sharpest critics, John McKinlay (with Stoeckle, 1988 and Marceau, 2002). For McKinlay, the rise of what he first termed 'proletarianization' and then 'corporatization' marks the end of the independent practitioner (based in the US on a fee-for-service system) to one where (global) corporate and financial systems come to dominate professional life. In England a wave of contractual and organizational changes (including most importantly the development of NHS Trusts and wider private provision) provide a comparable set of developments, shifting the balance of power towards managerial and corporate interests.

Among an array of changes in the position of the medical profession (eg, the 'loss of partisan support' for the professional by the state), McKinlay and Marceau also note the impact of the epidemiologic transition on professional dominance. Where once the 'glamorous activity' of curing could be invoked as the hallmark of doctoring (whatever the realities in practice) now the care of people with long-term conditions predominates. Under these conditions



physicians are expected to work alongside other practitioners on an equal footing as part of a team. The needs of patients with chronic illness effectively reduce the dominant position of the physician to one among many, including the patient him or herself. Indeed, with the current emphasis on self-care (especially when it is 'lay led'), the physician can be eliminated from the care of patients altogether.

There are, of course, limits to the 'decline of dominance' argument. As Brian Salter (2004) has pointed out, doctors still dominate the 'disposal of resources' in health care systems such as the English NHS. That is, when decisions are made to run tests, undergo surgery or take medicines, and despite a relative shift of influence towards other practitioners such as nurses or pharmacists, it is the doctor that remains the decision maker. In addition, the loss of influence of the profession in relation to state, managerial and corporate interests (all of great significance to be sure) does not necessarily mean that the influence that flows from the doctor-patient relationship has lessened (Hunter, 2006). When lay people are in distress, pain and discomfort they routinely turn to doctors, not to managers or politicians. Moreover, the 'indeterminacy' of the doctor-patient relationship – that is, its fluid and contingent character – places limits on its regulation by organizational or financial constraints. Although the 'golden age of medicine' may be over, care transition produces a complex mixture of old and new forms of professional practice. As medical autonomy wanes, a new terrain for medical practice open up, one which can be more or less successfully negotiated by individual practitioners and their professional organizations.

Transitions in professional autonomy

Alongside the reduction, if not elimination, of medical dominance, several other major changes in health care have been occurring in recent years. The first of these flows from the above discussion. One of the major developments noted by McKinlay and Marceau is that of the growth of 'medical pluralism', that is, the rise in numbers and importance of 'non physician clinicians' (Cooper and Stoflet, 2004). A range of occupations have been developing their educational and professional credentials, and making moves to undertake health care tasks that traditionally have been the sole province of doctors. In the NHS, for example, it has been estimated that there are approximately 387,000 FTE nurses, including about 250,000 in England (Buchan, 2004). In many areas of practice, both in hospitals and in the community, patients visiting clinics may now see a nurse rather than a doctor, and activities such as prescribing (albeit in restricted areas) are being devolved.

Similarly, community pharmacists have adopted new contracts through which they receive payments for an 'enhanced service'. This will involve



activities that erstwhile would have been carried out by general practitioners, such as health promotion, including weight reduction and smoking cessation. As with nurses, the salience of an older population dealing with long-term conditions is evident, with an emphasis on supporting self-care as well as health promotion. Consultation rooms are being established where patients can discuss their problems in private (rather than in front of others in a shop environment), and where broader advice on diet and health lifestyles can be offered. Prescribing practices are also changing in this setting, with repeat prescriptions being offered by pharmacists without recourse to the original prescribing physicians. This moves the community pharmacist away from their 'formulate and dispense' tradition to a more active engagement with their 'customer base'. It also signals, as do changes with other 'non physician clinicians', a transfer of trust from the doctor in matters medical. Whether this is part of a reduction in trust in the medical profession is a matter of debate – as lively exchanges in medical sociology testify (Stevenson and Scambler, 2005; Armstrong, 2005).

In addition, to the growth in professional pluralism is an equally significant growth in regulation. The self-regulation of medical practice through professional structures such as the General Medical Council (GMC) has now been transformed and supplemented by a series of state sponsored arrangements and organizations. In Salter's terms, the shifting balance of power in the triangle of state, patient and profession has moved decisively in favour of the first two at the expense of the last. High-profile cases such as that of the enquiry into deaths in a paediatric surgical ward at the Bristol Royal Infirmary in the 1980s only served to reinforce what was already underway – a more stringent regulatory regime. Now even surgeons, who have long protected their successes or failures from external scrutiny, are being required (and in some cases wish) to publish their success rates. More generally, bodies such as the Healthcare Commission (led by the barrister who chaired the Bristol Royal Infirmary Enquiry) have statutory rights to inspect health care facilities such as hospitals, rating their performance and requiring changes to be made if they deem it necessary. Under pressure from these developments, existing regulatory bodies such as the GMC have undergone a process of 'modernisation', involving a transition towards more open and transparent procedures and practices. With considerable political pressure in the 1980s and especially since 1997, the medical profession has moved from asserting its independence to cooperation.

Alongside this, it is important to note, in the English context at least, the rise in litigation. In former times it was rare for practitioners, and especially doctors, to find themselves in court facing criminal charges. Following the events in Bristol in particular (but also including a very different case of



numerous murders carried out by – the now deceased – general practitioner Harold Shipman), legal redress has been pursued much more vigorously. It has been noted that in England medical claims have doubled from £1.3 billion in 1996–1997 to 2.6 billion in 1999–2000 (National Audit Office, 2001). The report from which these figures are taken states that claims for negligence on such a scale reflect ‘an increase in litigiousness on the part of the patient’. The fact that claims for conditions such as cerebral palsy resulting from mistakes or incompetence at or around the time of birth can run into millions of pounds, means that pressures from health care organizations on individual practitioners can be considerable. Direct litigation against individual practitioners is also more evident than in previous times (for a wider discussion of these issues see Bury, 2008).

Of note here is the growth of ‘evidence based medicine’. In areas such as surgery, changes in scrutiny and audit have eroded medical power to control what is known about the quality of practitioners’ performance. Alongside regulatory changes have also been the growth in evaluating the processes and outcomes of treatment. Writing in 1998, Richard Doll was able to look back at the origins of the NHS and retell stories about the near total absence of objective evidence for the effectiveness of routine treatments for conditions such as peptic ulcer. All that could be adumbrated were the claims made of success by the (often prestigious) surgeons themselves. No comparative method was employed to evaluate one treatment modality against another (Doll, 1998).

In recent years, the adoption of randomized controlled trials has become widespread in areas such as cancer treatment, where a new drug will be tested against a placebo and/or ‘usual care’. The use of evaluative methods such as these has been enthusiastically promoted by ‘elite’ physicians, often working in academic clinical departments. Through a growing evidence base, it is assumed that practitioners can make better informed clinical judgments and provide more scientifically robust reasons for their treatment choices (Sackett *et al.*, 1996). Such developments involve a complex set of manoeuvres by the medical profession, on the one hand responding to long standing demands from epidemiologists such as Doll for more evaluation, and on the other meeting the needs of politicians for more accountability.

The growth of evidence-based medicine has one other important dimension that bears directly on care transition, that is, in the rationing of treatment. The English NHS faces particular difficulties in reconciling its character as a universal service (based on equity and free at the point of delivery), yet at the same time dealing with increased costs, especially as pharmaceutical products as well as other treatments become increasingly effective. One way of dealing with this is to review evidence of cost



effectiveness in order to provide 'guidance' on what should or should not be offered to patients. The setting up of the National Institute for Health and Clinical Excellence (NICE) provided a setting that has attempted to reconcile these contradictory pressures. The decisions it has made about treatments have often proved to be controversial, yet the political commitment to its basic procedures appears to carry cross-party support. Although independent clinical judgment is supported in principle, in governmental health policy circles it is clear that the medical profession cannot operate on its own terms as it once did. It is unlikely that this will change in the future.

Transitions in the social relations of health care

In recent years, the position of the medical profession, the state and the patient have undergone significant change. Such change involves a major shift in the social relations of health care. A number of different processes fall under this dimension of transition.

The first we should note is the widespread use of the language of 'partnership'. Promulgated widely by government ministers in the early years of the Blair administration, from 1997 onwards, partnership became the watchword for new relationships between the private and public sectors in financing large-scale projects such as hospital building. But its use was not confined to this arena alone. The idea that patients and their doctors (or other professional carers) should engage in partnership was seen to have relevance across a wide range of health care activities, especially in the management of long-term conditions. Harry Cayton, then head of Public and Patient Involvement at the DoH, gave renewed expression to the familiar economic concept of the 'co-production of health', by likening it to the construction of furniture bought at stores such as IKEA. In a paper called the 'Flat Pack Patient' (2006), Cayton argued that in the future patients would not simply receive treatment as a finished product, but 'co produce' it with their professional carers.

This more active view of the patient included another key ingredient – shared decision-making. The relation between professional and patient here is one of mutual understanding, rather than paternalistic guidance. The time of treating patients as passive individuals was seen to be at an end; in the words of one commentator on the subject, 'patients have grown up and there's no going back' (Coulter, 1999). In fact Coulter has gone on to review developments in shared decision-making in the context of the English NHS, and has found a mixed picture. Continued resistance by doctors is matched by reluctance on the part of at least some patients. Despite the stricture on doctors that they should 'never make choices for patients' (Coulter, 2005, p. 95), but instead 'play the role of navigator', Coulter also notes that patients



continue to value doctors' views and opinions and that these are 'likely to be the dominant influence on patients' decisions'. It may be that age plays a key role here, as patients in later life, as with those in their early years, are often not the main decision maker; a third party (carer, mother) is often involved (Gabe *et al.*, 2004). In any event, older people may not want to make decisions against the best advice of their doctors, and though this is consistent with shared decision-making it paints a picture that is less challenging to medical authority.

Linked to this has been the development of ideas surrounding 'concordance' in decisions over medicines use. Earlier research on 'compliance', whether to help promote it or to show its inappropriateness as a concept, has given way to studies of concordance. In this new model, patient preferences and understandings of their medicines are to be elicited by the prescribing professional (especially the general practitioner) so as to agree on what is required for successful treatment. It has been shown that misunderstandings between the parties concerned are widespread and that patients and doctors are often working from different agendas (Britten, 2004). Doctors' assumptions about patients' preferences may also be mistaken. Even so, doctors report frustration with the idea of concordance. It is seen to take too much time and detract from what the professional thinks is the right course of action for the patient. Doubts about its benefits to patients remain (Ferner, 2003).

Whatever shades of opinion about partnership, shared decision-making and concordance may exist, it is clear that new forms of social relations in health care are being fashioned and, in more or less enthusiastic ways, becoming watchwords for practice. In this view the patient becomes more active and the doctor less paternalistic. In turn, this shades into a perspective of the active citizen, exercising increased rights and taking on renewed responsibilities. In English health care this has been given emphasis in a range of policy initiatives, most notably in health promotion and self-care in long-term conditions. In the former case, the Wanless review, mentioned above, stressed the cost savings of a 'fully engaged scenario' in which patients and the public take responsibility for their own health and rely less on professional care. The extension of this to managing long-term conditions is also emphasized. Thus, the changing social relations of health care under conditions of transition involve pressures on patients to change their roles, as well as reductions in professional power.

The changing role of the patient and managed consumerism

Perhaps one of the clearest ways of engaging with care transition is to contrast the view of the patient role in the early days of medical sociology



with those of today. In the 1950s, Parsons saw the patient as largely passive, fulfilling obligations to withdraw from everyday activities (especially with respect to paid employment) on a temporary basis, follow doctors' orders and show a public demeanour of wishing to get well. Freidson's assault on the medical profession and its dominance over the health care system as well as the patient was in part a reaction to Parsons' view. Today, as we have already seen, much social science research is concerned with quite different matters. Studies of shared decision-making, concordance and the patient's viewpoint all chime in with the processes of transition discussed here. Even where such research is critical of such changes, or shows up their limitations, ideas of the active patient lie at the heart of the matter. Studies of long-term conditions, the experience of illness and treatment, or topics such as patient narratives in chronic illness, provide new cultural repertoires that can reflect and feed into the care transition process without much difficulty.

In official policy circles, these changes in the role of the patient, and the perspectives being developed to capture them, readily reinforce an emphasis on the patient as an active consumer. Whereas earlier sociological commentary saw patienthood and consumerism as 'a misconception' (Stacey, 1976), today few doubt the value, to some extent at least, of patients having more choice and more say in their care. Government policies have moved quickly to reinforce these trends. For example, from 2007, a 'choose and book' system has been introduced, giving patients the right to choose from at least four hospitals when making their first appointment. In support of this policy the DoH argues that 'research has shown that patients want to be more involved in making decisions and choosing their health care' (<http://www.chooseandbook.nhs.uk/patients/whatiscab>). In theory at least, this system allows patients to book an appointment at a time and date that suit them best. In a similar vein, recent negotiations between the government and general practitioners have secured more 'flexible' opening hours, in order to provide patients with more of what they want (or at least what they appear to want) as consumers. Behind such moves lies the idea that patient preferences should play a greater part in fashioning services, even to the point of confronting doctors' interests in implementing them.

The question as to whether patients actually want to engage in more active forms of consumerism (Calnan and Gabe, 2001) or whether consumerism remains inappropriate to being a patient is, perhaps, less an issue here than the 'refashioning' of the patient role that is expressed in such policies. It follows from what has been said above that the current emphasis on the active patient and consumer choice is not simply a reflection of underlying demand by patients. It is also an attempt to structure or shape patient experiences and expectations – to encourage some and reduce others.



To show that consumer choice (or concordance, shared decision making and the like) are not always reflected in actually existing health care settings may miss the point that they are being created as much as revealed.

From this point of view, the adoption of healthy lifestyles by the population as a whole, or the use of self-care by the majority of those with long-term conditions, act as responsibilities on the individual matched by rights to choice and preference recognition. Thus, active citizenship or 'full engagement' in health become key ingredients in 'managed consumerism'. It is managed because consumerism in health care (as in other areas of social or economic life) is difficult to operate in a pure form. Customers cannot buy food, cars or houses without a plethora of regulations, both on the producer and on them as consumers. By extension, consumerism in health care would be very difficult, not to say dangerous, if left to its own devices. The most obvious recent example is the widely cited case of the controversy over the triple MMR vaccinations – a controversy that still has the ability to resurface from time to time. In this case, health care consumers (mostly mothers of small children) demanded to have separate vaccinations. In fact, the official view was that this was inefficient, and was opposed on a number of fronts, with an alliance between the state and dominant sections of the medical profession effectively scotching parents' demands (Smith, 2002).

The changing role of the patient and 'managed consumerism' act as mutually reinforcing processes in care transition. They rest on a set of assumptions about the need to manage expectations and demand for health care, and at the same time trade these off with an emphasis on patient preferences and a 'choice agenda'. At the heart of the refashioned patient is a psychological model of 'self efficacy' and 'patient activation' in which people become more confident in maintaining their health or living with long-term conditions. Self-care takes on a renewed emphasis in this context, with initiatives such as the Expert Patients Programme, aimed at those in the bottom part of the 'Kaiser Triangle'. Professional care may provide 'support' for self-care, but much can be done through such programmes, it is hoped, without professional inputs (Taylor and Bury, 2007; Newbould *et al.*, 2006). A new 'concordat' between the state, professions and patients begins to come into view.

TOWARDS A THEORY OF CARE TRANSITION

The above discussion provides the basis for the contention that new forms of health care are emerging, at least in the English NHS. Although this system has its own peculiarities (stemming largely from its nationalized,



universalistic origins), it can be argued that in any system of care where the above features are developing, care transition is occurring. The emergence of a theory of care transition, distilling many of the processes examined here, is based on four main observations.

First, health care systems throughout the world face major cost containment problems. Care transition points to the attempts in many countries, including England, to control costs and develop systems that provide measurable value for money. In England, a greater involvement of the private sector in the provision of care reinforces a view of the patient as consumer. Developments such as 'choose and book', and more flexible arrangements in General Practice, are no more than individual examples of a growing trend. Just as more private-based systems such as that in the US have instituted state supported care for vulnerable groups of the poor and the elderly, so state controlled systems open up their provision to a more market-based, consumer-led approach. This is not to suggest convergence among health care systems. But changing demographic and epidemiologic profiles, together with rising expectations and educational levels, are accompanied by a greater desire for equity and protection in private systems and more consumer dynamics in socialized ones. Population ageing and the dominance of long-term conditions have major effects on these processes, as age rationing of more effective treatments lessens.

Second, there is a major shift from medical dominance to managed consumerism. The era of medical control over health care has given way to greater state involvement, especially seen in new organizational and management structures. Professional autonomy, at the heart of medical power, has been superseded by a number of processes including greater accountability (through self-regulation and litigation) and the discipline of evidence-based practice. The defence of actions as the result of a sacrosanct and unquestioned defence of individual 'clinical judgement' is no longer tenable. At the same time, patients are being treated as active consumers rather than the grateful recipients of medical largesse. Such developments include tensions and contradictions. Transition does not mean that all existing practices are replaced *tout court*. In the case of demographic transition, for example, the relative shift towards an older population is secular in character, but this has not meant that younger people have disappeared, merely that the overall picture has undergone radical change. Similarly, while elements of professional power and patient trust remain, the shift away from earlier strictures and structures based on unquestioned medical authority marks a defined break with the past.

Third, in care transition, the relationship between the professions and the laity are restructured. The reduction in professional autonomy is



accompanied by a reduction in paternalism. This is especially important in responding to the challenges of long-term conditions, where support and management (including self-management) become the watchwords rather than diagnosis and cure. The relative shift in attention from acute care to long-term care in an ageing population becomes a major feature of care transition. Under such circumstances, issues of partnership, concordance and shared decision-making come to the fore. In the case of lay-led self-care initiatives such as the Expert Patients Programme, professionals are relegated to a supportive role, if they are needed at all. Although specific programmes may come and go, the underlying trend towards greater involvement of patients in their own care is discernable and is likely to continue and develop in the future.

Fourth and finally, care transition is characterized by the adoption of policies that emphasize a patient orientation. In recent years in England, this process became so marked that the former head of the NHS (and Permanent Secretary at the DoH), Sir Nigel Crisp, could talk of a 'wholly patient led NHS' (DoH, 2005) developing in the future. It is not difficult to see why such language should be employed. It serves both to counteract the influence of the professions, especially the medical profession, and to act as the basis for refashioning the rights and responsibilities of the patient. The patient can expect a high quality, responsive and supportive service on the condition that responsibility for maintaining a healthy lifestyle and employing self-care are accepted. A new 'concordat' is sought, in a new balance between state, profession and patient.

As a coda, we should note that it is entirely understandable that an emphasis on the patient (as on 'partnership', 'choice' and other such terms) is often regarded as little more than rhetorical. We have indicated that many of the developments taking place in care transition are responses to entrenched interests, as well as responses to underlying pressures of an ageing population. It is hardly surprising, therefore, for much of the language employed to have a strongly rhetorical flavour. But, as Steve Harrison (2002) has pointed out, rhetoric is not the same as 'mere rhetoric'. In our view, the language currently employed in official policy circles (and not only in them) certainly serves the interests of government. At the same time, and whether for good or ill, it points to real aspects of health care change that cannot be dismissed.

Finally, we are aware that many of the processes discussed above can be seen as features of a particular system of health care; the English NHS. Care transition might therefore be seen as the result of the specific contingencies that comprise the NHS. Clearly each country creates local and historically recognizable health care organizations. Whether the distinctions we have



made are of more general applicability is an empirical and theoretical task requiring further work.

ENDNOTES

- 1 An earlier version of this paper was given by Michael Bury as the Annual Palgrave Lecture, London, February 2008.
- 2 Because of differences between health care systems with the UK's NHS, we have focussed on policies and developments in England. However, many if not all of the distinctions made here can be applied to other parts of the NHS.

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