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Consumers of human services: powerless or poorly informed?

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Consumers of human services: powerless or poorly informed?

Abstract

Consumer choice in social care may worsen quality at the low end of the quality scale. Many social care recipients are not consumer sovereign; they depend on others to safeguard their interests, but their representation may be weak. U.S. and Norwegian data on nursing home patients' complaint behaviour and family network substantiate this claim. A Schelling diagram shows how residents' dependency – when only some individuals have representatives who search for good homes and monitor care – increases (decreases) the proportion of residents with committed representatives monitoring care in high (low) quality homes. Though choice is important as an individual right, public supervision is necessary to protect vulnerable consumers.

JEL classification: I11

Keywords: human services, social care, information acquisition, limited consumer sovereignty, consumer choice, public supervision.

1. Introduction

The economic literature on social care predominantly views well-functioning markets as central to improving quality (see, e.g., the review by Norton, 2000). Consumers' free choice of provider promotes competition and thereby enhances quality. Competitive forces may work even when nursing home residents are funded by third parties. Public funding is common in many Western countries, including the USA, where 78 percent of residents have public funds as their primary source of support (Harrington, Carrilo and Blank, 2008).

Following the introduction of quasi-markets (Le Grand and Bartlett, 1993), consumer choice has become a tool to improve quality and efficiency of service in modern welfare states as well. Rothstein (1998) and other scholars see consumer choice as a way to make welfare states responsive to individual needs and preferences, and to increase public accountability and democratic control from below by giving decision rights to those who benefit from and experience the service.

Although there are strong reasons to secure decision rights for highly vulnerable individuals who depend on social care, this paper argues that consumer choice alone cannot be relied on to secure quality.

The vulnerability of social care recipients is recognised in economic research. The critical question, however, is how formal economic reasoning should take this vulnerability into account. Following Arrow (1963), the common approach in health economics is to assume that patients are susceptible to opportunistic behaviour by the provider because they lack information to assess quality. Arrow's classic article discusses medical care in general and the patient–physician relationship in particular. In this health care context, the main cause of information asymmetries is the need for specialised knowledge. Because of a doctor's medical training, he or she is in a better position to evaluate medical quality than a lay patient. The assumption of asymmetrically distributed information then reflects a *specific* incompetence of the patient, the lack of medical expertise (Arrow, 1963, 1996).

In social care, the asymmetric information assumption in fact accounts for service recipients' *general* incapacity (see, e.g., Hirth, 1999; Chou, 2002; Grabowski and Hirth, 2003; Hirth et al., 2003). In this literature, which focuses on nursing homes, the information asymmetry assumption is not adopted in the same way by all authors. In Hirth's (1999) study, the relatives who monitor care on behalf of residents have less information about quality than the provider. In Chou (2002), only residents without involved relatives in this sense have inferior information.

Both approaches raise the question: why do residents have to rely on family? The obvious answer is that residents may not have the personal capacity to monitor care. People move into nursing homes because they have lost some or all of their ability to care for themselves (Kane and Kane, 1988). For the same reasons—cognitive impairments, depression, physical illness or age fragility—residents may be unable to respond to poor quality by seeking alternative sources of care or complaining, or they may choose not to exercise exit and voice options because they are socially dependent on their care givers. My point here is that a loss of basic general skills has other and more profound implications for consumer behaviour than those that result from incomplete knowledge about quality.

Many nursing home residents are not autonomous consumers. Instead, they have limited consumer sovereignty, meaning limited ability to form consistent preferences or limited ability or authority to make available choices to maximise utility (Eika 2009). In my use of the term 'limited consumer sovereignty', I follow Thurow (1974), who views limited consumer sovereignty as limited decision-making competence¹. Limited consumer sovereignty implies a dual dependency

¹ Thurow (1974) does not make a distinction between competence and limited consumer sovereignty. While competence depends on a person's ability to make a competent decision, limited consumer sovereignty also incorporates issues of power; more specifically, the capacity to execute decisions.

on others. Service recipients depend on providers for care, and on friends, family or guardians to assist or represent them as consumers. To understand the logic of social care markets, these dependencies must clearly be taken into account.

Although the paper focuses on nursing homes, the discussion is relevant for a number of human services. Limited consumer sovereignty is a pervasive phenomenon; frail and sick elderly, individuals with intellectual disabilities, individuals with severe psychiatric problems and minors depend to varying degrees on representation to safeguard their interests. These groups also tend to be major consumers of human services, i.e. health and social care, and education.

There are few empirical investigations of consumer behaviour in nursing home markets. Two US studies are Nyman (1989), who estimates a demand function for private paying residents, and Hirth et al. (2003), who examine transfers. Nyman (1989, p. 210) articulates claims about nursing home markets that are often not clearly stated. First, even if some residents have cognitive difficulties, 'those who do not represent a sizeable proportion of residents' and may therefore (approximately) act as autonomous utility-maximising consumers. Second, residents often have representatives ('agents') who are likely to be both rational and well informed. Third, '[s]ince it is not necessary for all residents to be rational for firms to fear the consequences of providing low quality and charging high prices, the existence of this group may provide a sufficient amount of rationality to discipline the market'. The last claim is similar to that of Hirth et al. (2003, p. 344), who argue that '[a] precondition for the success of pro-competitive policies is the existence of at least some fraction of consumers [...] who make well-informed choices and reevaluate those choices over time.'

This paper questions all three of these claims. The latter is an assertion about the functioning of social care markets, which is the main issue I wish to address. My argument is theoretical but simple. If the degree of representation differs between residents, the uncoordinated decisions by residents or their agents result in an outcome that policy makers may judge undesirable. Increased quality differences between homes, and worsened quality in homes that from the outset were of the lowest quality, are possible scenarios.

Because the argument is premised on the assumption that nursing home residents depend on others to safeguard their interests as consumers, I first present data from the USA and Norway to illustrate this dependence and its immediate implications for residents' opportunity for agency (Section 2). Section 3 uses a Schelling diagram to show effects of inadequate representation on market outcomes. The final section discusses implications of residents' limited consumer sovereignty for policy and for interpretation of the empirical findings of previous research on consumer behaviour in nursing home markets.

2. The nursing home population

People rarely move to a nursing home until they have become very ill. Most people wish to be cared for in their own homes as long as it is feasible. Moreover, institutional care such as nursing home care is expensive, and eligibility criteria for non-paying individuals to enter a nursing facility may be strict.

A large majority of nursing home residents in the USA have mental disorders. About 46 per cent have a formal dementia diagnosis, and 21 per cent have another psychological diagnosis (Harrington, Carillo and Blank, 2008). Dementia may destroy decision-making competence even at an early stage of the disease. Short-term memory loss, which is an early symptom, makes it difficult to remember facts such as the information necessary to compare the quality of different nursing homes. Depression is not a cognitive impairment; a depressed person may know what is in his or her interest but does not care to act in accordance with it.

The prevalence of dementia and other mental disorders may be considerably higher than the percentage of residents with formal diagnoses. A UK study found dementia in 90 per cent of nursing home residents (Margallo-Lana et al., 2001), while close to 80 per cent of residents in a

sample of Sydney nursing homes had severe cognitive impairments (Brodaty et al., 2001). In Norway, 80 per cent of a representative sample of residents had dementia, while, consistent with the US findings, only 45 per cent had received a formal diagnosis (Selbæk, Kirkevold and Engedal., 2007).

2.1 Consumer behaviour

Hirschman (1970) divides possible consumer responses to poor quality into two categories. A consumer may use either an 'exit' option (i.e., change provider or exit the service) or a 'voice' option (i.e., any action to improve service quality other than termination of the service relationship).

I first examine nursing home residents' use of the voice option. In the USA, federal law requires every state to have an ombudsman program to advocate for social care recipients. Ombudsmen visit nursing homes and speak with residents, relatives, staff, management and others concerned. Table 1 displays complaints registered by ombudsmen and complaints filed with the state survey agency (the regulatory authority) in California in 2007. In that year, ombudsman representatives visited 90 per cent of all Californian homes at least quarterly (Administration on Aging, 2007).

Table 1. Number of cases registered with the ombudsman or state authority in nursing homes in California in 2007.

Type of complainant	Ombudsman*		State authority	
	number	%	number	%
Resident	6,922	26	769	12
Relative, friend	3,700	14	2,538	39
Ombudsman, ombudsman volunteer	4,445	17	1,007	15
Other	11,072	42	2,251	34
Total	26,139	100	6,565	100

* All cases concluded in 2007 are counted.

Source: Administration on Aging, and Centres for Medicare and Medicaid Service, OSCAR database.

A characteristic of social care is the low frequency of complaints from the service recipients themselves. To file a complaint to the ombudsman is easy. Complaints may be informal and need not be substantiated by the complainant. In table 1 only one out of four complaints was voiced by a resident.

The state survey agency registers far fewer complaints than the ombudsman. Not all complaints registered by the latter concerns a legal violation. Complainants may choose not to file a complaint if they do not expect state authorities to investigate it, and the ombudsman may eliminate some causes of complaints by negotiating with people such as the home's management or staff. These factors probably in part explain why the total number of complaints to the state regulator is only a quarter of the number of cases registered by the ombudsman.

The state receives about 90 per cent fewer complaints from residents than the ombudsman, and only about 30 per cent fewer complaints from family and friends. The requirement to call or send a written statement by mail or email to that authority may be a greater obstacle to residents than to more able groups. Furthermore, in cases of serious legal violations about which the state authority should be notified, the resident is often too compromised or too incapacitated to file a complaint personally. The resident must then rely on a friend or relative to act as a representative. Only 12 per cent of all complaints to the state authority are filed by a resident. In reality, the figure may be substantially lower. Complaints may be initiated and written by representatives and signed by the resident.

Table 2. Number of cases reported to the Health and Social Care Ombudsman in Oslo (%). 1 January 2004–30 June 2005. (Gynaecology/birth: 1 January–30 June 2005.)

Ombudsman contacted by	Nursing home %	Surgery %	Gynaecology/birth %
1. Patient	0	65	67
2. Patient and helper			
Family	0	3	19
Others	0	1	0
3. Representative			
Family	84	29	15
Friends	3	0	0
Provider employee	0	0	0
External social worker	3	1	0
Others	10	1	0
Total	100	100	100
(Number of observations)	(31)	(115)	(27)

Source: Health and Social Care Ombudsman in Oslo.

To illustrate more explicitly the difference between powerless consumers and those poorly informed, Table 2 compares complaints from nursing homes with two somatic health care services. My claim that nursing home residents and other individuals with comprehensive long-term incapacities behave fundamentally differently from service recipients without such incapacities is general and does not pertain only to the USA. Table 2 is derived from an informal log of requests made by the public to the Health and Social Care Ombudsman in Oslo, Norway. Unlike the American ombudsman institution, ombudsmen in Norway do not seek out nursing home residents by visiting homes to hear their views; individuals must contact the ombudsman's office. Moreover, because the log is informal—it consists of notes made by the ombudsman's officers—the log reports the actual complainant; e.g., whether it is the service recipient or a representative. Thus the log is a good indicator of the extent to which individuals are able to make complaints personally.

Table 2 categorises all contacts within two somatic health care services (gynaecology/birth and surgery) and one social care service (nursing homes) according to whether the service recipient contacted the ombudsman in person. There are three categories. In the first category are those cases where only the recipient acts (calls, visits or writes to the ombudsman), in the second category are cases where both the recipient and a representative contact the ombudsman, and in the third are cases where only a representative (relative, friend, social worker) makes contact.

If limited consumer sovereignty is a problem in nursing homes but less so for the two other services, clearly fewer cases concerning nursing homes should be expected in the first category (the resident contacting the ombudsman unassisted) and many more in the third category (contact is only made by a representative) compared with the other two services. Table 2 confirms these expectations. In surgery and gynaecology/birth, it is usually the patient who contacts the ombudsman, unassisted by a representative. In contrast, no nursing home resident contacted the ombudsman in that period.² The proportion of category 3 cases is 100 per cent for nursing homes, and, respectively, 31 and 15 per cent for surgery and gynaecology/birth.

These figures suggest that even residents with intact cognitive capacities are reluctant to complain. One reason is fear of retaliation; i.e., a conscious or subconscious reaction by staff or management to expressions of dissatisfaction. Retaliation may be subtle yet costly to the resident;

² This conclusion also holds when requests where no dissatisfaction was noted are included.

for instance, a less pleasant atmosphere and staff members who are less willing to comfort and support.

On average, the nursing home population may be somewhat less healthy in Norway than in the USA. They are nevertheless comparable with a large majority of American nursing home residents, notably those most vulnerable and dependent.

Neglect and violation of rights to autonomy and choice are common causes of complaint to the US ombudsmen (Administration of Aging, 2007). An assumption of poorly informed consumers cannot explain such quality problems. They are those of an experience good: recipients learn the quality when receiving the service. If dissatisfied, they may exit; e.g., by applying for a place in another nursing home.

Low rates of exit from nursing homes are, however, universally observed. Hirth et al. (2003), examining all home-to-home transfers in several US states in the mid 1990s, found an average transfer rate of 3.3 per cent per life-year in nursing homes. The rate of transfers induced by the resident or a representative is probably even lower. Some of these transfers are from hospital-based Medicare facilities, which are not intended for long-term stays.

Even for residents with representatives, it is not surprising that the exit option is infrequently used. First, exit costs tend to be positively correlated with the level of help dependency. Care relationships entail wide-ranging relation-specific investments by both residents and carers. It takes time to get to know demented nursing home residents, their wants, abilities and limitations, and how to handle aggression, confusion or passivity. Residents need time to know and trust the people on whom they depend and to become familiar with the environment. The cost of discontinuity may be considerable. The cost of the other exit option, to move home again, is also higher when individuals are more dependent on help. Second, residents often have strong geographical preferences limiting provider choice. They wish to be close to home or to family. Third, social care, whether organised through markets or in a bureaucratic mode, is often characterised by excess demand (Norton, 2000). One way of rationing demand and containing costs for third-party payers, such as the government, is to control nursing home capacity. However, this policy may severely restrict consumer choice in practice.

In summary, residents' practical and social dependence on caregivers may make it unattractive for residents to exercise agency. In addition, residents may not have the physical resources to execute decisions to exit or complain. They may be unable, for instance, to obtain an overview of alternative nursing homes and apply for a place, or to file a complaint by phone or letter. Cognitive impairments are therefore not the only factor that may inhibit individual agency. Limited consumer sovereignty is intrinsically linked to the individual's fundamental dependence on others for care.

2.2 Representatives

Individuals with limited consumer sovereignty also depend on individuals to represent their interests as care recipients. This dependence is significant for at least three reasons. First, many residents do not have relatives, or their relatives do not have the capacity to act as representatives. Second, representatives are not usually present in the home, and they know less about the service than they would if they were residents themselves. Information problems are therefore greater for representatives and other outside monitors. Third, representatives are not the primary beneficiary of service quality and may have weak self-centred incentives to safeguard the interest of residents.

Data on the number of residents that have individuals within their social networks willing to take on the role as a representative are scarce. Table 3 presents population statistics from Norway on elderly citizens' close family members. Many elderly survive their partners, and a significant proportion of the eldest people (over 80) also survive their children. The percentage without living children increases from 13 per cent for citizens in their late 60s and 70s to more

than 40 per cent for those over 90.³ Most of the representatives who contacted the ombudsman were children of nursing home residents. In only one case was the ombudsman contacted by the spouse of the resident. Partners are often old and weak themselves, and most of the elderly who still had partners also had children.

Table 3. Married and cohabitating individuals in Norway aged 67 years and over, with or without children. Percentage of all citizens in the respective age group. 1 January 2005.

	67–79	80–89	90+
	%	%	%
1. No children , no partner	9	19	39
2. No children, with partner	4	4	3
3. No children in county, no partner	13	25	46
4. No children in county, with partner	9	8	4
5. Children outside county, no partner	4	6	7
6. Children in county, no partner	28	42	43
No children (sum row 1 and 2)	13	23	42
No partner (sum row 1, 5 and 6)	41	67	89

Figures computed from population statistics by Statistics Norway on request.

To act as a representative monitoring the care of the resident, proximity to the nursing home is important. In Table 3, a measure of proximity is whether the representatives live in the same county (the Norwegian term is *fylke*). According to that measure, quite a few elderly do not have children nearby, especially among the oldest elderly. A third of the citizens in their 80s and half of the citizens over 90 do not have children nearby (sum of row 3 and 4).⁴ The figures are probably the most informative about the number of nursing home residents without close family to represent them. They are comparable with the exact figures in Romøren's 2001 longitudinal study of the entire elderly population (over 80 in 1982) in a medium-sized Norwegian city, Larvik. At the time of death, 42 per cent of the elderly had no children within a half-hour travel distance. For the elderly, dependency is inversely related to the size of the family network. That network is smaller among the oldest people, while their dependency on help and the use of a nursing home is markedly higher. Among the youngest elderly (aged 67-79) in Norway 11 per cent depend on social care services (2 per cent as nursing home residents), while 87 per cent of citizens aged 90 or more are social care recipients (36 per cent as nursing home residents).⁵

If individuals other than family members—e.g., friends or guardians—take on the role of personal advocate, the share of residents with a representative may be higher. On the other hand, some residents have relatives but none who is willing to act as a representative.

Evidence for the USA about the involvement of representatives can be derived from figures presented by Chou (2002). In his sample of nursing home residents, 42 per cent did not have a spouse or child visiting within a month of being admitted to the home.

³ Cohort differences in fertility may partly account for differences between age groups.

⁴ Within/without the county is a rough measure of proximity. On the other hand, counties are relatively large. My guess is that the number of children living outside the county does not overestimate the share of patients with children living, say, more than an hour away from their parent.

⁵ Statistics Norway (www.ssb.no). Figures are derived from <http://www.ssb.no/pleie/tab-2009-07-02-04.html> and <http://www.ssb.no/pleie/tab-2009-07-02-02.html>.

3. Implications for uncoordinated allocation

An individual with limited consumer sovereignty does not benefit from easier access to information, unless he or she has a representative acting on his or her behalf. The mechanisms of the market, if uncorrected, may even make their position worse. When presenting the argument, I make several simplifying assumptions. These are discussed at the end of the section.

Imagine a market for nursing home services where the government determines eligibility and finances nursing home expenses for all residents. At a certain point in time, there are a given number of available nursing home places. The number is at least as high as the number of individuals whom the government has deemed to be eligible for a nursing home.

Homes differ only with respect to quality. Consequently, quality of care is the only matter of concern for residents and their representatives. Quality is vertically differentiated; some homes are of high quality and others low.⁶

Quality is not directly observable by outsiders; i.e., individuals who are not present in the home. There are both hidden information ('adverse selection') and hidden action ('moral hazard') problems. The first refers to innate quality differences between homes; homes are either of the 'high' quality type or the 'low' quality type. In addition, quality within each home depends on the level of monitoring by residents or their representatives. The better they monitor care, the smaller is the hidden action problem in the home. The presence of involved representatives improves psycho-social quality (e.g. whether residents are treated with respect), makes it more likely that rooms and hallways are kept clean etc.

The individuals in need of nursing home care ('residents', for short) cannot search for a good home or monitor quality. I also assume that moving costs are so high that exit is not an option.

Residents differ only with respect to whether they have a representative, and the characteristics of the representative. There are two groups. In group 1, all residents are without a representative. Because the residents cannot act themselves, there must be someone who contacts a nursing home on their behalf. That person could be a public employee who randomly chooses a home. The choice is not based on information about quality, either because the employee does not have the time or does not care to acquire information, or because there are anti-discriminatory rules in the government preventing the employee from making quality judgments. The latter is relevant when the information that can be acquired is unverifiable; e.g., information about a nursing home's reputation.

Group 2 consists of the residents with a personal representative. A representative has two functions: finding a home for the resident and monitoring the quality of care once the resident has moved in. Searching for a good home is costly. When determining whether to search, a representative weighs his or her own personal costs against the gain for the resident. The gain for the resident is higher in proportion to the quality difference between good and poor homes. Search costs and the weight that representatives attach to the resident's gain vary. The higher the quality difference, the more representatives are willing to search.

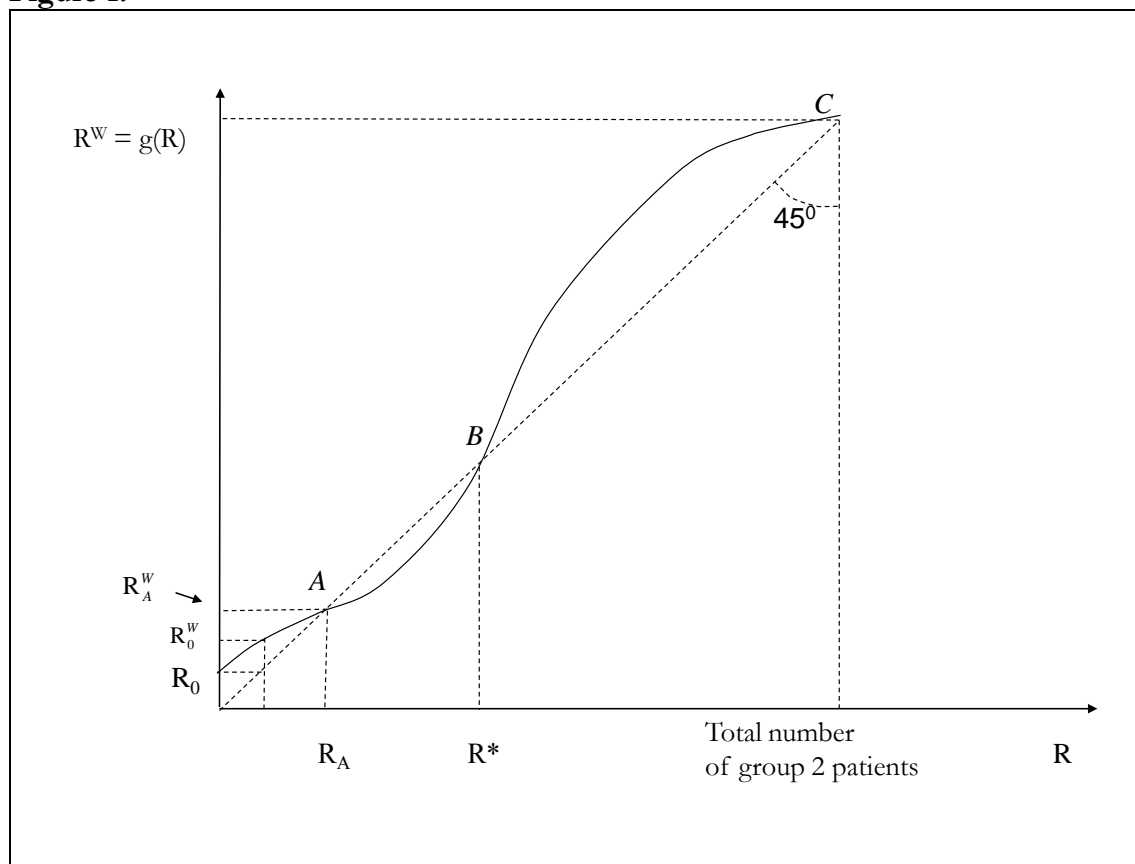
Group 1 residents cannot make use of information about quality. If information on the market is improved, so that searching for a good home becomes easier, there are several mechanisms that worsen the position of residents without representatives. First, the search for a good home by residents in group 2 (their representatives) may reduce the probability of group 1 residents finding a good home. Residents with representatives are more likely to find a place in a high-quality home than those without representatives. If most high-quality homes have few empty beds relative to the number of representatives searching (e.g., only one vacancy), the successful search by group 2 representatives also reduces the proportion of high-quality homes

⁶ Vertical differentiation means that all consumers rank quality in the same way. All prefer a high-quality home to a low-quality one (see Tirole 1988).

among homes with vacancies. Because group 1 residents ‘choose’ a home at random, the probability of group 1 residents coming to a high-quality home decreases. In this way, representatives’ searches cause a negative externality affecting group 1 residents. This externality is greater when the information about quality that the representatives are able to obtain is more accurate. The higher probability of group 1 residents coming to a poor home is problematic because hidden action problems are likely to be greater in poor than in good homes. One plausible reason why some homes are better than others is that these homes have superior professional ethics and work norms.

Second, quality of care is in important respects collective within each home. Good management, highly skilled and motivated workers, strong work norms and a pleasant atmosphere improve the quality for all residents. Discriminating between residents on grounds other than their care needs and their preferences is also a violation of the ethical code of health care professionals. Collective quality is a common assumption in the economic literature on nursing homes (see Norton, 2000; Grabowski, 2001).⁷

Figure 1.



When quality is collective, consumer choice may from a social point of view result in a situation which is clearly inferior to one in which residents and nursing homes are randomly matched. The mechanisms can be illustrated in a Schelling diagram (Schelling, 1978). The solid line in figure 1 shows the relationship between the number of representatives actually searching, R , and the number of representatives wishing to search, $R^w \equiv g(R)$. In the figure, the curve slopes upwards;

⁷ Using panel data for nursing home patients, Grabowski et al. (2006) conclude that homes provide approximately the same quality to their Medicaid and private-paying patients. McKay (1989) also finds no difference in quality between these two patient groups. Although homes may still discriminate along other dimensions—e.g., between patients with and without representatives—their findings support the conjecture that there are strong collective quality elements within each nursing home.

i.e., the number of representatives wishing to search increases with the number of representatives actually searching for a good home ($g' > 0$). When more representatives search, the number of group 2 residents increases in good homes and decreases in poor homes. Therefore the monitoring of collective quality improves in good homes and decreases in poor homes. As a result, quality differences increase, which in turn make it more attractive for representatives to search. The dotted line in the figure (the equality line) is defined by $R^W = R$; at any point along this line the number of representatives wanting to search equals the number of representatives that are in fact searching.

To illustrate the basic mechanisms, the upward sloping curve in Figure 1 crosses the equality line from above in point A , and then again from below in point B . According to the figure, very committed representatives (a total of R_0) always wish to search for a good home. Their search increases the quality differences between homes and attracts more representatives to search. The number of searchers increases from R_0 to R_0^W . As long as $R^W > R$ (i.e., $g(R)$ lies above the equality line), the number of representatives searching induces more representatives to search. Thus R increases until the equilibrium point A is reached. At A , the number of representatives wishing to search (R_A^W) equals the number actually searching (R_A). A is a stable equilibrium. If an external factor results in a moderate increase in R above R_A (meaning that $R < R^W$), this increase in the number of representatives searching is not permanent. Because in this case $R^W < R$ (i.e., $g(R)$ lies below the equality line), fewer representatives wish to search than the number actually searching. Therefore, R decreases until the equilibrium R_A is reached.

In the figure the $g(R)$ -curve has an S-shape to illustrate that multiple equilibria are possible. At A , relatively few representatives search, i.e., R_A does not greatly exceed 0. Viewing consumer choice as a tool for improving market pressure for quality, the authorities may wish to encourage more individuals to search for a home of their choice. The authorities could, for instance, subsidise the acquisition of information by representatives. Lower search costs reduce the hidden information problem, thus shifting the curve upwards, making it attractive for more representatives to search. If the positive vertical shift is sufficiently strong, so that no point on the curve is below the equality line, all representatives will eventually search for a good home (situation C).

A permanent increase in the number of searchers could also be obtained through a temporary policy change; e.g., a public campaign to encourage consumer choice, or a temporary reduction in information costs (the government publishes a one-time investigation of nursing home quality). If the direct effect is to increase the number of searchers above the critical level R^* in the figure, above which $R^W > R$, the temporary policy results in a permanent increase in the number of representatives searching, so that all eventually search (situation C).

The government may wish to rank A and C . This is not possible using standard welfare economic tools such as the Pareto criteria, which only consider differences in individuals' utility between the two situations. For individuals who are not consumer sovereign, such as demented people, individual utility is not in general well defined. However, if a society is particularly concerned with the welfare of people in the least favorable circumstances—in this case, residents in low-quality homes—it is reasonable to claim that A is preferable to C . More generally, it may be claimed that a situation where only a few or no representatives make informed decisions is preferable to a rigorous sorting of residents that predominantly places group 2 residents in high-quality homes.

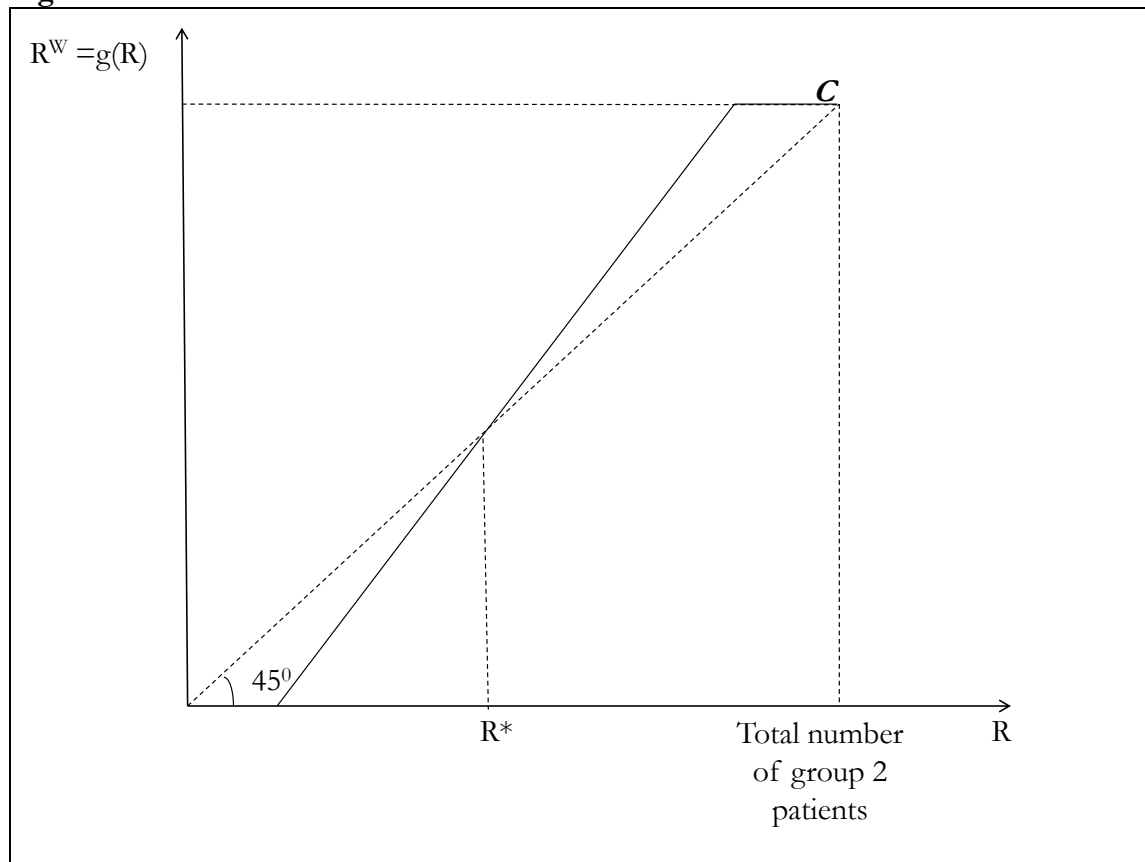
Initially (for $R = R_A$), the mix of group 1 and 2 residents may have been such that quality was at an acceptable level even in poor homes. There were good homes, and homes not quite as good, but no homes of really poor quality. If the sorting of residents intensifies, monitoring in low-quality homes may reach a critically low level. If monitoring decreases further, quality deteriorates substantially; the composition of workers may change, as highly skilled or committed workers wish to leave because high-quality care is not rewarded by the management or monitored by representatives. Those with the worst conditions are affected to a greater extent and may

experience a much lower quality of care than if the mix of group 1 and 2 residents were more balanced.

The shape of the $g(R)$ -curve is not important for the core argument; i.e., for the adverse effects of consumer choice on quality.⁸ The key premise is a positive correlation between residents' (or their representatives') willingness to choose a home (in an informed way) and to monitor the quality of care in that home. To the extent that quality is collective, there are mechanisms in the aggregate that reinforce the negative externalities of the decisions taken by the informed regarding the well-being of those unable to safeguard their own interests.

The placement of the curve is of importance for the extent to which representatives choose to make informed choices. An alternative curve is shown in Figure 2. Here no representatives wish to search if no one else does. However, if public policies increase the number of representatives searching so that $R > R^*$, all representatives wish to search.

Figure 2.



Given the existence of some good and some poor homes (differences in quality not caused by differences in resident mix), sorting of residents is socially desirable, but it would be the reverse sorting to that observed in the market. Quality in the poorest homes, a particular concern for policy makers, would increase. Moreover, if hidden action problems are higher in low-quality homes, the potential for improving quality through monitoring is higher in these homes than in high-quality homes.

The stylised model presented above disregards well-known beneficial effects of consumer choice, taking the number of high- and low-quality homes as given. A more realistic model would

⁸ A downward-sloping curve means that the number wishing to search falls as the number of representatives searching increases. Search costs increase as more representatives begin to search, and these costs outweigh the gain in terms of a higher quality difference.

take into account that well-informed consumers contribute to an increase in the proportion of high-quality homes. The proportion may rise even when it is difficult for consumers to observe quality, as long as low quality results in a bad reputation and if the loss in reputation, in turn, is sufficiently costly in terms of lower future demand and profits (Klein and Leffler, 1981). Limited consumer sovereignty dilutes such effects. First, residents' weak voice limits the information flow in the market, thus weakening the effect of quality on a firm's future reputation (cf. Tables 1 and 2). Second, residents without representatives cannot use quality information, and that in turn weakens the link between reputation and demand.

The demand for a nursing home place has been viewed as a one-time purchase because of high moving costs, following Hirth (1999). Conversely, if exit is not an exceptionally costly option, the effect of consumer choice on the systematic sorting of residents, and hence on quality differences, would be faster. Because a representative monitoring service quality is likely to gain more information about quality after a resident has moved into a home, quality differences may also increase. The more accurate the information, the more systematic the sorting of residents.

We have not considered the political implications of resident sorting. Residents without representatives have a weak voice in the political sphere and in the market. Therefore, sorting may weaken the political pressure to improve quality because there will be fewer committed representatives in poor homes to serve as watchdogs, contributing to political pressure to improve conditions.

Finally, the information assumptions are worth comment. A telling illustration of the costs of searching and the type of information that can be obtained is the *Consumer guide to choosing a nursing home*.⁹ It is written by the American advocacy group, the National Citizens' Coalition for Nursing Home Reform. The guide is addressed to individuals seeking a nursing home on behalf of a 'loved one'. The reader should consider the information published by the authorities (such as staffing, ownership and other nursing home characteristics, standardised quality measures, and reported deficiencies in state inspections). The guide advises the reader to consult a public ombudsman and advocacy groups, then to check the reputation of the homes (consulting friends, family, and clergy, among others), and finally to visit the homes under consideration, preferably as many as possible. Readers are advised to take the time to sit and observe interaction, to 'speak with residents and their family members to get a full understanding of the life in the home', and to visit homes a second and third time, also during evenings and weekends. This process is costly, requires time and physical resources, and also requires personal skills. Time and personal costs are likely to vary; representatives who are old and frail themselves may have low time costs but large effort costs.

The information is incomplete and judgmental. The guide warns that nursing homes may not have satisfactory quality even if public surveyors have not detected any regulatory violations. The guide advises representatives, who visit a home on behalf of a prospective resident, to use 'your senses—sight, hearing, smell, touch'; considering factors such as: 'Is there cheerful, respectful, pleasant, and warm interaction among staff and residents?' 'Do they enjoy their work?' This information is clearly unverifiable. It is intangible and highly judgmental. To protect public accountability, especially when provider competition on equal terms is a policy objective, a public employee, choosing a home for a group 1 resident, may not be in a position to use this type of information.

4. Consumer choice in social care

Are nursing home residents able to discipline the market? Only a minority of nursing home residents are without cognitive impairments. The discussion in Section 2 suggests that even residents with sufficient cognitive resources may be reluctant to exercise agency, either because

⁹See http://www.nccnhr.org/public/50_155_3274.cfm (last accessed 15 December, 2008).

they do not have the physical resources or because they do not wish to. Some may feel too dependent on their care givers for help, and for social support and fulfilment, to be willing to leave a familiar environment or to express dissatisfaction. In short, even cognitively able residents may have lost their autonomy as consumers.

Residents often have a relative or friend who may act as a representative, although as the data in Section 3 indicate, a significant minority do not. Moreover, representatives have lives of their own; they may have the capacity to obtain comprehensive information yet exert less effort in searching and monitoring than they would if they were residents themselves. From the point of view of self-interest, this behaviour may be fully rational. When Chou (2002) found that 42 per cent of residents did not have a representative looking after them, he used a liberal measure of representative involvement. To ease the transition to a nursing home, residents may have an urgent need for assistance by representatives immediately after entry; e.g., to communicate needs and preferences, and a month is a long time in this regard. Moreover, the proportion of residents who receive at least monthly visits by their representative(s) (which would be a liberal measure of monitoring intensity) may be even smaller.

The question remains whether the rational response of a fraction of consumers—rational in the sense that their demand is sensitive to quality (and to price if they pay out of their own pockets)—is sufficient to discipline firms. From the discussion in Section 3, we may conclude that the search by committed representatives strengthens the discipline of some firms; notably, nursing homes that from the outset are attractive. They are disciplined in particular because the increased sorting of residents in the market strengthens monitoring by representatives in these homes. On the other hand, it is not clear whether competitive forces increase or decrease quality in homes with problematic quality. There are two counteracting effects. The sorting of residents reduces monitoring and thus contributes to lower quality. This instability caused by the influence of representatives—improving and lowering the quality of respectively good and poor providers—was pointed out by Hirschman (1970) for the case of public schools. When public schools deteriorate, the most aware and informed parents may choose “exit”, thus cease to influence the public schools.

However, poor homes may be driven out of business or forced to improve quality to survive. The latter effect is weaker when there is lower excess capacity and a lower proportion of residents who have involved representatives in the market. As previously argued, many unrepresented residents not only may be insensitive to provider quality but also cannot contribute to the forming of provider reputations because of their weak voice.

Whether average quality in the market increases or decreases is an empirical question. Answering it is beyond the scope of this paper, but insights about the forces underlying demand may be gained from previous studies. For the USA, Nyman (1989), who only examines demand from self-paying residents, reports a strong negative price elasticity of demand (his main estimate is -1.7) but statistically insignificant effects of quality (in his preferred 2SLS equation). He suggests that the latter may be explained by poor data on quality. Hirth et al. (2003) find transfers between nursing homes to be positively correlated with quality but with relatively weak effects. Poor data for care quality notwithstanding, strong price responsiveness and less clear effects of quality are reconcilable with limited consumer sovereignty. Representatives are often heirs of the residents, and strong price elasticity may in part reflect representatives' incentives to protect their expected heritage.

The key issue is the response to quality. With full consumer sovereignty, there should be strong quality responsiveness because quality of nursing home care is vital to quality of life.¹⁰ Representatives, on the other hand, are not personally affected by quality, and weaker effects of quality are to be expected.

¹⁰Both papers use the number of regulatory violations as a measure of quality. This is public information. If this variable is considered to be a reasonable indicator of quality by those making demand decisions, it is reasonable to expect that the estimated effects of quality is significant in large data sets.

Although limited consumer sovereignty literally violates the conventional consumer rationality assumption (Nyman, 1989), it does not imply that market behaviour is erratic or irrational. When autonomy is lost, the question is rather: whose interests underlie demand decisions? Is it the interests of the residents or any agents assisting them or making decisions on their behalf? Depending on the situation, these agents may be friends, family or guardians representing individual residents, or public purchasers or care providers.

5. Concluding remarks

My objective has been to show that the aggregate effects of consumer choice may not be unambiguously favourable; the quality delivered by the least attractive care providers may deteriorate. In short, there are both gains and potential costs from user choice arrangements. It is equally important to stress that these costs are not fixed. Public regulation may compensate for weaknesses resulting from uncoordinated choices in the market. When representation is weak, limited consumer sovereignty justifies direct public intervention, such as setting minimum quality standards, public monitoring and enforcement. It may be difficult for public supervisors to identify homes with problematic quality. Here the choices of the well-informed may be useful. Are there some homes from which exits are more frequent? What are the reasons that residents (representatives) give for wishing to change to another nursing home? Such information becomes available when consumer choice is possible, and it may be used in addition to complaint information.

Governments are involved in social care because of a concern for disadvantaged individuals. The success of policies should be judged (at least to some extent) by its effect on those most disadvantaged—in the context of this paper, by the effect on individuals without representatives and individuals receiving care from the least attractive care providers.

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