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Do institutional logics predict interpretation of contract rules at the dental chair-side?

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ABSTRACT

In quasi-markets, contracts find purchasers influencing health care providers, although problems exist where providers use personal bias and heuristics to respond to written agreements, tending towards the moral hazard of opportunism. Previous research on quasi-market contracts typically understands opportunism as fully rational, individual responses selecting maximally efficient outcomes from a set of possibilities. We take a more emotive and collective view of contracting, exploring the influence of institutional logics in relation to the opportunistic behaviour of dentists. Following earlier qualitative work where we identified four institutional logics in English general dental practice, and six dental contract areas where there was scope for opportunism; in 2013 we surveyed 924 dentists to investigate these logics and whether they had predictive purchase over dentists' chair-side behaviour. Factor analysis involving 300 responses identified four logics entwined in (often technical) behaviour: entrepreneurial commercialism, duty to staff and patients, managerialism, public good.

1. Introduction

Contracts are the fulcrum of quasi-markets in health care (Allen, 2002): a separation of purchasers and providers can only work if there is agreement over what health care should be provided and at what price. Complete presentiment in contracts, however, is an abstraction of classical economics, not a product of contingent experience. Exchange is neither costless, nor the market 'free' – the prior costs of negotiating and the subsequent costs associated with regulation and monitoring complicate any exchange. Thus contracts are 'neither faceless, nor instantaneous' (Williamson, 1985, pp. 56). Sources of uncertainty and hence the costs of transacting are three fold. First, we cannot know all possibly relevant factors in the process of exchange, and as one contracts these factors and their possible relevance change – human behaviours are uncertain. Second, the less frequent, short and consistent a transaction the more complex the contract and the less secure its terms. Third, the less transferable and flexible the assets being invested in, the more vulnerable the investment is to wider environmental changes (new markets, technology, geo-politics) that change the value of the assets during the contracting process.

Of these sources 'behavioural uncertainty is of particular importance to an understanding of transaction cost economics issues' (Williamson, 1985, pp. 57). Whilst contracts might be designed to cope with the complexity of possible decision trees, and be flexible enough to allow for changes in investment, they struggle with uncertainties in behaviour that, for Williamson, are a function of adverse selection and moral hazard. Adverse selection is a function of bounded reason – we have no hawk's eye view, rather we occupy perspectives influenced by habit, adopting what Simon (1979) calls administrative behaviour. People strive for rational outcomes from previously established settings of group loyalty (friends, colleagues) and authority (hierarchies, law) and are forced into creating (pragmatic) procedures that work. Rather than being maximally rational, decisions are permeated with personal bias and historical preference, for without closed systems (falling upon habits and heuristics with limited variables and consequences) decisions would never get taken – thus adverse selection is inevitable. What is more, moral hazard emerges from human tendency to behave opportunistically – following stipulations as contributing to perceived interests. Thus contracts become prey to parties

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selectively and/or distortedly releasing information in a calculated manner to avoid, dilute, or re-orient contractual obligations (Williamson, 1985, pp. 45–47), putting onus on contract design to mitigate adverse selection and manage opportunism.

Health systems – notably the UK's National Health Service (NHS) – have witnessed a burgeoning use of contracts. Concomitantly, attending to moral hazard is becoming increasingly important in an environment where activities involve millions of people, where assets are expensive and highly specific, and where demographic changes and budget constraints put increasing strain on provision. Primarily it is the purchasers and government regulators – as commissioners of health services – who are advised to "scrutinize contracts for possible ways in which opportunism may affect all parties" (Roberts, 1993), so channelling the self-interest of contracting parties toward provision of what remains a public good (Ferlie, 1992). The emphasis is on identifying and closing loopholes, and a close monitoring of behaviours, to prevent opportunism from blossoming. Where opportunistic behaviour and transaction costs are extensive, the contract between purchaser and provider is widely seen as having failed.

The contract between purchasers and providers of a specific form of health care – NHS general dental practice, has been repeatedly revised to try to address unintended consequences arising from moral hazard (Harris et al., 2014); most notably seen where a trial of dentists' remuneration based on capitation payments (1984–1987) was associated with an increase in the proportion of untreated decayed teeth, raising concerns about 'supervised neglect' (Coventry et al., 1989). Payments for fillings and crowns were subsequently re-introduced. A further experiment with restructuring remuneration in Personal Dental Service (PDS) pilots (1998–2006) also found that clinical procedures declined when not specifically remunerated (Department of Health, 2009). These PDS type contracts were then replaced by a new dental contract in 2006, based on Units of Dental Activity (UDAs). But this UDA system has also failed, on account of a fall in complex treatments and an increase in the number of extractions (House of Commons, 2008). Work re-designing the dental contract is again underway with a new model expected in the next few years.

Most previous studies relating dentists' behavioural responses to incentives have tended to report on natural experiments associated with contract change and debate the relative efficiency of different remuneration systems (Chalkley et al., 2010; Tickle et al., 2011). Throughout the tactical behaviour of the dental practitioner remains unexplored since the research stance still tends toward a neoclassical assumption of hyper-rationality where the dental practitioner is seen as making optimal choices from a sharply defined set of possibilities. A weakness in current research is a narrow focus on dental practices as a production function with technological outputs, without considering behaviours and their influence on contract design and use.

To study behaviour, as is hinted at but little pursued in Williamson's posing moral hazard as a critical determinant of any contractual form, entails a dynamic view of quasi-market contracting where agents (human beings, organisations) are viewed as not emerging fully formed, but undergoing processes of creation and evolution (Ferlie, 1992), with local 'rules of the game', learning, and bargaining styles building incrementally over years of operation. Contracting becomes an iterative, learning process, with a series of inevitable unintended consequences, negotiations and amendments, and a means by which social institutions arise and are shaped, rather than planned (Hughes et al., 1997). This brings into question the prevailing rational assumption that institutions (routines, values, social objects like money) are instrumental devices enlisted through the decisions of sovereign agents. Far from being tools of rational ordering, such institutions carry structure and meaning in their own right. Institutions are instead defined by prevailing habits (e.g. recur to previously successful formulae for acting); scripts (procedures); and heuristics (moral guidance), all of which inform what does and/or should happen in evolving circumstances (Checkland et al., 2012). These understandings have been termed institutional logics: belief systems carried by agents as organising principles that create connections and a common purpose, allowing those within an organisational field a sense of grounding and habituated normalcy (Friedland and Alford, 1991); an organisational field here representing the environment in which institutional forces are structured, say in the form of specific organisations, laws, or symbolic patterns (Scott et al., 2000). They 'provide the formal and informal rules of action, interaction and interpretation that guide and constrain decision makers in accomplishing the organisation's tasks and in obtaining social status, credits, penalties and rewards in the process' (Ocasio, 1997).

Using the framing of institutional logics, our study examines the nature of contracting behaviour – with specific reference to the problem of opportunism – with regard for the evolving behaviour of dentists and dental practices. We conceive dentists (who combine the ownership of small businesses with the provision of care defined by professional codes), as acting from within the dental practice, itself structured as an organisation set in a wider organisational field of dental health care provision, across which are woven multiple, evolving and sometimes conflicting institutional logics. For example, dentists experience pressure to produce commercially sound returns, at the same time as conforming to professional norms associated with sustained and beneficial care, and in addition experience forces from other fields, say the legal field through employment laws, and the influence of community values in the field of local politics, all of which might unsettle and skew activity in ways often contractually unacknowledged. All the while these agents work within and contribute to institutionalised processes, they learn and adapt to activities governed by shared meaning and significance. In turn, they influence these processes of provision and value, both through habituation and the bringing of habit into re-alignment in the wake of unsettling or innovatory experience – professionalisation and institutionalisation are symbiotic (Scott et al., 2000; Muzio et al., 2013). New technologies, changing political priorities, changing demographics and expectations, the rise of alternative providers and myriad other influences make for a dynamic, evolving environment in which care practice is only ever on the move.

In an earlier paper, we identified four institutional logics being (re)woven into general dental practice: ownership responsibility, professionalism, population health managerialism and entrepreneurial commercialism; that whilst not mutually exclusive, and sometimes in competition, appeared distinct enough as sets of beliefs around which organisation occurred (Harris and Holt, 2013). In this paper we report findings from a subsequent quantitative study of dental practitioners. We confirm the presence of logics associated with entrepreneurial commercialism (dentists exploiting technical and business opportunities for commercial gain) and managerialism (dentists accounting for activity using administrative measurement systems). We further refine and reconfigure the logics of ownership responsibility and professionalism (the study found dentists committed to the sustainability of the dental practice understood as an enterprise, framed around a responsibility and obligation to staff employed by principal dentist/s and to patients). In doing so we add to the literature on public sector motivation and professionalism, where previously these two concepts have been identified as distinct, but also 'related in ways that have not yet been fully analysed' (Andersen, 2009). We further show how logics form and reform, rather than being static. In the frame of