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# THE CHALLENGE OF OBTAINING QUALITY CARE: LIMITED CONSUMER SOVEREIGNTY IN HUMAN SERVICES

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## ABSTRACT

This paper offers a conceptual analysis of the problem of quality in human services: in elementary school, psychiatric care, and the health and social care of children, the elderly, and the intellectually disabled. Geriatric nursing home patients are used as a case. These care recipients cannot enforce their legal right to quality service; their quality-effective demand is low. Formal economic analyses often characterize the weak position of the care recipient as an information asymmetry problem. An additional obstacle, however, is the recipient's inability to safeguard her personal interest due to physical, mental, or social incapacities; that is, "limited consumer sovereignty." Incapacitated individuals cannot enforce quality even when quality information is available. This creates a fundamental incentive problem in the monitoring of quality. They also depend on services that are complex and non-verifiable, making external monitoring difficult. This paper presents a typology of measures to increase the quality pressure facing providers.



## KEYWORDS

Consumer sovereignty, care quality, human services, impaired consumers, quality-effective demand, public supervision

JEL Codes: I1, I11, I18


## INTRODUCTION

The quality of long-term care receives considerable public attention in many countries. In Norway, nursing home quality has been one of the major issues in political elections for many years. In the United States, public criticism of living conditions in nursing homes has been long-standing and fierce (for example, Mary Adelaide Mendelson [1974], Bruce C. Vladeck [1980], and John Braithwaite [1993]). This criticism has resulted in comprehensive nursing home regulation in the US, regulations that are much more strict than in other countries in the world (Braithwaite 1993). Still, violations of patients' civil rights and of nursing home standards

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continue to be a problem. To quote Charlene Harrington's analysis of the situation in the US:

> Despite three decades of public concern, government surveys and data collected by the federal government continue to show that residents of nursing homes experience problems in their care. In 1998 and 1999, 25–33% of nursing homes had serious or potentially life-threatening problems in delivering care and were harming residents. (2001: 507)

In this essay, I offer a conceptual analysis of the problem of quality of human services provided in most Western nations such as within education, health, and social care. A number of human-service recipients are dependents, due to age, illness, or disability. Among them are children, frail and sick elderly, individuals with intellectual disabilities, and those suffering from depression, dementia, and other mental disorders. Maren A. Jochimsen (2003) views dependency as a defining characteristic of care relations. This is a common perspective in feminist economics (see, for example, Nancy Folbre and Julie A. Nelson [2000] and Paula England and Nancy Folbre [2003]). The care recipient depends on the caregiver in such a fundamental way that the recipient cannot exercise choice over the care provided. My concern is with those aspects of service quality that primarily benefit the service recipient only. How may a weak position as a consumer lead to a realized quality level below that which the provider is expected to fulfill by explicit or implicit agreement?

One long-term care service, geriatric nursing homes, will be taken as a case. Though dependency is a universal phenomenon, the discussion will predominantly make reference to the Western world, in particular the US, drawing on governmental reports, internationally published research, and other documents that are available in English.

Like most Western governments, the US government is involved in the nursing home industry both through regulation and funding. More than 1.3 million people live in US nursing homes (Charlene Harrington, Helen Carrillo, and Cynthia Mercado-Scott 2005: 15). About 80 percent of them are primarily financed by public programs (Harrington, Carrillo, and Mercado-Scott 2005: 19). Only 6 percent of US nursing homes are owned by the government, while about two-thirds are for-profit and 28 percent nonprofit (Harrington, Carrillo, and Mercado-Scott 2005: 21).

The purpose of long-term care is to compensate for a loss in the ability for self-care (Rosalie A. Kane and Robert L. Kane 1988). Care services are therefore highly complex and good quality requires that each service dimension is customized to individual needs and preferences. This complexity makes it impossible to specify the set of all relevant contingencies in a contract. Quality is also difficult to verify for other





reasons: important dimensions such as the quality of social relations are intangible and therefore impossible to describe contractually, and it is difficult to obtain information about quality unless one is present at the time and place of service provision.[1] Lastly, third parties may not observe care quality from the same point of view as the service recipient.

## THE NEGLECTED ISSUE OF LIMITED CONSUMER SOVEREIGNTY

At an analytical level, individuals who are dependent have "limited consumer sovereignty," meaning that they have insufficient capacity to guard their own interests. Consumer sovereignty is limited either because an individual cannot form consistent preferences or because she lacks the ability or authority to use available choice options on her own behalf.[2]

Individuals' decision-making capacity as economic agents comprises both decisions about entering into contracts and the monitoring of contracts. I use the term monitoring here to mean both contract supervision and enforcement. The proposed definition of limited consumer sovereignty is much in the spirit of Lester Thurow (1974), who thinks of limited consumer sovereignty as limited decision-making competence.[3] While in a legal context incompetence is a threshold concept, meaning that one is either competent or incompetent to make a certain decision (Allen E. Buchanan and Dan W. Brock 1990), it is useful to consider limited consumer sovereignty as a matter of degree, with the fully sovereign homo economicus at one end of the scale and consumers with no consumer sovereignty at the other.

By explicitly taking into account dependency as a defining characteristic of the service relationship (Jochimsen 2003), the assumption of limited consumer sovereignty integrates a contract theoretical framework with the feminist economics view of care.

Frank H. Knight (1921) and Gary S. Becker (1991) link dependency to age. Children are dependent and cannot make free contractual arrangements. As concerns long-term care, some recent economic research starts with the observation that the long-term care recipient "is often neither the decision maker nor able to easily evaluate care" (Richard A. Hirth 1999: 222). When also considering the high moving costs (for example, because of transfer trauma), Hirth argues that long-term care has the character of a once-and-for-all purchase. David C. Grabowski and Richard A. Hirth conclude: "Due to physical, cognitive and emotional disabilities, many nursing home consumers may fall far short of the homo economicus assumed in most economic models of behavior" (2003: 20). But none of these studies follow up on this insight with a deeper evaluation of how limited consumer sovereignty affects care quality.

More often, economists concerned with the issue of quality in the provision of long-term care emphasize problems of regulation or asymmetric information. John A. Nyman (1988) and Paul J. Gertler (1989) mainly see quality problems in the US as unintended side effects of public regulation that sought to contain public costs by restricting the number of nursing home places available to publicly funded patients. Capacity restrictions, they argue, have contributed to excess demand, thus weakening market pressure for quality. More recent research, such as Hirth (1999), Shin-Yi Chou (2002), and Grabowski and Hirth (2003), emphasizes the weak position of the care recipient. With reference to Kenneth J. Arrow (1963), this research conceptualizes the recipient's vulnerability as a problem of asymmetric information; the care recipient and her family do not have sufficient information to evaluate the quality of care. Arrow's ground-breaking article is about medical care in general and the patient-physician relationship in particular. Asymmetrically distributed information arises in healthcare because of economies of scale in information gathering, which make it efficient that a few individuals specialize in medical care and so serve the entire population (Kenneth J. Arrow 1963, 1996). Arrow does not address questions specific to long-term care, psychiatric care, or other contexts where the recipient may have insufficient capacity.

The literature that conceptualizes the weak position of the care recipient as an information asymmetry problem – such as Hirth (1999), Chou (2002), and Grabowski and Hirth (2003) – does so with explicit or implicit reference to contract theory and the principal-agent model, which is the main tool economists use for studying information asymmetry problems (see for example, Patrick Bolton and Mathias Dewatripont [2005]). In this model, all individuals have full consumer sovereignty; that is, all individuals have equally high decision-making competence. When the consumer (the principal) cannot judge service quality, it is only because the consumer lacks some specific knowledge required to judge service quality (or the value of the agent's contribution). The missing information may stem from the lack of specific skills, such as medical expertise, which makes it difficult to judge the appropriateness of the provider's chosen action (this is Arrow's case), or the recipient cannot observe (or infer from observable variables) the provider's action (for example, she cannot judge the nursing home's food hygiene because she was not present when the food was prepared).

The difference between the above literature and the approach taken in this study concerns the recipient's general decision-making competence as an economic agent. Whether consumers have inferior information about a service is not a criterion by which to differentiate these two approaches because impaired decision-making competence typically also causes information asymmetries. I will discuss this issue later.

The main point I want to make here is that the conventional approach in contract theory cannot study the implications of dependency. As concerns





the demand for quality, the most obvious implication of dependency is the need for representation. An assumption of limited consumer sovereignty makes it possible to make a distinction between the recipient and the individuals who may, or may not, represent her.

Though limited consumer sovereignty is distinct from the conventional assumption of information asymmetry (information asymmetries which would prevail even if consumers had full consumer sovereignty), these two problems do have common implications.

A service recipient has low quality-effective demand if the recipient is unable (herself or through a representative) to enforce the agreed-upon quality level.[4] Quality-effective demand may be low even if she has the financial means of paying for the service and even if the quality standards in principle are well defined. The recipient may even have strong legal entitlements and still not have the means to enforce quality.[5]

Low quality-effective demand may be seen as a case of "missing markets" (England and Folbre 2003: 69), which affects both efficiency and distribution. It can account for inefficiency in service provision and monitoring as well as insufficient provision of the productive resources needed to attain quality. However, consumers' low quality-effective demand does not imply that quality is always substandard. Workers often provide much higher quality than that which follows from the level of quality-effective demand. Workers' inner motivation for good care, their professional and human competence, and their commitment to professional norms are key determinants of quality in the care services. They are, however, not the only factors of importance.

The conventional assumption of asymmetric information (that is, presupposing fully sovereign consumers) has been discussed widely elsewhere in the literature. The remainder of this paper concentrates on the problem of limited consumer sovereignty, taking nursing home care as a case. I argue that limited consumer sovereignty is the most important cause of low quality-effective demand in long-term care. Though information problems are pervasive, often the incapacity of the care recipients lies behind these information problems. The next sections look at how limited consumer sovereignty reduces quality-effective demand in nursing homes and the resulting need for, and the incentive problem in, public surveillance and regulation.

## INDIVIDUAL QUALITY-EFFECTIVE DEMAND

Using Albert O. Hirschman's (1970) notions of exit and voice, Table 1 categorizes the main causes of low quality-effective demand according to how they affect the consumer's options to influence quality. Hirschman uses the term exit to refer to instances in which a recipient changes service providers or exits the market. The voice option refers to any kind of

*Table 1* Cases of low quality-effective demand

| | *Options to influence quality* | | | *Ex post costs from exit and voice?* |
|---|---|---|---|---|
| | *Voice* | *Change provider* | *Exit the market* | |
| *Case 1* Limited consumer sovereignty (no representation) | Limited | Limited | Limited | Yes |
| *Case 2* Limited consumer sovereignty (with representation) | Yes, if and when the representative learns about quality | Yes, if and when the representative learns about quality, and if a present or prospective customer | Yes, if and when the representative learns about quality; alternatively, no entry ex ante in expectation of low quality | Yes |
| *Case 3* Asymmetric information | Yes, if and when the consumer learns about quality | Yes, if and when the consumer learns about quality, and if a present or prospective customer | Yes, if and when the consumer learns about quality; alternatively, no entry ex ante in expectation of low quality | No |

attempt at changing provider performance other than through terminating the customer relationship. Individuals who have limited consumer sovereignty in a given situation have a very limited capacity to further their own interests through the use of exit or voice options. In case 1, the consumer has no representative available to act in her interests.

In case 2, a representative assists the individual. Representatives do not always promote the recipient's interest but may, consciously or subconsciously, have their own agenda. Representatives are typically close family, and family relations are often complex in ways that affect representatives' willingness and ability to advocate for the recipient.[6] This difficult issue is mainly left aside in the rest of the paper. Case 3 is the standard case of asymmetric information in healthcare (Arrow 1963). Compared with case 3, limited consumer sovereignty (case 1 and case 2) aggravates information problems in several respects. First, with poor general competence it is more difficult for the recipient to obtain information, for example, about medical quality, quality standards, or complaint procedures. Second, recipients' weak voices limit the extent to which information about quality is accessible





to outside monitors, such as individual representatives and public surveyors. Recipients may not inform outsiders about substandard quality of experience goods, which is a common problem in long-term care. Disrespectful behavior by staff and food that is not appetizing are examples of service dimensions that have an experience good character. Service recipients get to know quality through their own experience. Substandard experienced quality is not consistent with the recipient being poorly informed (case 3), when the use of these services is long-term.

I use geriatric nursing home patients as a case. A common cause of limited consumer sovereignty in nursing homes is mental disorders, in particular dementia. In the US, 45 percent of nursing home patients have a dementia diagnosis and 19 percent have other mental health diagnoses (Harrington, Carrillo, and Mercado-Scott 2005). The prevalence of mental disorders is probably considerably higher than these statistics suggest. The high degree of dementia in the US is comparable with other Western countries and may be comparable with many non-Western countries as well. In a representative sample of nursing home patients in Norway, 81 percent had symptoms of dementia, while much in line with the findings for the US, only 45 percent formally had this diagnosis (Geir Selbæk, Øyvind Kirkevold, and Knut Engedal 2007). The proportion of patients with dementia was 90 percent in an English study (M. Margallo-Lana, A. Swann, J. O'Brien, A. Fairbairn, K. Reichelt, D. Potkins, P. Mynt, and C. Ballard 2001), and 60 percent in a Lebanese study (L. Chahine, A. Bijlsma, A. P. N. Hospers, and Z. Chemali 2007). Henry Brodaty, Brian Draper, Dania Saab, Lee-Fay Low, Vicky Richards, Helen Paton, and David Lie (2001) report that close to 80 percent of patients in their sample of Sydney nursing homes had severe cognitive impairments.

Dementia causes a continuous deterioration in cognitive and intellectual functions and is problematic even at an early stage. First, an early symptom is short-term memory loss, which makes it difficult to remember the information required to make an informed choice of nursing home or to voice complaints in a coherent way. Second, many patients with early dementia also have symptoms of depression. People who are depressed may know what is in their best interest but still not care to act in accordance with it. Third, individuals with mental disorders also have a credibility problem when voicing complaints, which further contributes to weakening their voices. Fourth, if they are formally incompetent they are deprived of the authority to exit and to file formal complaints.

Geriatric nursing home patients who do not have mental disorders still often have limited consumer sovereignty. Many are too sick and physically frail to use exit and voice options in response to low quality. Furthermore, because nursing home patients socially and practically depend on their caregivers, the use of exit and voice options has effects that are personally costly. These are the ex post costs referred to in Table 1. Retaliation by

caregivers and patients' fears thereof pose considerable costs to a patient's speaking out against problems. Even subtle (perhaps unconscious) and seemingly minor retaliation may lower psychosocial quality a lot (for example, workers taking less pleasure in visiting with the patient or holding her hand). Moving back home (exiting the market) is obviously personally very costly when care needs are high. Most people want to be cared for in their own home as long as it is feasible, and when they apply for a nursing home, it is often because they (or their representatives) see no other option. Prospective nursing home patients may not have the personal resources or the time for a thorough comparison of the quality of various homes. The need for a home may be urgent, for example following acute-care hospitalization. If there are few nursing home vacancies, the urgency to find a home may mean that a prospective patient has no choice other than to move to the only home with an empty bed. It is also personally costly to move from one nursing home to another. For patients with dementia, the moving costs, called transfer trauma, can be very high. These costs reflect the value of continuity in care relations. Very dependent and vulnerable patients need to feel secure and be familiar with the environment and the people there (care workers and other patients). High quality therefore necessitates considerable relationship-specific investments by both the caregivers and the patients.

The more dependent and vulnerable the recipient is, the higher the costs of using exit and voice options. With increasing recipient vulnerability and dependency, the complexity of the services needed also increases as does the importance of non-verifiable information about the service (for example, the psychosocial quality of the patient's experience). For nursing home patients, dependency is negatively correlated with the size of the patient's social network from which representatives are typically recruited. Individuals with no work affiliation and with physical, cognitive, or mental handicaps have fewer resources than others to maintain a social network. Spouse, siblings, and friends may also be weakened by age. Many geriatric nursing home patients, particularly women, have survived friends and relatives, sometimes including their own children. Furthermore, children may not live nearby. In Norway, more than 40 percent of elderly in their 90s have no living children, and about 50 percent do not have children in the vicinity of their home (Kari H. Eika 2006a).

Children usually assist or represent patients (Eika 2006a). In the US, one rough indication of the prevalence of case 1, in which the patient has no representative, is provided by Chou (2002). In his sample of nursing home patients, 42 percent did not have a spouse or child visiting within a month after they had been admitted to the home.

In case 2 in Table 1, the nursing home patient has a representative to advocate her interests. Even in this case, quality-effective demand is often low. In these situations, issues of asymmetric information are very





important. Case 2 (explicit assumption of limited consumer sovereignty) provides a richer account of the obstacles to quality-effective demand than case 3. One reason is that information problems for a consumer with limited sovereignty are greater and more complex than in the standard case of asymmetric information. As in case 3, representatives lack the expertise to judge the quality of medical care. In addition, representatives have at best partial information about experienced quality since they are not themselves service recipients and are only occasionally present in the home. The more difficult it is for representatives to visit the home, the greater is the information problem. Lastly, representatives and care providers may have different views about the personal needs and wishes of the patient and what services the patient requires (Kari H. Eika 2006b). Limited consumer sovereignty, particularly recipients' weak voices, causes the latter two information problems. This compound information problem makes monitoring a particularly challenging task for representatives.

Another reason why case 2, in comparison with case 3, gives a fuller description of the obstacles to quality-effective demand is that a representative cannot eliminate the personal ex post costs from the use of exit and voice options.[7] Having a representative may even restrict the choice of home further, particularly in rural areas. The closer the home is to the representative, the easier it is for the latter to monitor care. Of course, costly exit and voice options restrict their use, which in turn inhibits the information flow in the market. In cases 1 and 2, a prospective patient cannot check out the quality of nursing homes by moving from home to home. Consequently, patients base their choices of home only on the information that outsiders can obtain. Since non-verifiable quality is important, informal information such as provider reputation is very valuable. At the same time, reputation effects are naturally modest in nursing home markets. If a patient has a representative, the representative must be informed and fears of retaliation must not inhibit his or her willingness to voice complaints.

The complexity of the information and the limited information flows imply that the quality of information that is easily available to outsiders is highly imperfect. Obtaining better information is a highly challenging task.

The US organization the National Citizens' Coalition for Nursing Home Reform (NCCNHR) posts a "Consumer Guide to Choosing a Nursing Home," which illustrates the information problem (2006). Consistent with the notion of limited consumer sovereignty and the need for representation, the consumer guide does not address a prospective resident but presumes that the reader is someone who has a "loved one" who needs a home. The consumer guide first recommends that the consumer's representative check out consumer information published by US authorities about publicly certified nursing homes. Information about state inspections (reported deficiencies), standardized quality measures, and

nursing home characteristics (for example, staffing and ownership) is easily available, for example, through the Internet (www.medicare.gov). Public agencies can also assist in accessing and interpreting the facts presented. If this information were easily conveyed, the governmental websites would, on the whole, be expected to be sufficient. However, the guide advises that the help of an "expert" is needed to interpret the information available on that website and others; thus it recommends consulting both a public ombudsman and an advocacy group. Furthermore, obtaining this information is just the start of a long process. The organization warns against naïve beliefs that nursing homes without registered deficiencies have satisfactory quality.

Finally, after checking out the reputation of each facility in the region (consulting friends, family, clergy, and others), the representative is recommended to visit the specific nursing homes under consideration. According to the guide, representatives should visit as many homes as possible, take the time to sit and observe interaction, "speak with residents to get a full understanding of the life in the home" (NCCNHR 2006: 6), and visit homes a second and third time also during evenings and weekends. The guide presents a list of issues to consider. For example, "Is there cheerful, respectful, pleasant, and warm interaction among staff and residents?" "Are there residents in physical restraints. . .? Why?" "Do (staff) enjoy their work?" This is "the Scratch and Sniff test": What is in the air? Sniff! What is under the surface? Scratch! (NCCNHR 2002). Clearly, this is unverifiable information and it is information that is hard to obtain and perhaps not possible to obtain for many prospective residents. If the prospective residents are not very able themselves to obtain this information (had they been able, they might not need a home), each person would need a personal assistant to undertake the investigation.

Even for healthy representatives such an investigation is challenging, in terms of the knowledge required to understand the system and time costs. Family or other representatives may have neither sufficient willingness nor the human and material resources to exercise an informed consumer choice on behalf of the service recipients.

## LIMITED CONSUMER SOVEREIGNTY AND PUBLIC MONITORING

One justification for public monitoring is service recipients' lack of medical expertise. When recipients have limited consumer sovereignty, there are additional reasons for public involvement. Two of these reasons have already been discussed: some recipients do not have a representative, and in cases where there are representatives, they may have less information about quality than the recipients since they themselves do not experience the service. A third reason for public involvement is that those who act as





representatives are not as eager to represent the interests of the recipient as the recipient herself would have been had she not been incapacitated. This is the fundamental incentive problem in the monitoring of services to individuals with limited consumer sovereignty. Though it applies equally to all outsiders, representatives as well as public regulatory agencies, the following discussion concerns public monitoring specifically.

Services available to recipients with weak consumer sovereignty are typically highly regulated and monitored in Western countries. Public institutions have been set up in many countries both to certify professionals and provider organizations and to monitor actual service delivery. In the US, state and federal agencies share the responsibility for monitoring nursing homes. In practice, the states have the primary responsibility for inspecting nursing homes and enforcing regulatory requirements. Monitoring procedures include the surveillance of homes through visits, conducted approximately on an annual basis; registering and investigating complaints from patients or their representatives; and taking measures to enforce quality standards in homes where these have been violated. The Centers for Medicare and Medicaid Services (CMS) is the federal regulatory agency that monitors the performance of each state's survey agency and is also directly responsible for the enforcement of federally set quality standards. (Medicare and Medicaid are the two main public funding programs in the US.) The ultimate appointed monitor, an agency that oversees both the CMS and state agencies, is the US General Accounting Office (US GAO), which produces the reports to which I will refer below. And finally, in practice, non-public outsiders, such as the media, also have important monitoring functions. This is an issue to which I will return.

### The incentive problem

Jean Tirole (1986) models third-party monitoring as a principal-agent problem. In Tirole's model the principal, in our case the service recipient, hires an outside monitor (a "supervisor") because she does not herself possess sufficient information to evaluate quality. This is case 3 in Table 1.

Outside monitors can never be given perfect incentives, since only the principal benefits from high quality. The essence of the problem is that the supervisor's monitoring efforts cannot be observed. The central question in the principal-agent literature is how the principal can use available information to optimally design and monitor contracts. If dissatisfied with the agent (whether the agent is the service provider or a supervisor), the principal may use voice (including enforcing the contract by taking the agent to court) or terminate the contract. In that sense, the principal monitors the supervisor and the service providers. In contrast, individuals with limited consumer sovereignty do not have the general competence required to monitor contracts in this way. Therefore, outside monitors have

weaker incentives to monitor service provision when consumer sovereignty is limited than when a poorly informed but able recipient hires the monitor (case 3).

All else being equal, in particular given the same information imperfections, the incentive problem in monitoring is more severe when the primary beneficiaries of a service have limited consumer sovereignty than when the recipients are merely poorly informed. Furthermore, all else is not equal, since compared with case 3, there is less information available to outsiders when consumer sovereignty is limited. The greater the information deficit, the more unobservable monitoring efforts are required to assess quality, and thus the greater are incentive problems in public monitoring.

The US government spent nearly US$300 million on quality surveillance (the certification and survey process) of nursing homes in 1998 (United States General Accounting Office [US GAO] 1999a). Even so, the US GAO finds that the data collected probably understate the extent of the quality problems. Data based on self-reporting by the nursing homes raise the question of credibility. For example, US nursing homes have been found to exaggerate their true staffing levels, illustrating the problem of hard-to-observe quality.

### Failures in monitoring

A number of reports from the US GAO find public surveillance practices in the US to be faulty. Tirole's (1986) three-party, principal-supervisor-agent model is a useful starting point for understanding failures in monitoring. The productive agent's effort is unobservable, although a supervisor employed by the principal may detect it with some probability. The principal monitors the supervisor. This multi-tier principal-agent problem should not merely be understood as the combination of two principal-agent relationships. The reason is that the two parties with superior information, the supervisor and the agent, may collude.

Sociological literature (referenced by Tirole [1986]) describes common forms of collusive behavior in organizations. US GAO points to failures in public surveillance that resemble these descriptions of collusion: First, serious observed deficiencies are not always reported, and there are too few (sometimes no) unexpected visits by state surveyors to nursing homes. Second, regarding complaint investigation, some states have procedures that "may discourage the public from filing a complaint," and some states fail to investigate complaints promptly or properly.

> Consequently, we found several instances in which, after an extended delay, the complaint investigators substantiated that residents had been harmed and other cases in which the state was unable to





> determine whether the allegations were true partly because so much time had elapsed since the complaint was received. (US GAO 1999b: 6)

The state does not always take actions required to enforce quality. The US GAO points to the need for strengthening the enforcement of quality standards. Despite sustained efforts to improve such enforcement, these problems persist, though some improvements have been achieved (US GAO 2003). In Tirole (1986), as in theoretical principal-agent relationships in general, the principal enforces the contract. When the supervisor is a public regulatory agency, the supervisor is also responsible for enforcement.[8] Hence, one way of colluding with the agent is through weak enforcement. Reasons to collude are not necessarily monetary, explicit, or even deliberate. It might be in the monitors' own interest not to detect substandard care. They could be compromised by such information; surveyors would have to explain why they had not detected it earlier.

Inadequacies in the surveillance of nursing homes are not in themselves evidence of problems caused by limited consumer sovereignty. A third-party monitor cannot be given perfect incentives to monitor, whatever the reason that occasions the monitoring. In Tirole (1986), the principal's problem is asymmetric information. At first sight, it may appear that the asymmetric information model of third-party supervision is sufficient to understand the failures in monitoring when service recipients have limited consumer sovereignty. However, identifying the problem of consumer vulnerability, the inability of recipients to act in their own interest is not only informative about the degree of incentive problems but also about how public monitoring may fail.

### Weak voices

Limited consumer sovereignty gives rise to other types of quality problems not evident in case 3, notably substandard quality of experience goods. Therefore, policy implications also differ. The most severe quality problems concerning experience goods are abuse and neglect, which are a primary concern for public regulators (see US GAO [2002] for a report about problems in the US). According to Jean Tirole, asymmetric information underlies the quality issue: "The government may then improve welfare by subsidizing the acquisition of information" (1988: 113). However, the policy challenge for experience goods in long-term care is not to reduce the information costs. A critical challenge in public regulation is the reverse information flow, from recipients to representatives and from recipients and representatives to regulators and the public (the democratic constituency). Clearly, this is more challenging the more common case 1 is, that is, the larger the number of recipients who do not have

representatives who may inform governmental monitors and the public about instances of substandard quality.

Because of recipients' weak voices, monitors may not receive information even about grave or long-lasting instances of substandard care. Furthermore, monitors may be unaware of their own ignorance. Formal economic analyses typically ignore this problem. The principal-agent model assumes that the outcome space and the probability of each outcome are known. The principal therefore has very precise knowledge about the information that is missing. This greatly simplifies the decision problem for the principal but oversimplifies the true monitoring task in human-service provision. An imperfectly informed outsider, not understanding the complexity of a specific service, may not be able to assess how well informed she is even if she can verify the information to which she has access. Consequently, a monitor might be unable to detect when available information is insufficient or make proper use of the information she has. Such an inadequacy on the part of the monitor may occur because the monitor lacks relevant professional skills or basic human insight and experiences, has never observed the service situations, or has never identified with the recipient.[9]

The public availability of information about quality is a great policy challenge. Both regulation and much of long-term care research commonly rely on invalidated and often highly incomplete data for quality. Mark A. Davis (1991) illustrates this in his review of US literature on nursing home quality. This literature "consists of a morass of findings that are largely inconsistent due to disparate methods of defining and measuring quality" (Davis 1991: 130). However, this problem is not specific to the US. As Davis notes, quality is an elusive concept. I have already mentioned the problem of misreporting. A more subtle but important problem is that the publicly available data about quality is predominantly derived from tangible measures of quality. As I have previously argued, intangible quality is important in long-term care, in particular for those with a profound incapacity to self-care. The strong emphasis on standardized or tangible quality measures may help circumvent the problem of subjective judgment, but it may also produce invalid quality indicators; that is, the indicators do not measure what they are intended to measure (Britt Slagsvold 1998). Standardized quality measures are based on characteristics that are easily registered and often naturally quantifiable. They are partial measures, only representing some dimensions of quality. For example, a choice of dinner menu is a positive though incomplete measure of the quality dimension "autonomy." Constructing an index of this and other tangible measures on autonomy – for example, restrictions on alcohol consumption or board representation – is still likely to result in an incomplete measure of resident autonomy. Moreover, standardized measures may only indicate rather than represent good quality. For example, low consumption of sedatives has





been used as an indicator, taken to reflect or indicate a caring and warm milieu (Slagsvold 1998). When patients receive good care and feel well, they need fewer sedatives. However, the actual consumption of sedatives may not necessarily reflect the need for sedatives, as nursing homes may use to much or too little sedatives relative to patients' need. Moreover, other factors than service quality affect patients' need for medication.

To study the validity of so-called standardized (and in fact, tangible) quality measures, Slagsvold (1998) assessed nineteen Norwegian nursing home wards both by a broad set of standardized quality measures and by participant observation by two psychologists.[10] Validity seemed to be particularly problematic for intangible quality dimensions such as the psychosocial aspects of care. While there was a high correlation between the two psychologists' independent rating of each quality dimension in Slagsvold's study, allowing the study to take these ratings as an accurate representation of the corresponding quality dimensions, these ratings had a zero or slightly negative correlation with the standardized measures on all quality dimensions on psychosocial aspects (Slagsvold 1998). Assessing Australian nursing home inspections, Ann Jenkins and John Braithwaite (1993) found discretionary judgment to be important for the consistent evaluation of quality dimensions by different inspectors.

When either the management or monitoring authorities apply inadequate quality measures as governance tools, the guidelines and incentives for how care should be provided are distorted. First, standardized measures may cause multitasking problems: caregivers try to perform well only with regard to those aspects of care that affect the measures (Bengt Holmström and Paul Milgrom 1991). "In my area, if we specify clearly their employee evaluation criteria, they won't do anything else" (US nursing home staff member quoted in Braithwaite [1993: 41]). Moreover, if these measures are only indicative of quality, rather than actually representing quality, resources may be wasted on targets that are irrelevant or even destructive for quality. Simply reducing the use of sedatives in order to conform to quality standards does not make the environment more caring. (The indicator is intended to pick up the reverse causality.) Going "by the book" may twist priorities and distort social processes (Slagsvold 1998). For example, Slagsvold found that the best-functioning ward in the study was closed because it did not fulfill the quality standards of the International Standards Organization.

Braithwaite (1993) argues that the key problem in the public monitoring of US nursing homes is not weak enforcement, at least not in relative terms. American nursing home enforcement is the toughest in the world and tougher than most other areas of business regulation in the US. The US government makes comprehensive efforts to gather information about nursing homes and their compliance with the law. In accordance with regulatory requirements, nursing home inspectors visit almost all homes

annually (in twelve to fifteen month intervals), a practice that differs from many other regulatory settings. The problem of US nursing homes is rather that of "ritualism," the providers going along with institutionalized means for achieving regulatory goals while not actually attaining the goals themselves (Braithwaite 1993). According to Braithwaite (1993), public regulation has to a large extent contributed to this problem. A nursing home is usually checked for compliance with a large number of standards. The result may be a bureaucratization of care provision and an overemphasis on tangible care aspects or aspects that are irrelevant to or a hindrance to individualized care. This regulatory practice leaves little room for discretionary evaluations by either the care providers or the state surveyors. An overemphasis on tangible aspects may also undermine the motivation of care workers; formal requirements that are perceived as problematic may crowd out workers' genuine motivation for good care (Bruno S. Frey 1992). Furthermore, the detailed documentation system that each US home must then manage, along with strict physical capital requirements, such as particularly tough fire standards, have increased the economies of scale in the industry. This has resulted in much larger US nursing home facilities than what is common in other countries and large corporate chains. Large facilities, for-profit ownership, and chain affiliation are all factors commonly found to reduce quality (see for example, Jenkins and Braithwaite [1993]; Charlene Harrington, David Zimmermann, Sarita L. Karon, James Robinson, and Patricia Beutel [2000]; and Charlene Harrington, Steffie Woolhandler, Joseph Mullan, Helen Carrillo, and David U. Himmelstein [2001]).

Although US nursing home regulation is very comprehensive when compared with other countries, the quality problems are no less serious (Braithwaite 1993). In fact, the little indicative evidence there is on cross-country differences, for example on the use of physical constraints, suggests the opposite to be true. For instance, there are indications of much more grave abuse of residents in US nursing homes (see Braithwaite 1993: 15). The US nursing home sector therefore illustrates that the incentive problem in monitoring may take many forms. Even when monitoring (quality requirements, information gathering, and enforcement) is comprehensive, the efficacy of the system in attaining good quality outcomes can rightly be questioned.

## POLICY IMPLICATIONS

In the human services, when quality-effective demand is low and sub-standard quality is a public concern, how should the government design public policies so as to counter the intrinsic quality problems? In line with the previous discussion, I focus only on measures that increase the pressure for nursing home providers to improve the quality of their services.





### Increasing the pressure for better-quality services

When looking for ways of improving social outcomes, economists tend to focus on policies contributing to more market-like interaction. If serious obstacles to well-functioning markets can be eliminated, this may be a good policy. However, when consumer sovereignty is limited, the inability of consumers to rationally choose the best price-quality option is an integral characteristic of the services with which this essay is concerned.

To look for solutions, rather than only searching for arrangements that produce market-like mechanisms, a better idea would be to focus directly on desirable outcomes and following that, identify arrangements that can approximate those outcomes. Such arrangements may or may not include market mechanisms, such as free consumer choice. One guideline in this search is to look for arrangements that increase quality-effective demand either directly or by increasing the efficiency in outside monitoring. One way to characterize these arrangements is the following typology:

1) Those that enhance voice
2) Those that enhance an informed choice of provider
3) Those that facilitate outside monitoring by groups or individuals with a strong commitment to high quality and with a capacity to monitor

#### *Arrangements that enhance voice*

Voice is usually the main – and sometimes the only – channel through which a recipient may respond to poor treatment. Improving the information flow from the recipients to concerned others is a major challenge both at the system level (in particular improving information accruing to public monitors) and at the individual level. Even when care workers are highly dedicated, there is a potential for improving quality by facilitating voice. Care workers (as well as representatives) need to know and understand the individual being served to fulfill the responsibilities they are given. User organizations, researchers, and professionals advocate for "consumer direction" in long-term care, but for individuals with truly weak voices, using voice is no easy task. In the case study by David M. Rea (2005), individuals with learning disabilities were able to express their views, but the researchers spent two years preparing for the interviews to build trust and familiarity. Moreover, service users in Rea's study depended on their caregivers (and in the interviews, the researchers) for effective communication. The interviews did reveal new information, notably what services users felt were missing from the care but that workers said they were doing.[11]

Complaint procedures must take into account the personal capacities of the recipients. Procedures should be well known, simple to follow, and difficult to manipulate by the provider or shirking monitors. Care should also be taken to reduce the potential for retaliation, which may be considerable, particularly in institutionalized care. In nursing homes, patients or their representatives may be less reluctant to voice complaints as a group rather than individually. For example, a meeting may be arranged with external public monitors and politicians, who then, in turn, communicate the view of the recipients to the home management.

Limited consumer sovereignty violates a very basic assumption in economic theory, namely that of autonomous agents. Recipients' fear of retaliation and their dependency on caregivers for effective communication merely illustrate this problem. Lack of autonomy means that consumer choice and voice at the individual level must be understood and implemented in a different way than in the standard case of fully sovereign consumers. In particular, the use of exit and voice options by recipients with involved representatives may have negative or positive effects on other more vulnerable recipients, those highly dependent and without such representation. A public policy objective should be to facilitate activities with positive externalities and reduce or offset negative externalities. Voice often has positive externalities: for example, the complaint by some representatives in a nursing home may improve work practices and workers' attitude and thus benefit all patients. This mechanism hinges on quality being at least partly collective within a home. Collective quality (that is, quality is the same for all patients within a home) is a common assumption in the nursing home literature that uses formal economic models. The stronger collective quality elements a service has, the greater are the positive externalities from voice. The ombudsman institution can be justified on these grounds. Assisting individuals in complaint processes reduces private voice costs, which is socially efficient given the positive externalities.

### *Arrangements that enhance choice*

The standard way of thinking about consumer choice in economics is the central tool for creating an aggregate pressure for quality (for example, Christine E. Bishop [1988], Gertler [1989], John A. Nyman [1989], and Edward C. Norton [2000]).

When limited consumer sovereignty causes low quality-effective demand, it does so in part through weakening market pressures for quality. Reputation may give firms incentive for quality even if consumers are poorly informed (Benjamin Klein and Keith B. Leffler 1981),[12] but such incentives are not strong when recipients have truly weak voices. Moreover, consumer choice may have adverse effects, for example, on nursing home





quality (Eika 2007). Representatives search for homes with good quality. Their search inflicts a negative externality on those without representation. When good homes are in scarce supply, the latter group of patients is more likely to come to the less attractive nursing homes. Moreover, quality in good homes is likely to improve, while quality in poor homes deteriorates. The reason is that poor quality homes have fewer patients with committed representatives. There are, therefore, fewer watchdogs in the homes that most need external monitoring. Public monitoring could counteract these negative effects from consumer choice by focusing in particular on identifying and monitoring problematic homes.

Consumer choice in services with limited consumer sovereignty is important as an individual right, particularly in services where the care is very comprehensive, and consequently recipients are highly dependent on the care provided. Nursing homes and other forms of institutionalized care are examples. The possibility of exit also strengthens voice since retaliation becomes less threatening, and since in response to a threat of exit, the provider may become more attentive to voice.

### *Facilitating the outside monitoring by able groups or individuals*

Changing the institutional design of consumer choice and voice channels is important for strengthening individual rights and quality-effective demand, but it will not eliminate the necessity of outside monitoring as the ultimate guarantee for quality. Given the fundamental incentive problem in outside monitoring, additional measures must complement institutionalized monitoring by the authorities. It is particularly important to reduce monitoring costs for the public and for groups with a particular commitment to monitor quality. A key word here is transparency. Democratic societies recognize the virtues of making information public, or facilitating information gathering, although practice varies between countries. The US is comparably good in this respect. The writing of this article has been facilitated by easy access to public information about certified nursing homes and the many reports about public surveillance. Such information allows others – journalists, researchers, and concerned citizens – to monitor service providers and publicly appointed monitors.

Community services are generally easier to monitor than institutions. Life within institutions, particularly large institutions, tends to be cut off from the rest of society, as described in the classic text by Erving Goffman (1961). Therefore, there is less transparency, which may explain why larger nursing homes appear to have more quality deficiencies than smaller homes.

Another issue is to facilitate monitoring by specific groups. For most recipients, individually or as a group, there are outsiders with both a strong commitment to high quality and the capacity to monitor. Many of those with a strong commitment are also in some regards better informed than

the service provider. Monitoring may therefore also entail cooperation with the service provider to improve service quality.

Family and past and present service recipients are an important collective resource, for example through interest group organizations. Policies enabling these organizations to monitor providers and governmental monitors can be very important for the fulfillment of quality standards and represent substantial efficiency gains. At an individual level, differences in resources across recipients lead to differences in quality-effective demand; those with greater personal or family resources are better able to take care of their interests. Involvement that goes through collective channels may contribute to even out such differences, so those recipients with the least personal resources are those benefiting the most from collective monitoring action.

The ombudsman's institution is another collective voice channel for recipients, representatives, and concerned others. The ombudsman does not only provide assistance and advice in individual cases but is also a spokesman toward the authorities for groups of recipients in matters of general interest.

Collective monitoring may be very valuable. Groups or individuals not directly affected by the service themselves can have a strong moral commitment to high quality, for example, because they have a common interest or identify with the individuals affected by the service. For example, senior citizens constitute a resourceful group as monitors of geriatric long-term care: they have time and competence (they are doctors, nurses, and lawyers), and those who want to devote their time to ensuring high quality of elderly care services are likely to have a strong identification with help-dependent elderly because they know that they may become dependent on these services in a few years or have friends, spouses, or relatives who are long-term care recipients.

## SERVICES WITH LOW QUALITY-EFFECTIVE DEMAND

The preceding section discussed implications for policy of low quality-effective demand. Focusing on geriatric nursing homes, one problem was ignored, that of identifying services where quality problems may be severe due to low quality-effective demand. Most people have had a friend or relative in a nursing home or know someone who has. Everyone knows that in old age, one may end up in a home. For these reasons, the general public is concerned with nursing home quality, and we may learn about problems of substandard care through visits to a home, personal acquaintances, and the media.

For some other services, serious quality problems may not be known to the public, and hence there may not be a political pressure to improve conditions. Individuals with limited consumer sovereignty have weak voices.





If representation is also weak, the group is small and socially marginal, and quality highly idiosyncratic, severe problems of substandard quality may not be disclosed. Psychiatric care, care of the intellectually disabled, and protective services for children are examples. The gap between the extent of quality problems perceived by the public and actual problems of substandard care may be substantial, and the gap may be greater in these services than in nursing homes.

## CONCLUSION

A number of human service recipients are dependents, due to age, illness, or disability. Many of them have insufficient resources to enforce their right to quality of care; they have low quality-effective demand. Recurrent problems of substandard care are evident in psychiatric care; health and social care to children, the elderly, and the intellectually disabled; and less frequently, elementary education.

One long-term care service, geriatric nursing homes in Western nations, has been taken as a case. In economics, the weak position of nursing home patients as consumers is often seen as a problem of asymmetric information; patients (and their representatives) have less information to judge quality than the service providers. In models of asymmetric information, consumers have full consumer sovereignty, meaning that all individuals have equally high decision-making competence. When the consumer cannot judge quality, the model assumes this is only because the consumer lacks some specific knowledge required to judge quality, for example, medical expertise or information about the actions taken by the provider. Nursing home patients' main problem, however, is a lack of general decision-making competence. They have insufficient physical, mental, or social capacities to safeguard their personal interests, so they have limited consumer sovereignty.

This paper has aimed to show how this general incapacity reduces quality-effective demand. Individuals with limited consumer sovereignty depend on others to represent their interests. Two major obstacles to quality-effective demand arise from this dependence: First, those with the capacity to monitor, such as individual representatives and public monitors, are not the beneficiaries of the service and therefore have insufficient personal incentives to monitor quality. Second, because of their weak voices, recipients cannot adequately inform outsiders about experienced quality, making it more difficult for representatives and public monitors to monitor quality. Both factors increase the incentive problem in the monitoring of service quality compared with a situation where the recipients are merely poorly informed. An almost universal failure in the public regulation of nursing homes is the reliance on invalidated and often highly incomplete data for quality, particularly for quality dimensions that recipients themselves experience, such as psychosocial quality.

The extent to which limited consumer sovereignty causes low quality-effective demand varies from service to service. It depends on how common it is for recipients to have a representative, the representatives' commitment to advocate the interest of the recipient, and the difficulty of the latter task. Each human service must be analyzed individually.

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## NOTES

[1] I use "verifiability" the way it is used in economic contract theory. Service quality is verifiable if it is possible to specify in a contract (without great costs) all relevant dimensions of quality. Furthermore, these dimensions must be observable by third parties. Such cases are only taken to court if litigation is needed to enforce the contract. The court also settles issues that are not clear-cut verifiable in this sense. Disputes and the need for a court ruling arise because the contract terms or the information available are ambiguous.

[2] For ease of exposition, the service recipient is assumed to be a "she" in this paper.

[3] It should be noted that the scarce literature that uses the term "limited consumer sovereignty" does not appear to be in agreement on its definition; see for example, Soonman Kwon (2001) and Peter Kooreman and Henriëtte Prast (2007). Authors often do not make clear precisely what they mean by the term.

[4] The term "low quality-effective demand" is inspired by Keynes's notion of effective demand". I thank Alice Amsden for suggesting this term.

[5] In the absence of fully effective outside monitoring, low quality-effective demand results in an entitlement failure but of a different kind than that known in the literature and introduced by Amartya Sen (1982). The latter refers to situations in which, given their wealth and productive resources, people are not legally entitled (through production or trade) to a sufficient amount of a basic commodity (food). Low quality-effective demand, on the other hand, refers to the inability of the individual to realize her legally established entitlements or the quality level that the legal requirements are intended to ensure.

[6] One problem is self-serving biases (Linda Babcock and George F. Loewenstein 1997), which may be particularly powerful to the extent to which the close kin feels morally obliged to act as representative. For example, a daughter (or son) of a nursing home patient may deceive herself into believing that her mother's low functioning is due to age and other external factors, when in fact it is caused by apathy and depression in response to the home's neglect of psychosocial quality. For the daughter, the alternatives to self-deception would be guilt and shame, in the case that she did nothing, or it may be lower income and career expectations and less time for her own children, among other consequences, if she really took her advocacy role seriously.

[7] A representative may reduce these personal costs for the recipient: in the case of provider change, the representative may help the recipient to familiarize herself with the new environment; in the case of exiting the market, the representative may enable the recipient to move out of the nursing home by providing or organizing domestic care; and in the case of voice, the representative may prevent retaliation by monitoring care particularly well. In any case, there are personal costs that are borne by the recipient or the representative.





[8] A supervisor may be above the principal in a hierarchical structure. For example, "One may think of instances in which the agent is the police ... the principal the convict ... and the supervisor the judicial system" (Tirole 1986: 200).

[9] Identification is a powerful, though complex, psychological mechanism; see, for example, Karen E. Jenni and George F. Loewenstein (1997) and Deborah A. Small and George F. Loewenstein (2003).

[10] The correlation coefficient between the two psychologists scores ranged from 0.79 to 0.97 (Slagsvold 1998: 297). These independent observational scores were taken to be sufficiently valid on the basis of "what we saw with our own eyes" (Slagsvold 1998: 307) and their high intercorrelations.

[11] The study only concerned some aspects of the provided service, specifically user involvement in the care-management process.

[12] A non-myopic firm, taking into account that reputation has value in terms of maintaining a high mark-up on costs in the future, may refrain from shirking on quality today.

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