inter-country comparisons of trust relations in health care, it is important to identify countries that show particular developments that are relevant from a theoretical point of view. One could think of variations in institutional guarantees, such as patient charters, in the introduction of patient choice in social health insurance systems, and in contracting arrangements.

References

1 Rowe R, Calnan M. Trust relations in health care: the new agenda. *Eur J Pub Health* 2006;16:4–6.

2 Freidson E. *Doctoring together: A study of professional social control.* Amsterdam: Elsevier, 1975.

3 Timmermans S, Berg M. *The gold standard: An exploration of evidence-based medicine and standardization in health care.* Philadelphia: Temple University Press, 2003.

4 Batenburg R, Groenewegen PP. Vrije beroepen in Europa: de verschuivende grenzen van de nationale mededingingswetgeving. In: Arts W, Batenburg R, Groenewegen P, editors. *Een kwestie van vertrouwen:over veranderingen op de markt voor professionele diensten en in de organisatie van vrije beroepen.* Amsterdam: Amsterdam University Press, 2001.

5 Abbott A. *The system of professions: an essay on the division of expert labor.* Chicago: University of Chicago Press, 1988.

6 Kao AC, Green DC, Zaslavsky AM, Koplan JP, Cleary PD. The relationship between method of physician payment and patient trust. *JAMA* 1998;280:1708–14.

7 Johnson TJ. *Professions and power.* London: MacMillan Press, 1972.

8 Flap HD. No man is an island: the research program of a social capital theory. In: Favereau O, Lazega E, editors. *Conventions and structures in economic organization.* Cheltenham: Edward Elgar, 2002.

9 Lazega E. *The collegial phenomenon: The social mechanisms of cooperation among peers in a corporate law partnership.* Oxford: Oxford University Press, 2002.

10 Banks D. Transaction cost economics and its applications to health services research. *J. Health Serv. Res. Policy* 1996;1: 250–2.

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Trust relations in health care—the new agenda

Introduction

Trust has traditionally been considered a cornerstone of effective doctor–patient relationships. The need for interpersonal trust relates to the vulnerability associated with being ill, the information asymmetries arising from the specialist nature of medical knowledge, and the uncertainty and element of risk regarding the competence and intentions of the practitioner on whom the patient is dependent. Without trust patients may well not access services at all, let alone disclose all medically relevant information. Trust is also important at an institutional level, as trust in particular hospitals, insurers and health care systems may affect patient support for and use of services and thus their economic and political viability. However, in our so-called post-traditional order[1] is trust still necessary? The days of 'doctor knows best' when patients blindly trusted in and deferred to medical expertize are fast becoming a distant memory in industrialized societies where the consumer is dubbed 'king' and where the 'expert patient' expects to play an active part in decision-making regarding their treatment. Might lower levels of trust, or in fact distrust, be merited in light of medical errors, drug side effects, and the slow adoption of 'evidence-based' medical innovations and clinical guidelines? In this paper we set out how and why trust relations in the healthcare context are changing, arguing that although trust may now be more conditional it is still vitally important for both health care providers and institutions.

How have trust relations changed?

Trust relationships are characterized by one party, the trustor, having positive expectations regarding both the competence of the other party, the trustee, and that they will work in their best interests.[2] In the context of healthcare there have been changes to both interpersonal trust relations and to institutional trust relations.

Traditionally, patients have placed high levels of trust in health care professionals. Such interpersonal trust relations have been typified by a type of blind, embodied trust that developed as a result of a patient's knowledge of and relationship with their personal physician. Institutional trust in health care practitioners in general, health care organizations and systems have also tended to be high. This may well have been the effect of patients' high level of interpersonal trust in their doctor, and also have been due to clinician's professional status, and the relatively recent provision of health care as a state guaranteed welfare right. However, we would argue that these relationships have been fundamentally altered by changes in the organizational structure of medical care and the culture of health care delivery which have been prompted by wider social change. Public attitudes towards professionals and their authority as medical experts are changing, reflecting a more general decline in deference to authority and trust in experts and institutions, together with increasing reliance on personal judgments of risk.[3] The days of blind trust in a doctor 'who knows best' have been consigned to history. These broader social and cultural processes that have encouraged change in interpersonal trust relations have also stimulated changes in institutional trust. Beliefs about the limits of medical expertize together with concerns about the effectiveness of professional regulatory systems to ensure high standards of clinical care, highlighted by the media coverage of medical errors and examples of medical incompetence, have eroded trust in health care organizations, in the medical professions in general, and in health systems as a whole. Levels of public trust in individual clinicians may remain high but levels of trust and confidence in managers is considerably lower, a UK study[4] found that <40% had a great deal of confidence in them compared with over 80% who always trusted doctors or nurses.

The lower level of institutional trust and the emergence of more informed and potentially demanding patients who are aware that expert knowledge may be contested and who may actively seek further opinions and treatment options poses challenges for both

governments and the medical professions and raises the question of whether trust is still relevant and necessary to the provision of medical care in the 21st century.

Is trust still necessary?

We would argue that trust is still essential to health care encounters, even if patients today no longer rely exclusively on their 'family doctor' as an entry point to care. Trust encourages use of services, facilitates disclosure of important medical information and has an indirect influence on health outcomes through patient satisfaction, adherence and continuity of provider.[5] Although trust is highly correlated with patient satisfaction[6] it is conceptually distinct. Trust is forward looking and reflects a commitment to an ongoing relationship whereas satisfaction tends to be based on past experience and refers to assessment of performance. As an indicator of future behaviour high levels of institutional trust are still very important. Now that patients are able to participate in decisions as to where, when and how they are treated poses considerable challenges for health systems. Those systems which have used GP gatekeepers to control referrals to specialist care in order to contain costs may find that they can no longer do so in the light of patients' preferences for a particular hospital or consultant. Efforts to restrict patient choice are likely to be strongly resisted as witnessed by the failure of the médecin référent scheme in France which sought to reduce choice of physician. However, trust may offer a solution to these problems by limiting patients' desire to shop around or seek a second or third opinion as it engenders loyalty. Institutional trust is also important to organizations in promoting efficiency, team working and job satisfaction and may bring benefits to health systems as a source of social capital, reducing transaction costs due to lower monitoring and surveillance and the general enhancement of efficiency.[7] It may also offer political capital in sustaining support for publicly funded services. However, whilst public and patient trust is still important it can no longer be taken for granted. We would suggest that new forms of trust relations are emerging now, in which trust has to be actively negotiated and nurtured.

New forms of trust

The shift towards more informed patients willing to participate in decision-making we would argue has produced greater inter-dependence between patient and clinician. This has not removed the need for trust in clinical encounters, rather trust is now more conditional and negotiated and depends on the communication, provision of information, and the use of 'evidence' to support decisions. This is particularly important in the management of many chronic diseases such as diabetes where success depends at least as much on changes that the patient can make, requiring a partnership between patient and health care practitioner. The realization of such new forms of trust of course requires greater communicative competence on the part of clinicians. The ways in which clinicians interact with service users have to change, providing information and supporting their participation in decision-making requires greater communication skills and may result in longer or more consultations. It also depends on patients' willingness and ability to adopt a more 'active' stance, and whether they have access to the resources (finance, time, and energy) to do this.

Just as interpersonal trust is more conditional so is institutional trust. Rather than assuming that high standards of care will be provided, the public increasingly requires information that this is the case. In countries like the UK where public trust in the health system is believed to be in decline the political response has been to seek to use performance management as a mechanism for rebuilding public trust. Rather than relying on traditional processes of professional self-regulation to ensure high standards of competence and conduct, governments are increasingly turning to external agencies to regulate, monitor, and publicly report on the quality of care. The use of health technology assessment agencies in standard setting to encourage the provision of care that is clinically and cost effective, and of external regulators such as the Healthcare Commission in the UK to assess quality of services, act to provide visible reassurance that services are being monitored and that standards of care can be relied upon. The public reporting of an organization's results (in terms of meeting targets such as waiting times, patient satisfaction, and clinical outcomes) also in theory enables patients to make an informed choice about where to seek treatment.

Such public disclosure of performance is designed to rebuild public confidence in health care organizations but ironically this very mechanism further undermines trust. Clinicians distrust managers' efforts to meet centrally determined targets, fearing that it will reduce their autonomy and ability to prioritise treatment according to patient need. Patients are sceptical about the reality of performance figures in light of evidence of mangers' 'gaming' the system to meet targets. Indeed, we would argue that low levels of trust are implicit in performance management approaches to governance with their increased monitoring and surveillance of professional behaviour inevitably causing a decline in trust within organizations and between health services.

How can trust be nurtured?

Given that trust remains important, how can new forms of trust relations be developed and sustained? There is considerable evidence as to what factors encourage patient trust in clinicians: the clinician's technical competence, respect for patient views, information sharing, and their confidence in patient's ability to manage their illness.[8] Patient participation per se does not necessarily result in higher trust, rather it is associated with value congruence regarding participation, patient involvement produced higher trust where patients wanted to participate.[9] In contrast, evidence as to what builds institutional trust is sparse, with trust relations between providers and between providers and managers a particularly neglected area. Hall et al US survey of HMO members[10] found that system trust could help the development of interpersonal trust, where there was no prior knowledge of the clinician, but it is not known how interpersonal trust affects institutional trust. Medical errors and cost containment are associated with distrust of health care systems, whereas relationship building with the local community is regarded as an important trust building mechanism. However, little research has been conducted to identify how different modes of governance affect institutional trust.

The focus of trust relationships may of course differ according to the model of health care delivery; in market based systems such as the US patient trust may be more important to secure loyalty to particular providers whereas in tax-financed systems which are organized by national or regional agencies public trust may be more necessary. However, as health systems converge and increasingly share common challenges including: providing adequate patient choice; managing a mixed economy of provision; and more explicit rationing, then both interpersonal and institutional trust will continue to be important for all health systems.

In conclusion, we would argue that clinicians and managers need to address and respond to the changing nature of trust relations in health care. The benefits of trust demonstrate the value to be

gained from ensuring that both interpersonal and institutional trust are developed, sustained, and where necessary rebuilt. Trust is still fundamental to the clinician–patient relationship but as that relationship has changed so has the nature of trust. Trust is now conditional and has to be negotiated but, whilst clinicians may have to earn patients' trust, there is good evidence as to what is required to build and sustain such interpersonal trust. The lack of knowledge about how institutional trust can be developed indicates the need for research, ideally through inter-country comparisons to identify whether such trust varies by health system and how it can be generated. The cost of failing to recognize the importance of trust and to address the changing nature of trust relations could be substantial: economically, politically, and most important of all, in terms of health outcomes.

References

1 Giddens A. *Beyond left and right: The future of radical politics*. Cambridge: Polity Press, 1994.

2 Calnan M, Rowe R. *Trust in health care: an agenda for future research*. London: The Nuffield Trust, 2004.

3 Beck U. *Risk society*. London: Sage, 1992.

4 Calnan M, Sanford E. Public trust in health care: the system or the doctor? *Qual Saf Health Care* 2004;13:92–7.

5 Safran D, Taira D, Rogers W, et al. Linking primary care performance to outcomes of care. *J Fam Pract* 1998;47 Suppl 3:213–20.

6 Thom D, Ribisi K. Further validation and reliability testing of the trust in physician scale. *Med Care* 1999;37 Suppl 5: 510–17.

7 Gilson L. Trust and the development of health care as a social institution. *Soc Sci Med* 2003;56:1453–68.

8 Dibben M, Lena M. Achieving compliance in chronic illness management: illustrations of trust relationships between physicians and nutrition clinic patients. *Health Risk Soc* 2003;5 Suppl 3:241–59.

9 Krupat E, Bell R, Kravitz R, et al. When physicians and patients think alike: patient-centred beliefs and their impact on satisfaction and trust. *J Fam Pract* 2001;50 Suppl 12: 1057–62.

10 Hall M, Camacho F, Dugan E, et al. Trust in the medical profession: conceptual and measurement issues. *Health Ser Res* 2002;37 Suppl 5:1419–32.

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