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Interacting institutional logics in general dental practice☆

Rebecca Harris [a,*], Robin Holt [b]

[a] The University of Liverpool Department of Health Services Research, UK
[b] University of Liverpool School of Management, UK

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ABSTRACT

We investigate the organisational field of general dental practice and how agents change or maintain the institution of values associated with the everyday work of health care provision. Our dataset comprise archival literature and policy documents, interview data from field level actors, as well as service delivery level interview data and secondary data gathered (2011–12) from 16 English dental practices. Our analysis provides a typology of institutional logics (prevailing systems of value) experienced in the field of dental practice. Confirming current literature, we find two logics dominate how care is assessed: business-like health care and medical professionalism. We advance the literature by finding the business-like health care logic further distinguished by values of commercialism on the one hand and those of accountability and procedural diligence on the other. The logic of professionalism we also find is further distinguished into a commitment to clinical expertise and independence in delivering patient care on the one hand, and concerns for the autonomy and sustainability of a business enterprise on the other.

Introduction

Market-based health care reforms, emphasising reductions in state involvement, creating incentives for greater efficiency through competition, and moving from 'public service ethic' towards private management styles, have been sources of concern in the UK and beyond (Segall, 2000). There is pervasive unease that demands for greater care efficiencies traduce professional standards; logics of cost can restrict ability to give the best available care, and logics of commodification belie the idea of a patient being special, unique even (Gabriel, 2009). Relman (2007) for example, writes 'the essence of medicine is so different from that of ordinary business that they are inherently at odds' (p.2669), predicting medical professionalism cannot survive a commercialised health care market. UK general dental practice is, however, somewhat distinct; whilst being part of the National Health Service (NHS), provision has been governed using quasi-market principles for many years and a mixed economy of publicly subsidized and fully out-of-pocket paid (private) care exists (Taylor-Gooby, Sylvester, Calnan & Manley, 2000). Our study investigates the institutionalization of this joining of professional and commercial 'logics', specifically recent developments, from the organizational perspective of providers, the dental practice.

At the outset we approach our study as one concerning the institutional work of agents in which it is neither individual agents nor institutional structures, but their mutual expression, that forms, sustains and upsets the logics by which everyday activity finds legitimation. Thus we investigate agents absorbing, adapting or challenging prevailing and emerging institutional expectations surrounding innovation, accountability, economic efficiencies, well-being and professionalism. One such logic can dominate (Greenwood and Hinings, 1993), for example the prevailing pre-eminence of clinicians in health care decision-making (Battilana, 2009), which then gives way, or is accompanied by 'rival' logics, associated with commercialism say (Currie, Lockett, Finn, Martin & Waring, 2012; Reay & Hinings, 2009).

In the context of UK dental practice we too find multiple logics associated with clinical professionalism and commerce. The professionalism associated with clinical expertise we find extended to a concern with preserving the viability of an enterprise (the practice) upon whose flourishing the livelihood of employees and the integrity of the wider local community depend. The logic of business is also refined, as through making sense of institutional pressures to be a business, dental practices experience values associated with both accounting probity and commercial innovation. In some instances we find dental practice accommodating all

* Corresponding author. Department of Health Services Research, University of Liverpool, Waterhouse Building, Block B, 1st Floor, Room B113, 1-5 Brownlow Street, Liverpool L69 3GL, UK. Tel.: +44 (0)151 795 5334; fax: +44 (0)151 794 5604.
E-mail address: harrisrv@liverpool.ac.uk (R. Harris).

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four forms of logic, readily moving between them, or invoking them at one and the same time.

Our paper proceeds as follows. We introduce institutional work theory and its use within the field of health care, into which we also bring other studies of dental practice touching on questions of institutional reform and evaluation of care. We then describe our secondary and interview data. Our findings we organize into a typology of logics and discuss their implication for understanding how evaluations of health care provision in dental practice, and more broadly, are configured through mutual expressions of structure and agency.

The institutional setting of UK dental practice

Almost 80% of the 31,000 practising dentists (40% are female) in the UK work in dental practice (Kravitz & Treasure, 2009). Since the establishment of the General Dental Service (GDS), practitioners have acted as independent contractors to the NHS. They own their own premises, employ their own staff and pay expenses (like materials) from income. Under NHS contractual terms practices are free to provide as much or as little NHS care and private care as they wish. The vast majority of practitioners do at least some NHS work; on average NHS practitioners spend 75% of their time on NHS work. Whilst the majority of UK practitioners work alongside other dentists in professional partnerships (P^2), (Greenwood, Hinings & Brown, 1990), a third of the 11,000 practices are solo practices, where just one dentist owns the practice and provides care (Kravitz & Treasure, 2009). Government removal of restriction on the number of Bodies Corporate (DBCs) in 2006 made market entry easier for practices owned by external commercial organisations, giving rise recently to several large chains of DBCs, trading on stock markets and owning upwards of 300 practices. Supplementary material.

The GDS is one of the few areas of the NHS where patients are involved in co-payment, meaning commercial and health-care concerns are intimate. Legislation enacted in 1951 allowing patient charges for dentures became the first charges of any kind to be levied for NHS care (King, 1998). This was quickly extended to allow for patient charges for other types of treatments. This precedent of co-payment has been a feature of NHS GDS care ever since.

Studying the established and emerging criteria by which dental practice is evaluated involves concern for multiple agents (clinicians, managers, suppliers, patients, politicians, commissioning bodies, professional bodies etc.); institutional settings (public policy agenda, health and safety procedures, market forces, etc.) and norms (professionalism, affordability). There is no dominant agent or institutional force, rather agency is experienced in following established institutional settings, and institutions are animated, deepened and resisted in being taken-up within ordinary lives. In UK dentistry this has evolved into a mix of publicly/privately funded provision. Following DiMaggio and Powell (1983), we can identify such institutional settings as an organizational 'field' governed by prevailing logics, often tacitly expressed, that are beyond the gift of individuals to change, and which govern what effective care means. A field acts as a 'common meaning system, where participants interact more frequently and fatefully with each other than with actors outside the field' (Meyer, 2010; Scott, 2001: pp. 138–139). Thornton & Ocasio (1999), p. 804, for example, define institutional logics as 'the socially constructed, historical patterns of material practices, assumptions, values, beliefs and rules by which individuals produce and reproduce their material subsistence, organise time and space, and provide meaning to their social reality'. Logics are the predominating beliefs that create connections and a common purpose allowing those within a field a sense of grounding, orthodoxy and habituated normalcy; it is through logics that organization, actors and agency are woven into one another (Friedland & Alford, 1991).

To study health care logics is to investigate how agency, whether from individuals or organizations, commits, adapts and challenges prevailing structures of symbolic value and evaluation (the criteria by which care provision is considered effective) from within the field and beyond, whilst accepting agency persists only by being institutionalised within such structures (Lawrence, Suddaby & Leca, 2009, 2011, pp. 1–28; Meyer, 2010). By agency is meant the capacity to effect somehow the social world; professions, for example, being institutional agents who shape, legitimate and distribute the knowledge and practices governing activity like health care provision (Scott, 2008). This institutional perspective fosters analysis of the ways in which agents enact their environment and are similarly acted upon by the same environment, in everyday work settings (Lawrence et al., 2009, pp. 1–28).

So understanding how health care in UK dental practice is appreciated we attend to, and look beyond, specific decisional responses to immediate problems of co-ordination and control; accepting that institutional structures like professional ethics, profit-based market forces and prevailing ideas of 'health' have meaning outside of any specific individual's interpretation. Institutionalized conditions form the non-negotiable grounding allowing agency to occur. These processes of institution cannot be reduced to the instrumental logic of a decision, to institutionalize is to infuse the field with values that pertain beyond the immediate technical requirements of tasks at hand (Berger & Luckmann, 1967). For example, a patient's decision to open their mouth whilst lying prostrate in a chair is only possible in a setting of habituated expectations concerning: the competence and integrity of professionals; the desirability of healthy teeth; the probity of payment mechanisms, and so on. Yet none of this institutional settlement is immutable. No sooner is such a field posited than its dynamic nature becomes apparent (Lawrence et al., 2011). Fields are permeable, influenced by logics from other fields (e.g. employment law and litigation systems in legal fields) and from within as actors espouse multiple logics (e.g. personal dogmas). In being enacted, disruption can occur as actors take the logics on, tarry with them, innovate even. Such enactment is often open, with agency effects being more nuanced than simply resistance to or acceptance of institutional values (Currie, Lockett, et al., 2012).

Several logics may co-exist within an organisational field, although one is generally dominant. Kitchener and Mertz (2010), for example, found a dominant logic in US dental practice of clinical excellence coupled to a top-down, well-structured governance systems whereby each dental practice was led by the dentist (typically male) with other actors' fitting into allotted roles. Competing with this, though, was an emerging logic associated with the agency of hygienists, who, seeking alliances within and beyond the organisational field (for example with consumer groups representing the disadvantaged, and with public health professionals) wanted to extend provision into disenfranchised areas and to constitute alternative practices askance from the traditional professional logic associated with dentist-governed care.

Such struggles are experienced as new practices and norms - perhaps prompted by breakdown events, new actors, shifts in leadership, or new technologies - are advocated, and established ones defended, or amended (Kitchener, 2000; Meyer, 1982). How actors respond to institutional pressures varies, and in this process of struggle and resolution, actors are understood to gain skills and capital for future institutional involvement (Oliver, 1991; Reay & Hinings, 2005). In the course of such, the meaning and priority of activities can change given differing logics, with some becoming redundant or anachronistic, and others lying dormant, to be resurrected at a later time, and others surfacing. Reay and Hinings