Contracting with General Dental Services: a mixed-methods study on factors influencing responses to contracts in English general dental practice

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Disclaimer: This report contains transcripts of interviews conducted in the course of the research and contains language that may offend some readers.

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Scientific summary

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Background

Both general dental practitioners (GDPs) and general medical practitioners (GMPs) are independent contractors to the NHS. They offer their services to patients in return for payment from the general tax fund, with their relationship with the state governed by a contract with the NHS. The NHS dental contract has been revised several times in recent years, as remuneration has shifted from a model based on a centrally administered fee-for-item system to one involving local contracts with commissioners. New forms of NHS dental contract such as the Personal Dental Service contract and the 2006 Units of Dental Activity contract have been found to be unsatisfactory on account of perverse incentives. Now a new type of approach is being piloted, with reform of the NHS dental contract likely in the next few years. Much of the previous policy and research effort in this area has been focused on discussing the consequences of alternative types of contract design. That providers will seek to exploit loopholes in any new contract is now accepted and effort to identify a 'successful' new contract is increasingly geared towards scrutinising contracts in order to anticipate opportunism. This stance, along with increased efforts to develop new systems to closely monitor agents' behaviour, adds to transaction costs. Paradoxically, where opportunistic behaviour and transaction costs are extensive, the contract would be judged as having failed, given that contracts are a tool arising from new public management ideals concerned with 'doing more with less' in an era of constrained public finances.

Current approaches are rooted in a neoclassical assumption of hyper-rationality, where the GDP is seen as making optimal choices from a sharply defined set of possibilities. Dental practices viewed in this way are characterised merely as a production function with solely technological outputs. The underlying strategic behaviour of GDPs remains largely uncharted and the nature of dental practice decision-making within a human service organisation is under-represented. In this study we address this gap by applying institutional theory to the study of NHS dental contracting. Not only do we bring institutional theory into this context for the first time, but we apply it to the study of NHS contracting in a way that has not been done before. Institutional analysis attempts to understand the working rules that individuals use when making decisions. Institutional rules involve multiple layers of individuals' conscious and unconscious (habits) responses to their environment. Individuals are seen essentially as being 'problem-solvers': their behavioural responses evolve from a series of interactions with their environment, discovering what works best in any given situation. In institutional theory, this enactment of everyday practices by actors is understood to be both influenced by, as well as contributing to, shifts in wider tensions which exist at an institutional (organisational field) level (e.g. between long-held values of medical professional autonomy and the growing demands of consumers). Actors hold values and beliefs that are consistent with certain institutional logics, and by describing the logic structure of the organisational field, and any tensions which exist, we gain a fuller understanding of what underpins individuals' ongoing responses to their environment. In the NHS dental contracting context, actors can be dental practitioners, but the study of commissioner logics is relevant too.

Institutional theory provides us with a dynamic view of contracting. It accepts that there will be a series of unintended consequences, negotiations and amendments in the years following the implementation of the contract, as actors create, modify and resist the rules as part of a process of institutional evolution. These struggles take place at both the micro level (at the dental chair side) and the macro level (in dyadic relationships between GDPs and commissioners, and also at higher professional, political and societal levels). In our study, having described the institutional logics of GDPs and commissioners (and medical practitioners too, to identify features of the dental practice field which are unique to that context), we link wider institutional forces to individual behaviour by showing that institutional logics are predictive of both micro-level and macro-level responses to NHS dental contracts.

Aims

This study aimed to identify the factors which facilitate and hinder the use of contractual processes to manage and strategically develop General Dental Services. In particular we aimed to investigate the relationship between commissioners and GDPs and explore how their relationship was affected by the differing needs and professional outlooks of both parties. We used a comparison with medical practice to highlight factors which are particular to NHS dental practice.

Specific objectives were:

1. to understand what constitutes 'success' in contractual agreements from the different perspectives of GDPs and commissioners
2. to understand the factors which influence successful (or unsuccessful) outcomes being reached in contractual negotiations between GDPs and commissioners
3. to make recommendations of approaches that would facilitate the reaching of mutually agreeable contractual agreements between GDPs and commissioners, and help avoid the potential difficulties of this contracting process.

Methods

Our study was divided into three phases and involved the use of both qualitative and quantitative research methods. In phase 1 we undertook a systematic review of health-care contracting theory. The 82 included papers were grouped according to five grand theories of health-care contracting: the theory of managed competition; the principal–agent model; transaction cost economic theory; relational contract theory; and markets are institutionally as well as socially embedded. In order to produce an aggregative synthesis of theory, concepts and relationships were identified at the mid-theory level and a logic map produced to outline internal pathways linking the input 'contracts' to the intermediate outcome of 'opportunism'. In phase 1 we also collected qualitative data in the form of interviews with a range of stakeholders (Department of Health, primary care commissioning, Dental Bodies Corporate, medical corporates, dental professional and practitioner representatives, legal advisors, consultants in dental public health, dental and medical commissioners as well as GDPs and GMPs). Phase 1 informed our approach to phase 2 data collection and analysis, which comprised general dental practice and general medical practice case studies. Sixteen dental practices and six medical practices were purposively sampled from six primary care trusts (PCTs). We included private as well as NHS practices in our sample of dental cases, as well as four different models of NHS dental contract (including the new form of dental contract currently being piloted). Case study data were collected between February 2011 and April 2012. Data collection involved interviews with a variety of actors in each practice, following events (particularly contractual negotiations) in each practice over that time. We observed care and contract review meetings, interviewed commissioners and collected documentary evidence to explore and triangulate findings. Qualitative analysis using grounded theory was concurrent with data collection. In total 120 interviews were undertaken in case studies, 39 involving patients.

Phase 3 involved a postal questionnaire to all dental practitioners in the six PCTs studied, as well as an additional eight PCTs chosen randomly from a national list of PCTs. Nine hundred and fifty-five dental practitioners received a questionnaire and returns were received from 393 – a 43% response rate. Alongside this quantitative phase we undertook telephone or face-to-face interviews with nine dental commissioners across these 14 areas, as well as further stakeholder interviews to further explore and test our emerging findings. In all, we undertook 28 stakeholder interviews.

Results

We found that, for all three sets of actors (GDPs, commissioners, GMPs), multiple logics exist and, rather than as often portrayed in institutional studies, as an either–or opposition and struggle, these various logics were contingent and constantly interacting. For GDPs, for example, action and behaviour was shaped first by a logic of professionalism (although care provision was influenced by patients' views as well as from a distance of clinical dominance), along with a logic of practice ownership. The reality of a commercial logic was also very evident. We observed GDPs striving to come to workable solutions in providing care which satisfied all three of these ideological drivers, and a fourth logic of population health managerialism, to a greater or lesser extent. Our quantitative work then allowed us to test and refine our conceptions of these logics, and directed us towards an understanding that the notion of clinical professional values in dental practice is very closely entwined with ownership of the dental practice: professionalism in dental practice is experienced as a duty to staff, patients and the local community, geared towards maintaining the practice as a viable enterprise. We suggest that, in the particular dental practice context where there is no co-ownership of capital assets and little shared contractual risk, activity, norms and behaviour are skewed in this direction.

We identified the fourth institutional logic (population health managerialism) as emergent in dental practice, but less compatible with the other three dental practice logics, and often resisted. This was in contrast to our findings in medical practice, where we found a more ready acceptance of targets, external accountability and a cost-conscious logic. Doctors talked about their practice goals as providing 'cost-effective' care in a way that was unusual in dental practice. Our quantitative work again allowed us to elaborate on population health managerialism as a logic in dental practice, and we were able see that a public goods logic as well as a managerialism logic exists in dental practice, for it is possible for GDPs to resist managerialism but still be moved by a public goods logic (where resources are sufficient to cater to the need to satisfy professionalism, ownership and commercial logics at the same time). With the establishment of a new centralised NHS dental commissioning structure, and plans for a reform to the NHS dental contract under way, policy-makers have identified a need to align current levers and enablers in order to successfully discharge the NHS Commissioning Board's function. Our work directly addresses this requirement, making clearer what is often taken for granted but rarely made explicit in the complex environment of dental practice.

In our quantitative work we tested a hypothesis that institutional logics could predict GDPs' micro-level responses to NHS contracts in six grey areas of the current contract which were identified in our qualitative work as being open to opportunism. Our findings confirmed our stance and showed, for example, that dentists scoring higher for commercialism logic were more likely to restrict high-cost treatments and stop providing routine treatment towards the end of the financial year, and were less likely to allocate treatment to a lower band of care because the copayment was unfair to the patient. Moreover, when we added dentists' perception of their relationships with commissioners (perceived injustice etc.) we saw an interaction between this, their institutional logics and their opportunistic responses. Where dentists had negative experiences of commissioning, this moderated the effect of institutional logics, with the result that they were much more likely to refuse to accept patients (e.g. those with a lot of dental disease) who would result in a financial loss to the practice. This underlines our finding that an interaction between the context and the individual shapes responses to NHS contracts. Thus, as we move forward to a new era of dental commissioning and contracting, the focus should be wider than just considering contract design and monitoring issues.

In exploring macro-level responses to NHS contracts we identified a typology of three responses – 'argumentative', 'co-operative' and 'acceptance' behaviour – and showed that it was not just micro-level behaviour that could be explained by institutional logics, but also macro-level responses. In our quantitative work we found that 'argumentative' behaviour intention was associated with more dental professional network contacts, lower trust in commissioners and high commercialism logic scores. 'Co-operative' behaviour intention was associated with higher trust scores, public goods and commercialism logic scores.

We also found a relationship between micro-level and macro-level behaviour: GDPs adopting 'acceptance' behaviour were more likely to act in a self-interested way in two of the six grey areas. This suggests a 'comply and rebalance' strategy is adopted whereby, if practitioners are unable to command what they see as appropriate resources at the macro level, they try to use their chair-side capacity to be flexible around contract rules in order to command more resources. This again substantiates our main finding that practitioners' responses to contracts should not be seen as always extrinsically motivated; they are often shaped by a much wider set of influences.

In our logic map generated from our synthesis of health-care contracting theory we identified some wider direct and indirect drivers of opportunism. Practitioners thus occupy perspectives which are shaped from a range of what is deemed to be appropriate, with, for example, social and professional networks as well as media influences contributing to determining what 'appropriate behaviour' means. Clinical and payment decisions are a result of habit and heuristics framed by these personal biases and historical preferences in a way that becomes so dispositional that it becomes the 'divine law' by which the dentist practices. When contract rules and commissioning and accountability structures change, this causes these heuristics and habits to surface. Existing practices are queried and institutional work occurs as agents respond to the new environment, attempting to shape the environment by resistance or strategic co-operation as well as responding in the immediate clinical environment. Hence design and consequent behavioural responses to contracts will be only ever be something which is constantly on the move, and search for the 'final' NHS dental contract form is never likely to result in the 'ideal'.

Conclusions

We conclude that each contracting party will inevitably seek to act in its own self-interest, particularly where goals between purchaser and provider differ, as in the case of GDPs and NHS commissioners. There are underlying tensions in NHS dental contracting because GDPs are primarily driven by values concerned with commerciality, maintaining the practice as a viable enterprise, and social obligations to staff, patients and the local community, and these logics can conflict with managerialist commissioning ideology. In general medical practice, goals are more closely aligned with NHS commissioning goals, with the relationship between practitioners and commissioners more one of mutual dependency than is the case in general dental practice. The optimal contractual agreement between GDPs and commissioners therefore will be one which aims at the 'satisfactory' rather than the 'ideal', and a 'successful' NHS dental contract will be one where neither party promotes its self-interest above the other's. Future work on opportunism in health care should widen its focus beyond the self-interest of providers and look at the contribution of contextual factors such as the relationship between the government and professional bodies, the role of the media, and providers' social and professional networks.

Structure of the report

This report is arranged as follows:

Chapter 1 positions the study in the literature. We give an initial outline of the research field concerned with the use of contracts in health care. We argue that current approaches focusing on opportunism are based on a rational choice perspective which misrepresents the complexity of organisations, the wider social context and institutional change, which also shape behaviour. Studying contracts in this wider sense inevitably brings into consideration a range of various factors, many of which are related to each other. Theory can help us as a means of simplifying complex realities. We describe our systematic review of health-care contracting theory and outline the five macro-level theories concerned with health-care contracting as well as the various concepts and relationships between concepts which are relevant to study in this area. We provide a logic map as a synthesis of this lower-level theory.

We then turn to describe the policy context of the study, which is general dental practice; we give contextual detail relating to the concepts (such as asset ownership, etc.) which have been identified as important factors influencing how contracts work. We include in this section a history of the implementation of contracts in general dental practice, reflecting the cycle of contract implementation, reform and institutional change which has taken place in this setting since the 1980s. We include in our institutional background a contrast between general dental practice and general medical practice, since both have the same status as independent contractors to the NHS. The comparison enables us to draw out the factors which make contracting in general dental practice distinct.

Chapter 2 describes our research questions, aims and objectives.

Chapter 3 describes the research design and methods.

Chapter 4 presents the findings of the research in relation to, first, the qualitative and then the quantitative findings.

Chapter 5 details policy, commissioning and research implications of the study.

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