MEMORANDUM

No 36/2003

Low Quality-Effective Demand

Kari Eika

ISSN: 0801-1117

Department of Economics
University of Oslo

This series is published by the
University of Oslo
Department of Economics

P. O.Box 1095 Blindern
N-0317 OSLO Norway
Telephone: + 47 22855127
Fax: + 47 22855035
Internet: http://www.oekonomi.uio.no/
e-mail: econdep@econ.uio.no

In co-operation with
The Frisch Centre for Economic Research

Gaustadalleén 21
N-0371 OSLO Norway
Telephone: +47 22 95 88 20
Fax: +47 22 95 88 25
Internet: http://www.frisch.uio.no/
e-mail: frisch@frisch.uio.no

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Low Quality-Effective Demand*

Kari Eika†

October 2003

Abstract

Sub-standard quality is a recurrent problem within parts of the human services - in the care for frail elderly, mentally ill, the intellectually disabled, and children in need - and within law enforcement.

Service quality is of great concern to the individual, and the larger society. If so important, why then is it so difficult to attain? I address this issue introducing the notion of low quality-effective demand (QED). Low QED is signified either by asymmetric information or weak consumer sovereignty, or a combination. In the standard principal-agent problem the principal may have poor information about the service quality that the agent provides, but has full incentives to monitor. With weak consumer sovereignty the service recipient cannot function as the principal, lacking the ability or the authority to monitor quality.

With the U.S. nursing home sector as one particular case, I demonstrate how a better understanding of weak consumer sovereignty and low QED is important to improve the problematic quality of the human services.

1 Introduction

Sub-standard quality is a recurrent problem within parts of the human services, which in the following is taken to include law enforcement. These quality problems are rarely documented to their full extent. Even so, there is ample evidence of inadequate and at times severe deficiencies in the care for frail elderly, for orphaned children, for the mentally ill and for people with intellectual disabilities,

*I am grateful for comments and discussions with Karl Ove Moene in particular, and with Geir Asheim, Oliver Hart and Ole Christian Moen.

†Please address correspondence to: Kari Eika, University of Oslo, Department of Economics. P.O. Box 1095 Blindern. N-0317 Oslo, Norway. Internet: kari.eika@econ.uio.no.

historically as well as today (Goffman (1961), Braithwaite (1993), Mechanic (1994), Bergen Commission (2003)). Similar problems are well known in some other types of personal services; in schools, particularly in the teaching of children with special needs; and in law enforcement services such as the police and in prisons.

Even in affluent and modern economies, the quality of care and the quality of the other services just mentioned are often (though to a varying degree) compromised. Nursing home conditions in one of the richest countries in the world, the U.S., are one telling illustration. In 1980, Vladeck wrote that

> "(nursing homes in the United States) have been described as "Houses of Death", "concentration camps", "warehouses for the dying." It is a documented fact that nursing home residents tend to deteriorate, physically and psychologically, after being placed in what are presumably therapeutic institutions. The overuse of potent medications in nursing homes is a scandal in itself. Thousand of facilities in every state of the nation fail to meet minimal government standards of sanitation, staffing and patient care. The best governmental estimate is that roughly half the nation's nursing homes are "substandard".

These problems were not new (Mendelson (1974), Vladeck (1980)), and they have proven to be persistent. Harrington (2001) observes that

> "(d)espite 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".

Also in the Scandinavian welfare states, there is great public concern over the quality of nursing home care as evidenced by frequent reports in the media (see for example VG, 10 March 2003). The quality of many aspects of law enforcement services, such as the treatment of prisoners attracts much less public attention than the quality problems in the care for the elderly, but severe quality deficiencies may nevertheless be a problem.

The welfare of the individuals to whom the service is directed often depend fundamentally on the quality of the service. Fairness principles and other ethical

considerations are also involved. Consistent with this, these services are in most countries subject to public regulation, with providers having to adhere to publicly set quality standards.

In this essay I offer a descriptive analysis of the problematic quality within the human services. An important puzzle is to understand why high service quality is so difficult to attain in circumstances where it matters so much. My objective is to first identify the main characteristics of the service contexts in which such serious quality problems arise. This identification in turn can help in our understanding of how potential quality problems can be countered.

The starting point for the analysis is that the service contexts of concern share one important feature: The service recipients' consumer sovereignty is in practice severely restricted. By consumer sovereignty is meant the service recipient's opportunity to act as a rational and sovereign consumer. Consumer sovereignty is weak by nature of the service or the recipients' service needs. In the most extreme cases there is no consumer sovereignty, that is, rational consumer choice is not possible or not permitted. If so, recipients cannot respond to low quality by changing provider, exiting the market or take other actions to improve the quality of service. To the extent that the service recipients are those that primarily benefit from high quality service, this creates a fundamental incentive problem in the provision of high quality. I conjecture that weak consumer sovereignty accounts for substantial reported and latent instances of substandard quality within these services, whether these are organized in market-like or in more bureaucratic modes.

Weak consumer sovereignty and asymmetric information about service quality have similar implications. Both result in weak incentives for high quality service. Furthermore, many service contexts are characterized by both weak consumer sovereignty and information asymmetries, and in their negative effect on quality they tend to reinforce each other. Because of this interaction it is often difficult in practice to separate one effect from the other. To capture this commonality, I introduce the notion of quality-effective demand. This concept is explained in the next section.

Analytically it is useful to distinguish between information asymmetries and weak consumer sovereignty. In some respects, these are distinctly different market failures. My focus in the following is on exploring the mechanisms through which weak consumer sovereignty leads to weak incentives for quality. In contrast, the difficulty of obtaining satisfactory quality in the presence of information asymmetries

is relatively well explored by economic research.

More specifically, my focus is on the extent to which a weak position as a consumer leads to a realized quality level below accepted quality standards. The latter is the quality that a provider implicitly or explicitly is committed to fulfill. A quality standard or guideline specifies good or acceptable quality. My concern is with those aspects of service quality that primarily benefit the service recipient (whose consumer sovereignty is weak). For a nursing home resident that comprises virtually all the quality aspects, for a prisoner it does not. Detention is not (neither is it intended to be) in the interest of the one detained. Still the detention institution must also respect the rights of the prisoner and consider his welfare. Furthermore, appropriate guidelines for good quality are by necessity open-ended if service quality is non-contractible. Quality standards cannot then be fully specific, though they may be well defined at a general level. Beyond these two points, I am not concerned with the normative content of quality. Within each of the human services there is a significant professional and public discourse regarding the understanding of service needs and the appropriate guidelines for service performance. For the present analysis, however, it suffices to assume that there exist some given quality standards (whatever they are), the fulfillment of which is of primary concern to the service recipient.

The determination of quality standards is, however, not unrelated to the degree of quality-effective demand. Since these services are highly regulated, the quality standards are largely determined politically. A weak position as a consumer is correlated with a weak political voice. Consequently, the circumstances that cause quality to be substandard often also lead to low standards for quality, or to standards that are irrelevant or even obstructive to true service quality.

Quality standards have overall been raised substantially in the developed countries throughout most of the twentieth century with the development of welfare states and increasing prosperity. In other words, service recipients have been given legal entitlement to higher quality service. Stronger legal entitlements do not, however, imply that the actual quality is improved correspondingly. With low quality-effective demand, the result is often entitlement failure. According to Steiner (1991) an entitlement is something owned by one set of persons (here, the recipient) to another (the provider). The recipient has certain claims and rights that the provider is committed to fulfill or respect. It can be the right to a certain performance (proper care

for a nursing home resident) or a forbearance from interfering (the right to privacy, to file complaints etc.). When quality-effective demand is low, a service recipient does not have sufficient means to enforce a given quality standard, however strong legal entitlements he may have. This is a somewhat different notion of entitlement failure than that known in the literature and introduced by Amarthya Sen (see Sen (1982)). In Sen's terminology entitlement failure arises when people, given their wealth and productive resources, are not legally entitled (through production or trade) to a sufficient amount of a basic commodity (food). The entitlement failure resulting from low quality-effective demand, on the other hand, refers to the inability of the individual, lacking the means to enforce his claims, to realize his legally established entitlements.

2 Low quality-effective demand and its two sources

According to Hirschman (1970) there are two ways to influence quality, through exit or through voice. In the former case, the consumer changes service provider or exits the market. Alternatively, the consumer can remain with the provider, but influence quality through voice. By the use of voice in the market Hirschman refers to any kind of attempt at changing firm performance other than through terminating the customer relationship.

The term low quality-effective demand is inspired by Keynes' notion of effective demand[1]. The problem is not a lack of purchasing power, as is the case with low effective demand. A subject (whether or not the service recipient herself) may purchase the service.

The problem is neither a lack of quality standards (although they are not necessarily very specific). Such standards may be well understood by the contracting parties, and agreed upon prior to the service transaction.

Quality-effective demand is low because the one party to whom quality really matters, is unable to enforce the agreed upon quality level. One reason could be that the consumer is badly informed about true quality. However, quality-effective demand can be low even when the consumer is perfectly informed. If the ability of the consumer to act upon that information is inhibited, the information is of little

[1]I thank Alice Amsden for suggesting this term.

use. Weak consumer sovereignty – impaired consumer choice and voice – creates a fundamental incentive problem in the monitoring of quality.

Information imperfections aggravate, however, the incentive problem in monitoring that weak consumer sovereignty gives rise to. Though quality information can be obtainable for outsiders, it is frequently so only at considerable cost. Non-verifiability of the acquired quality information limits further the possibility to enforce quality standards. Typically, the result of these imperfections is that the sanctioning of poor quality to a larger extent relies on non-contractible monitoring efforts.

To argue that quality-effective demand is low entails, however, no claims about what, in technical terms, causes quality to be low. It is merely an argument about weak demands for quality, and thereby weak incentives to supply high quality for those agents with the capacity to do so[2]. Low quality-effective demand affects both effiency and distribution. It can account for inefficiency in service provision and monitoring, as well as insufficient provision of the productive resources needed to attain given quality requirements.

3 Service quality and consumer sovereignty

All of the services with which I am concerned are wholly or mainly "people-work", for example, to care for a nursing home resident, to be a foster home for a neglected or orphaned child, to detain a prisoner, or to allocate income support and housing to people in acute need out of this. Many of these individuals have low consumer sovereignty for reasons explained below. However, I choose to call them service recipients, rather than consumers. The recipient does not always want the service. Or the recipient is in a, typically involuntary, and unfortunate position, which occasions his service demands. In the latter case, the demand reflects basic needs, more than wants.

Following Hirschman (1970) a rational consumer response to low quality is either to exit from a provider, or to remain as a consumer but voice complaints. In the

[2]By incentives, I mean incentives for selfish subjects. However, it has become generally accepted, not least because of a substantial body of experimental evidence, that work motivation may not derive from the prospect of personal benefits alone, and that the role of incentives can be quite complex. Intrinsic motivation for high quality service is particularly valuable in the service contexts of concern, since it can counteract the problems of low quality-effective demand. Some informational problems may nevertheless remain.

service contexts of interest, the service recipients have both a very limited opportunity for rational consumer choice and weak voices. Weak consumer sovereignty, as I use it, refers to the combination of these two circumstances.

The reasons for recipients having weak consumer sovereignty can be divided into three categories. In a specific service context, the recipient may be characterized by one of these, or a combination.

In the first category are all those service recipients that for cognitive or other personal reasons do not have the ability to evaluate quality information or to act rationally given such information. Rational consumer choice and voice are for that reason highly restricted, and in some cases not present at all.

A substantial portion of nursing home residents has cognitive impairments. Physical fragility and fatigue may also limit a resident's ability to act as a rational and apt consumer. Other examples are psychiatric patients, particularly those with serious mental disorders, and individuals with intellectual disabilities. Though the degree to which the ability to be ones own advocate varies, it is generally lower the more substantial are the service needs. Moreover, service quality is likely to be particularly important for those with great needs.

Not all service recipients within this category are without committed personal advocates even if not able themselves. Relatives or other close affiliates can act on behalf and in the interest of the service recipient. A visit to a random nursing home will reveal that the extent of such involvement vary widely across service recipients. Some have frequent visits and much involvement from relatives, and others do not. The findings of Chou (2002) confirm that kin involvement improves quality.

The ability of relatives to be effective advocates is likely to vary systematically, according to such factors as wealth, education and social background etc. On Norwegian data, when correcting for the severity of health condition, Finnvold (2003) found that asthmatic children were more likely to receive specialized health care at the top of the medical hierarchy if their parents had high education (typically, both parents having an academic background). In Norway, those services are allocated through a bureaucratic process. The findings therefore illustrate the importance of personal ability and status for the effectiveness of voice[3].

[3]However, interaction with market arrangements also influenced allocations, such as independent pediatricians having an interest in securing access for their own patients to a publicly financed highly specialized treatment center.

Consumer choice for services where that is a formal option can be restricted for other reasons than the ability of the recipient or his relatives to evaluate quality. Moving costs can be high. For example, that is generally so for dement nursing home residents. The cost of moving is also high if the provider is a local monopolist, and the resident has a strong geographical preference, for example, a desire for living close to home. Furthermore, excess demand can eliminate the exit option all together. That is, however, not an intrinsic characteristic of the service itself, but largely the result of regulation.

Costs or obstacles to exit do not by itself restrict the opportunity to voice complaints, but it can reduce its efficiency. Complaints cannot be supported by a credible threat of exit. With a high cost to exit a possible threat of retaliation from the service provider becomes more serious. That can make residents and relatives reluctant to use voice. Retaliation has been found to be a problem within the U.S. nursing home sector.

One group with low quality-effective demand can be identified: Residents with few cognitive and other personal resources that do not have committed personal advocates with the capacity to guard their interest. Furthermore, the more challenging the process of quality information gathering and processing, the less likely is it that consumer choice is an effective quality-enhancing tool. Physical disability or minor mental limitations can then easily become a definite obstacle for the exercise of real consumer choice. Moving costs, in addition or alone, also reduce recipients' quality-effective demand. The next section, discussing consumer choice for nursing home services in the US., should demonstrate the relevance of this category.

A second category is those recipients that are deprived of their consumer sovereignty. Many recipients of law enforcement services fall in this category. Crime suspects are subject to police investigation and court trial even if they do not want to. Prison is clearly involuntary consumption. Furthermore, many of those receiving comprehensive psychiatric care are compelled to do so by the courts (see Frank and McGuire (1999) p. 11 for US. data).

Though it is in principle possible to allow for a choice of service providers even to recipients whose consumption is involuntary, the character of the service may preclude it. The exercise of extensive authority, such as that granted to most providers of law enforcement services, entails unavoidably a monopoly position. Authority is of course granted within certain limits. However, within these limits the authority

cannot be contested, for example, by a competitor, otherwise it is not authority. The courts, and much of the police services, are granted extensive authority. Though some citizens have the option available in monopoly markets, whether or not to make use of the service, for example to press charges on a (minor) criminal offense, a choice of provider may for that reason not be possible. The authority of prisons is more limited, and may in principle be combinable with consumer choice, the latter functioning as a quality enhancing mechanism.

Even if consumer choice within law enforcement is restricted or precluded by nature of the service, voice as a powerful influence mechanism is not unavoidably so. Perhaps more than in any other sector, institutions are designed to allow and facilitate recipients' voice. All suspects have for example the right to a lawyer. If a suspect has few economic means, he has also the right to a publicly paid lawyer. Many service recipients are well capable of advocating their own interest within the system. The ability to voice complaints and thus the ability to demand quality differs notably across individuals and contexts. Education, wealth, social background and social standing matters for a person's credibility, his knowledge of the system and contacts within it, and for the economic means with which he can advocate his interests. The character of the suspected crime may also affect a person's credibility and thus the effectiveness of voice.

Voice can, however, be restricted institutionally. For example, physical isolation may cut off voice options. An extreme example is the 9-11 prisoners at Guantanamo or all those aliens detained within the U.S. for related suspicions whose identity is not made known to the public.

School, health and social services for children and adolescents may come in either or both of the two categories mentioned above. Children do not in general have low quality-effective demand. Parents as caretakers have both a formal right and an obligation to act in the interest of their children, and do usually have a strong commitment to do so. Nevertheless, parents differ in their ability to advocate the interests of their children. The previously mentioned study by Finnvold (2003), showing that children from well-educated families had easier access to publicly provided specialized health care, is illustrative. Furthermore, sometimes parents fail to take care of their children, for example because of drug abuse or other social problems. Or they themselves abuse the children. These children are in great need of social care, but for that reason they are also highly vulnerable recipients, with

low capacity or authority to guard their own interest.

A third category is the combination of a great need for the service, and the service being a gift. Public housing services and the deliverance of income support to the poor are some examples. The municipality of Oslo has experienced several scandals lately in the provision of short-term accommodation to meet some citizens' acute housing needs. In Norway all citizens have the right to food and shelter, but renting rooms from landlords that are violent or exploit tenants as prostitutes are clear examples of substandard quality housing (Aftenposten, 4 April, 24 April and 25 September 2002, and Avis1, 21 November 2002). Typically the recipients have weak voices, for such obvious reasons as drug abuse, social problems and distress. In a court trial against one hostel manager with a 15 year record of violence, theft and rape, many victims said that they did not tell the social service department (which sponsored the hostel stay) their real reasons for resenting that hostel. The court did not find that surprising; the clients feared retaliation and that they would no longer be offered a hostel place. Moreover, they did not expect to be believed if they reported the abuse to the police (Avis1, 21 November 2002).

4 Consumer choice and information imperfections

Consumer choice is made more difficult in the presence of asymmetric information. What would otherwise be minor personal limitations in the ability to exercise consumer choice become much more serious obstacles in the presence of information imperfections. I exemplify this by discussing consumer choice in the US. market for nursing home services.

To enhance informed consumer choice the US authorities publish consumer information about publicly certified nursing homes. Information about state inspections (reported deficiencies), standardized quality measures, and nursing home characteristics (staffing, ownership etc.) is easily available, for example through the Internet (www.medicare.gov). Public agencies can also assist in accessing and interpreting the facts presented. The extent to which this apparently comprehensive information actually is a good guide to prospective residents can still be questioned. Not least due to its intangible nature, quality in the care services is difficult to convey to outsiders.

The National Citizens' Coalition for Nursing Home Reform posts a "Consumer

Guide to Choosing a Nursing Home" which is quite illustrative. Had information been easy to convey one would expect that this public information on the whole would be sufficient. However, clicking on that governmental web site is just the start of a long process. The organization warns against naïve beliefs that nursing homes without registered deficiencies have satisfactory quality. Furthermore, to interpret the information available on that and other web sites you need the help of an "expert": Consult both a public ombudsman and an advocacy group.

Finally, after also checking out the reputation of each facility in the region (consulting friends, family, clergy and others) comes a visit to the specific nursing homes under consideration. Visit as many homes as possible, and take time to sit and observe interaction, to "speak with residents 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. The guide presents a list of issues to consider. For example, "(i)s there cheerful, respectful, pleasant, and warm interaction among staff and residents?" "Do (staff) enjoy their work?" "Are staff responsive to resident request?" This is "the sniff-and-scratch test". What is in the air? Sniff! What is under the surface? Scratch! Clearly, this is not only unverifiable information, this is information that is hard to obtain, and perhaps not possible to obtain for many coming residents. If not very able themselves (in which case they might not need a home), each would need a personal assistant undertaking the investigation. Consistent with this, the consumer guide is addressed not to a prospective resident, but presumes that the reader has a "loved one" that is. But even for healthy family members or other representatives such an investigation is challenging, both in human terms and in terms of the system knowledge it requires. Time costs may also be substantial. By far all individuals in need of a nursing home have such personal assistance. Family or other representatives may neither have sufficient willingness nor the human and material resources to exercise an informed consumer choice on their behalf.

Individuals in need of nursing home services face both a selection problem and a moral hazard problem. The tedious procedure recommended by the consumer guide can help in the selection process by identifying which of the nursing homes in an area that seems to have an overall better quality standard than the others. However, that procedure cannot overcome the moral hazard problem: The nursing home cannot commit to future high care quality since quality is unverifiable.

If nursing home care was an experience good for which there was effective

reputation mechanisms or low moving costs, unverifiability would not be a problem. Either of these two conditions is however questionable.

Residents with weak voices cannot but generate modest reputation effects. Moreover, a resident with in principle an extensive experience with the nursing home where he is currently living may not have more helpful information than an individual that chooses a nursing home for the first time if he is not also better informed about quality in other nursing homes. For a resident to whom moving back home again is not an option, it is only relative quality performance that matters.

Furthermore, changing to a new nursing home means moving into a new building, receiving care from new care workers and not knowing the coresidents. This may be very costly in personal terms, particularly so for, for example, senile residents. These have generally very low quality-effective demand if they do not have a good personal advocate among family or friends. They have both a low cognitive ability to choose, and typically, high moving costs once in a nursing home.

Clearly, there *is* non-verifiability and it *is* a problem. Nursing homes are being sued, by the government and by residents or their representatives. Monitoring authorities report that serious deficiencies detected by state surveyors or serious complaints from residents are not being investigated further because they are difficult to prove. The extent of such law-suits is in itself an indication of non-verifiability and of its costs. If quality was fully verifiable, there would be no need for court cases. Since the court rulings would be fully predictable, the parties would reach an agreement outside the court in accordance with the previously agreed-upon quality standards.

In the US nursing home sector low quality care has been a persistent phenomenon despite three decades of public concern (Mendelson (1974), Vladeck (1980), Braithwaite (1993), Harrington (2001)). Press reports about inadequate care and public protests are frequent. Data collected by state surveyors and federal authorities continue to show that substandard quality are both widespread and in many cases severe. Each year from 1995 to 2000 inspectors found that at least one quarter of all US nursing homes had serious, harmful and potentially life-threatening quality problems (GAO (1999a), Harrington et al. (2001a)). Over 3/4 of homes that were performing poorly continued to have problems the subsequent year (GAO (1999a)). Still, understatement of the quality problems by the state surveyors remains a serious issue (GAO (2003)).

Neglect of residents through insufficient or inadequate care is the most serious quality problem in US nursing homes, but there is also abuse. Braithwaite (1993) asked state monitors in virtually all states about the worst case abuse they had experienced in the past year. Many then mentioned the murder of a resident by a nursing home staff. More recently, GAO (2003) recognizes that physical and sexual abuse, in some cases mortal, is a significant problem.

Many social researchers outside economics are skeptical to free consumer choice as a way to ensure quality. "Most patients in acute-care hospital will return to their homes ... They can generally change physicians and hospitals if dissatisfied. But most nursing home patients cannot go home again: many are too impaired to exercise meaningful choices or protest poor treatment" (Harrington (2001)). Braithwaite, an expert on regulation, writes that "(a)s a model for improving the quality of care in nursing homes, relying on fees and consumer choice is naive. Residents are too sick to vote with their feet" (Braithwaite (2001)).

Much of the economic literature focus on the benefits of competition in establishing well functioning markets for nursing home care, for example Bishop (1988). Start-up costs are not a hinder for entry, and in most urban areas local monopolies are not important. In contrast to many markets for medical care, nursing home services are also technically simple and the quality easy to judge by the recipient. Furthermore, the share of users that pay for the service themselves rather than through private insurance or public welfare is substantial and much higher than in medical markets. Availability of alternative care provision as evidenced by a large proportion of people with long term care needs being cared for at home by family or friends and by paid providers is also stressed. From this one would expect that consumer choice would work well.

The quality problems are mainly seen as the result of regulation obstructing the quality competition among homes that consumer choice otherwise would lead to, and the failure of the regulatory measures targeted at improving quality (Bishop (1988)).

Even in the market based US nursing home sector the government plays a major role, financing 60 per cent of total nursing home expenditure in 2000[4]. The most important public program is Medicaid. It is directed at the financially indigent

[4]Source: CMS, Office of the Acturay, National Health Statistice Group. Data available at http://cms.hhs.gov/charts/series/sec1.pdf.

and offers the lowest public payment rate. Medicaid pays for around two-thirds of the 1.7 million people residing in nursing homes in the US (GAO (2003)). In the presence of excess demand the Medicaid payment rate represents a lower price floor in the market. There is indirect evidence of excess demand around 1980 as a result of public regulation aimed at restricting bed supply and thus public costs (Nyman (1988), Gertler (1989)). Nyman (1988) found that excess demand had adverse effects on service quality. Excess demand eliminates quality competition for those with the lowest ability to pay, that is, poor residents paid for by the government (through the Medicaid program).

Excess demand can therefore also explain the observed negative relationship between the proportion of Medicaid resident at a facility and observed quality. Many public health researchers (and the nursing home industry) have claimed that the low Medicaid reimbursement rate was a major reason for the quality problems. Gertler (1989) has, however, shown that in the presence of excess demand the reverse causality is possible, higher public payment rates may reduce quality. He also found that to be the case on data for New York state for 1980. Higher reimbursement increases the marginal profitability of Medicaid residents. With no empty beds, more Medicaid residents mean fewer private-paying residents. One way to reduce the demand from the latter group is through lowering quality. Later studies, based on comprehensive data from the 1990s do not confirm Gertler's finding. To the contrary, in Grabowski (2001) higher reimbursement increases quality, though less so in the tighter segments of the nursing home markets. The differences in results can be reconciled if excess demand was significant in the early 80s, but less so recently. Evidence on excess demand from the late 1980s is inconclusive (Nyman (1993)), and there are indications that relative demand has decreased further over this period (Bishop (1999)).

However, weak consumer sovereignty, as previously defined, can also account for a negative relationship between the share of Medicaid residents in a home and quality. Medicaid residents have on average higher care needs. One reason for this is that many self-paying residents end-up as Medicaid after having spend-down their wealth. They are then older and sicker, and consequently less able to guard their own interest.

Though the economics literature can say much about the many adverse side effects of (otherwise justifiable) regulation, it is less informative about consumer

choice. It is usually taken for granted that residents can judge quality and that self-financed individuals successfully can choose nursing home on the basis of that. Medicaid residents may not be able to do so if their low purchasing power and higher care needs restrict their choice of home. Still it is argued that consumer choice improves quality for all residents in a home. The reason for this is that quality is assumed to be a public good within each home (Nyman (1988), Bishop (1988), Gertler (1989)). As long as there is a significant proportion of private-paying residents in the nursing home, consumer choice will therefore contribute to higher quality also for Medicaid residents (Bishop (1988)).

To this, I have several objections. The efficiency of consumer choice is usually at best only tested indirectly, as one of several assumptions from which testable hypotheses are deduced. An exception is Nyman (1989) who finds that private patients' response to price and quality differences is consistent with rational consumer choice. The significance of this result for the efficacy of consumer choice to ensure satisfactory quality for the weakest residents rests to a large extent on the assumption that quality is a collective good. Furthermore, it is hard to reconcile effective consumer choice with the following observation made by (Bishop (1988)) "The physical and cognitive impairments that suggest consideration of nursing home placement also make it difficult for individuals to consider alternatives or to choose among nursing homes. Once nursing home consumers are placed in an institution, multiple factors make it extremely unlikely that they will "vote with their feet" by switching to another nursing home: the institutionalization itself may increase dependency; patients and families are unlikely to continue any comparison shopping; and concern about the trauma resulting from changing the living environments of debilitated patients may impede the consideration of shifting to another nursing home." Much then would rest on the ability of a few, relatively able self-paying prospective residents (with purchasing power for quality) to increase significantly the presumably collective quality level. Clearly, if quality is a collective good problem, individual private purchase leads to under-provision. This is not emphasized in this literature. Moreover, it is doubtful that quality is a collective good in that respect. It is the most dependent residents that are most vulnerable to low quality, also in regard to the less tangible aspects, such as the respect for autonomy (cf. the use of physical constraints). Those quality aspects may not be of particular concern to the more well-functioning residents. Grabowski (2001) identifies this issue,

whether residents within the same home enjoy the same or a differentiated quality level, as an important one for future economic research.

Recent economic research takes as an analytical starting point that the long term care recipient "is often neither the decision-maker nor able to easily evaluate care" (Hirth (1999))[5]. When also considering the high moving costs (for example because of transfer trauma) Hirth (1999) argues that long term care has the character of once-and-for-all purchase. Grabowski and Hirth (2003) conclude that "(d)ue 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." However, none of these studies points to the incentive problem in outside monitoring that this gives rise to.

5 The importance and difficulty of outside monitoring

When service recipients themselves cannot demand service according to quality standards, outside monitoring of service provision is essential. This concern is generally recognized by the authorities in modern democratic economies. These services are typically highly regulated and monitored. Public institutions have been set up not only to certify professionals and provider organizations, but also to monitor actual service delivery. These are institutions additional to any consumer ombudsman, which is common in many countries. I am referring to additional institutions with a mandate to monitor some specific services, such as the health and social care services, schools, and law enforcement. For example, in the US. nursing home sector, the responsibility for monitoring homes is shared between state and federal agencies. In practice, the states have the primary responsibility for inspecting nursing homes and enforcing regulatory requirements. These monitoring procedures include surveillance of each home through approximately annual visits, registering and investigating complaints from residents or their representatives, and taking measures to enforce quality standard in homes where these have been violated. CMS[6] is the

[5]Outside the analytical mainstream there is an extensive literature on care questioning the marketization of care for several reasons. One is that highly dependent recipients, "such as children, the sick and the elderly ... may lack the ability or the information they need to make good decisions as consumers" (Folbre and Nelson (2000)). Similarly, Arrow (1996) is sceptical to competition through consumer (parental) choice in elementary education.

[6]CMS is an acronym for the Centers for Medicare & Medicaid Services. Until July 2003 called the Health Care Financing Administration (HCFA).

federal regulatory agency. CMS monitors the performance of each states' survey agency, and is also directly responsible for the enforcement of federally set quality standards. The ultimate appointed monitor, an agency monitoring the monitors, is the General Accounting Office (GAO), whose reports I will refer to in the following.

Additionally, information is made available to the public. This enables monitoring through the market where that is possible, and also monitoring through democratic voice channels. The media and other non-public outsiders have important de facto monitoring functions. This is an issue to which I return in section 6.

Weak consumer sovereignty creates particular incentive problems in the provision of service quality. To see this, imagine the following stylized service situation. A service is directed to one particular recipient, for example a dement nursing home resident or a prisoner[7]. This recipient has in practice very little consumer sovereignty. For analytical convenience, I assume that the recipient has no capacity to influence quality. Furthermore, the recipient is the only one that benefits from high service quality.

There is, however, some given quality standard which has been passed by the country's legislative authorities. To ensure that this quality standard is met, the authorities have appointed an agent to monitor service provision. Monitoring is interpreted in a wide sense, taken to include if necessary the design and management of an appropriate contract. I assume that the concern for quality is the only task assigned to this outside monitor. If the government financed the service it would have a separate interest in monitoring costs. Such concerns are disregarded in the following.

This set-up differs from the standard principal-agent model in that there are three rather than two parties involved in the service transaction. In addition to the service recipient, there are now two agents, the service provider and the outside monitor. The outside monitor is to represent the interests of the service recipient as those are articulated in the public quality standard.

The crucial role of the outside monitor in enforcing the agreed-upon quality level is the fundamental difference to the standard principal-agent framework. In the latter model the main task of the principal is to monitor service quality through

[7]The service recipient may or may not be the formal principal to the service contract or the one that pays for the service.

designing an appropriate contract and monitoring contract compliance. The principal as the owner of the project monitors service quality to the best of her ability. She has perfect incentives to do so, since that maximizes her own income. In contrast, a service recipient that has no real consumer sovereignty cannot function as a principal. This is so even when the recipient is the one that formally has initiated the contract. The only one that can establish incentives for high quality to the provider, in that sense the de facto principal to the service contract, is a third party, an outside monitor.

The economic literature on the human services has tended to focus on the agency problems in service provision itself (Arrow (1996), Hart et al. (1997) and Chalkley and Malcolmson (2000)). However, for services directed at highly vulnerable recipients, that is, when consumer sovereignty is weak, there is an additional incentive problem in the monitoring of service provision. For such service situations, the agency in monitoring is often at the core of the quality problem. Though a public monitor in most of these cases has been set up to protect the legitimate interests of the service recipient, that monitor has insufficient incentives to do so, not being the one that benefits from high quality service.

The incentive problem in monitoring is fundamental. It will persist even if there are no informational imperfections in the service provision itself. All it takes is that non-observable monitoring efforts matter for the effectiveness with which quality standards can be realized.

To see this, assume that there are no information imperfections in the service provision itself so that for any service transaction a complete and court-enforceable contract can be written. Under reasonable assumptions there is still an incentive problem in the monitoring of service quality. The public quality standards are general, intended as they are to cover all possible service contexts. For each specific service situation the outside monitor, the de facto principal, would have to decide how these standards translate into a fully specified service contract. If the design of an adequate contract requires monitoring efforts that cannot be observed by the larger society (the ultimate monitors, for example, represented by the legislative bodies), a selfish monitor cannot be given proper incentives. This creates a moral hazard problem in outside monitoring of service quality.

Evidence on this incentive problem in monitoring is unfortunately not hard to find. One example is the US. nursing home sector. Despite sustained efforts

over the last decades to improve public monitoring, the GAO finds that the states' monitoring practices are faulty. See, for example, GAO (2003) and GAO (1999b). Firstly, serious observed deficiencies are not always reported, and there are too few (sometimes none) unexpected visits by state surveyors to nursing homes. Secondly, 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" (GAO (1999b)). Thirdly, actions required to enforce quality are not always taken. The GAO points to the need to strengthen enforcement of quality standards. Despite sustained efforts to improve the enforcement of quality standards, these problems persist, though some improvements have been achieved (GAO (2003)).

Children's homes in Norway are another example. During the first post-war decades many children in such homes experienced unacceptable living standards and serious infringements of various kinds. This has become publicly known only recently, as a result of some of these children, now adults, having managed to speak up about their experiences, and mass media being attentive to their stories. This publicity lead eventually to public inquiries. One comprehensive report has been published so far (Bergen Commission (2003)), confirming the more than rare occurrence of vastly substandard care provision. Notably this was substandard care provision that was not detected by the public monitors at that time. Moreover, it took 30-50 years before these grave conditions became publicly known.

The moral hazard problem in monitoring increases in the presence of information imperfections in the service transaction itself. The fulfillment of quality standards then necessitates more comprehensive monitoring. This is likely to demand non-observable effort from the monitor both in obtaining and evaluating information.

Several types of informational imperfections complicate monitoring and thus aggravate the incentive problem. Firstly, quality in the human services is generally not verifiable by a third party, such as the courts. One reason is that important quality dimensions are intangible, often related to the quality of social relations. Quality assessment therefore has unavoidably a judgmental character. Another com-

plementary reason is that the appropriateness of any given action is highly context dependent, and it is not possible ex. ante (prior to the specific service context is known) to specify high quality service for each possible context.

An example serves to illustrate both types of non-contractability. A police shoots and injures a man who he feels threatened by, believing that the man was armed and dangerous. Is the shooting justifiable? Just by the number of relevant dimensions needed to describe the situation, it would not be possible to instruct the policeman in advance about what to do in each specific case. The quality of a performed service (the appropriateness of any given action) is specific to the situation, to the individual service recipient and, to some extent, also to the relations between the service provider and the recipients involved. Moreover, many of the relevant dimensions are intangible, perhaps only captured by an experienced policeman's intuition.

I have already argued that nursing home quality in important respects is intangible and thus non-verifiable. Jenkins and Braithwaite (1993) show that discretionary judgment is important for the consistent evaluation of such quality dimensions by different individual nursing home inspectors. Such efforts are essentially non-contractible.

Secondly, for outsiders to the service transaction quality information can only be observed imperfectly and at considerable cost. Complete information about the actions of the service provider necessitates direct observation at all times, which is practically and economically impossible for outsiders to the service relationship. Furthermore, information about actions alone is generally not sufficient. Quality assessment also requires an understanding of the complexity of the quality concept for the type of service under study (derived from professional and general human insight) and of the particularities of the specific service context. Whether the police shooting was justifiable depends on the beliefs the policeman reasonably could hold about the victim being armed and dangerous. Judging the policeman's action would often require background knowledge about this specific situation, and experience from similar situations.

Collecting information is costly. The US government spent nearly 300 million USD on quality surveillance (the certification and survey process) of nursing homes in 1998 (GAO (1999a)). The GAO still finds that the data collected probably understate the extent of quality problems, illustrating that monitoring only gives

partial information about quality.

Thirdly, the complexity matters also for other reasons. Due to the insufficiency of hard-facts, whether verifiable or not, it is difficult for anyone observing the service relationship to fully convey quality information to non-observing outsiders. Another important concern is that an imperfectly informed outsider, not understanding the complexity of a specific service, may not be able to assess how well informed she is. This may be so even if she can verify or in other ways check the reliability of the information she has access to. Lacking an understanding of the complexity she may not know that she does not know. In other words, an outsider may not know that she is uninformed (or ill-informed) about important quality dimensions.

Consequently, a monitor could be unable to detect when available information is insufficient or to make proper use of the information that she has. Lacking relevant professional skills or basic human insights and experiences, never having observed the service situations, or never identified with the recipient, could cause such an inadequacy on the part of the monitor[8].

This problem is typically ignored in formal economic analysis because the set of all possible outcomes or states is assumed known. Agents basically know what they do not know, for example, which state that has been realized within the set of all possible (which are also the imaginable) outcomes. This greatly simplifies the informational problem, but oversimplify the true monitoring task in human service provision.

Two examples can illustrate this. One is the substandard care and the instances of abuse in post-war children's homes in Norway. How could such things happen? That was a question frequently asked in public, many being deeply shocked by what was revealed. Clearly, monitoring had failed, since these circumstances had not been known previously. But why? Selfish monitors that did not care about the living conditions of the children are probably only part of the story, and often perhaps even a minor one. Ignorance among monitors, not knowing the degree and nature of the substandard care that possibly could be realized, may have played a major role. The reaction in hindsight by one that had been a public monitor at that time resembles that of the larger public, "we did not imagine that such things could

[8]Identification is a powerful, though complex, psychological mechanism, see e.g. Jenni and Loewenstein (1997) and Small and Loewenstein (2002).

happen"[9]. What you do not imagine, you do not easily look for.

Eva Joly, a former french judge and key investigator of the Elf corruption scandal has similar experiences. Legitimate backing within the legal system for the investigation was sometimes hard to get. Colleagues and superiors found it difficult to imagine the full extent of the corruption, and therefore also to acknowledge the available evidence (Joly (2003)).

To some extent research on the human services reflects this phenomenon as well. Those recipients that have weak consumer sovereignty belong in social terms to the marginal spheres of society and their weak voices do not bring forward their experiences, however important. The person that wears the shoe is not only the one that knows where it pinches, but (possibly apart from the service providers) he may also be the only one that knows *that* it pinches, and the extent to which it hurts. Consequently, the significance and the magnitude of the quality problems may neither be well understood in research communities. This is perhaps one reason for formal analytical economics having devoted relatively little attention to the particularities of human service delivery, especially to those service situations in which consumer sovereignty is weak. There is however a richer literature outside the analytical mainstream see for example, Folbre and Nelson (2000), Martin Knapp and Forder (2001) and Jochimsen (2003) for the care services.

One fundamental problem here is that the challenge in obtaining adequate information about quality is not always recognized to its full extent. When recipients have truly weak voices, and there are substantial informational imperfections for outsiders of the kinds just mentioned, how do we know that the acquired data is informative about true quality? Quality evaluation in nursing homes serves as an illustration. It is common for outsiders to assess quality with reference to some universal quality standards, that is, quality standards that are the same for all homes. This type of measures are applied both in research and in the governance of care provision. However, very few studies have tried to check their validity, and those that do find that to be distressingly low (Slagsvold (1998)). Slagsvold's study of standardized quality measures is illustrative. These widely applied measures are based on characteristics that are easy to register and often naturally quantifiable. They are not complete measures of quality, representing only some dimensions, and

[9]Gerd Hagen, in the TV-program Brennpunkt, on the Norwegian public broadcasting channel NRK1, 1 April 2003.

may also only indicate good quality rather than represent good quality. To exemplify the former, 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, board representation etc., is likely still to result in an incomplete measure of resident autonomy. To exemplify the latter, a caring and warm milieu is thought to reduce the need for sedatives. That in itself would suggest that sedatives is negatively correlated with and thus an indicator of the quality of caring in a home. Not surprisingly, such measures is particularly problematic for intangible quality dimensions such as the psychosocial aspects of care. In Slagsvold (1998) 19 wards in 9 Norwegian nursing homes of varying size were assessed both by a broad set of standardized quality measures and by participant observation by two psychologists. While each psychologist's independent rating on each quality dimension were highly correlated, these ratings had around zero or slightly negative correlation with the standardized measures on all quality dimensions on psychosocial aspects.[10].

This is problematic for research. It is however even more problematic when such measures are applied as governance tools by either the management or by monitoring authorities. The biases in the measurement of quality distort the guidelines and incentives for how care should be provided. Firstly, standardized measures give rise to the problem of multitasking (Holmström and Milgrom (1991)) in which only (some) tangible care aspects are attended for. "In my area, if we specify clearly their employee evaluation criteria, they won't do anything else" (US. nursing home staff, quoted in Braithwaite (1993)). Secondly, measurement biases is likely to increase since much of this information is self-reported and providers then have an incentive to misreport. For example, many US nursing homes exaggerate their true staffing levels. Moreover, since these measures in part are only indicative of quality, rather than actually representing quality, resources may be waisted on targets that are irrelevant or even destructive for quality. Simply reducing the use of sedatives in order to conform with quality standards does not make the environment more caring. (The indicator is intended to capture the reverse causality.) Going "by the book" may twist priorities and distort social processes (Slagsvold (1998)). What

[10]The correlation coefficient between the two psychologists scores ranged from 0.79 to 0.97. These independent observational scores were taken to be sufficiently valid, based on "what we with our own eyes" and their high intercorrelations.

Slagsvold found to be the best-functioning ward was closed because it did not fulfill the public quality standards (ISO standards of quality which are widely used in the Scandinavian countries). Braithwaite (1993) argues that the key problem in the public monitoring of US nursing home 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. Efforts to gather information is also comprehensive. The requirement of annual inspector visits is achieved for almost all homes, a practice that differs from many other regulatory settings. The problem is rather that of "ritualism", the providers "going along with institutionalized means for achieving regulatory goals while not attaining the goals themselves" (Braithwaite (1993)).

Public regulation has, however, to a large extent contributed to this (Braithwaite (1993)). A nursing home is usually checked for compliance with around 500 standards, in some states even a higher number. The result is a bureaucratization of care provision, and an overemphasis on tangible care aspects, or aspects irrelevant to or in hindrance of individualized care. It leaves little room for discretionary evaluations by either the care providers or the state surveyors. Furthermore, the detailed documentation system that each home then must manage, along with strict physical capital requirements, particularly tough fire standards, have increased the economies of scale in the industry. This has resulted in much larger nursing home facilities than what are common in other countries, and to large corporate chains. Large facilities, for-profit ownership and chain affiliation are all factors commonly found to lower quality (see for example, Harrington et al. (2000), Harrington et al. (2001b) and Jenkins and Braithwaite (1993)).

Though US nursing home regulation is very comprehensive compared to other countries, the quality problems are not less serious (Braithwaite (1993)). The little indicative evidence there is on cross-country differences, for example on the use of physical constraints, suggests that the opposite is true. There are also indications that there is much more grave abuse of residents in US nursing homes (see Braithwaite (1993), p. 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 be rightly questioned.

6 Policy implications – improving quality-effective demand

The recurrence of extensive and occasionally grave instances of substandard quality in nursing homes, in the care for orphaned or neglected children, in psychiatric care and in prisons shows that attaining high quality service is a continuous challenge within parts of the human services.

This "quality challenge" is not specific to one organizational mode of service provision. For example, the U.S. and the Scandinavian countries have organized their nursing home sector quite differently, with the former relying more on private provision, to some extent on private financing, and on free consumer choice. Still, in both regions there is considerable public concern over nursing home quality. The quality challenges are rather connected to intrinsic characteristics of the service provision itself, most notably the weak position of the service recipient. Weak consumer sovereignty, in particular, but also poor information about quality make the service recipient unable to enforce a quality level in accordance with agreed-upon standards. In the terminology of this paper, quality-effective demand is low. Outside monitoring is then called for, but will be under-provided since an outside monitor, not being the one that benefits from high quality service, does not have sufficient incentives.

However, when the quality problems are related to intrinsic characteristics of the service itself, the more so do institutional arrangements matter for the service quality attained. In the following, I address this issue from a normative point of view. When quality-effective demand is low, and sub-standard quality is a public concern, how should public policies be designed so as to counter the intrinsic quality problems?

One lesson for the authorities is to identify groups with low quality-effective demand, and monitor service quality to these groups particularly well. Service recipients that have little ability or authority to exercise consumer choice or voice, either themselves or through personal advocates, and to whom the quality of service is important belong to such groups. Also, for services with comprehensive informational imperfections, which make it more difficult to make informed choices and to communicate complaints, quality-effective demand may be low even for relatively able recipients. Furthermore, outside monitoring becomes more challenging. The combination of weak consumer sovereignty and information imperfections are therefore particularly worrisome, however, not rare within the human services.

Nursing home residents with dementia, in particular those without able advocates are one such group. If the service is purchased individually in the market, quality-effective demand is often also low for the least wealthy especially if there is excess demand. Consistent with this, quality has been found to be lower in nursing homes with many Medicaid residents. Medicaid has the lowest payment rates, and residents on Medicaid also tend to be more sick (Harrington et al. (2000)).

This lesson does not address the incentive problem in monitoring. If monitoring efforts are unobservable, the monitoring of the monitor is so as well. Alchian and Demsetz (1972)'s question, "who should monitor the monitor?" is relevant also here.

A second lesson to remember, therefore, is transparency. The way service provision and monitoring is organized, including the larger institutional set-up, matters for how easily available information about service and monitoring quality is to the public. Additional to improving the functioning of markets, it enables monitoring by the general public, including the press and the local communities within which service provision takes place. It does so to the extent that there is a public interest in or an awareness about the significance of service quality. In that sense, monitoring costs are endogenous to the larger institutional setting. For example, large institutions, such as large nursing homes, institutionalized care for the mentally ill or intellectually disabled, or prisons are more difficult and costly to monitor. There is less transparency because life within these institutions tend to be cut-off from the rest of the society[11].

Thirdly, the ultimate policy goal must be to mimic the efficiency properties of a perfect market outcome, given other considerations such as equity, and not the market mechanism itself. Economists tend to focus on policies that contribute to more market-like interaction. If serious obstacles to well-functioning markets can be eliminated, then this may be a good policy. However, the inability of the service recipients to rationally choose the best price-quality service is an integral characteristic of the services with which I am concerned. A common alternative "market-like" mechanism is then to rely on formal contracts and the outside monitoring of these contracts. Given the difficulty and the incentive problem in the monitoring of these service situations, much rests on the qualification and the commitment of these monitors.

[11] A classic reference here is Goffman (1961). Also, in the US there are more quality deficiencies in larger nursing homes, see for example Harrington et al. (2000).

To look for solutions, a better idea than only searching for arrangements that produce market-like mechanisms would be to focus directly on desirable outcomes, and from that identifying 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. These arrangements can be divided into three categories:

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

The services with which I am concerned share a general problem. Quality-effective demand is low because of weak consumer sovereignty, often in combination with extensive informational imperfections. Still I find it difficult to make further generalizations about possible solutions. The specific arrangements that may improve quality vary, not only with the type of service, but from situation to situation. In particular it depends on the available larger institutional setting (type of community within which the service takes place, culture, the role of the press) and the human resources (persons and organizations).

6.1 Arrangements that enhance consumer choice

Welfare states have traditionally provided these services publicly. The institutional arrangement has typically precluded consumer choice, leaving decisions mainly to professionals within the bureaucracy and the provider organizations. Many economists, emphasizing the efficiency properties of well-functioning markets, are natural advocates of free consumer choice. The following discussion applies of course only to services where that in principle is possible. As argued in section 3, this leaves out much of law enforcement.

Some groups would clearly benefit from consumer choice. It would increase their quality-effective demand, and thus also the efficiency with which a service

is provided. For example, people with long-term physical disabilities mainly need practical assistance in the activities of daily living. These services are like any other experience good. It is easy for the recipient to evaluate quality and, in principle, to change service provider.

Information is a collective good. In the presence of information imperfections there is generally great efficiency gains from the government providing quality information to the public. The US nursing home sector exemplifies this. Firstly, the government certifies providers. Secondly, information about each of these providers is easily available. As previously argued, some information, in particular intangible quality aspects, may be both costly and difficult to convey to the public. However, the availability of information, even if quite complete, may not be sufficient to ensure rational consumer choice. An alternative then is assisted consumer choice: Help in interpreting information and in formulating choice.

For recipients with truly weak consumer sovereignty it is inherently difficult to obtain, evaluate or act upon quality information, even if given the formal opportunity. In such cases institutionalizing free consumer choice is not sufficient, and in some settings not appropriate. Then other quality-enhancing mechanisms must be relied on, in addition to or instead of consumer choice.

6.2 Arrangements that enhance voice

Hirschman (1970) defines voice as "any attempt at all to change rather than escape from an objectionable state of affairs, whether through individual or collective petition to the management directly in charge, through appeal to a higher authority with the intention of forcing a change in the management, or through various types of actions and protests, including those that are meant to mobilize the public." Voice therefore refers to actions taken by the recipient himself (in person or through a personal representative) aimed at improving quality from the present provider.

In the human services one characteristic of high quality is that the service is customized to the individual's needs and preferences. Since the recipient is better informed, at least in some respects, quality could be enhanced by giving the recipient decision rights, enabling him to take part in the forming of that specific service. The voice channels must also be customized to the specific recipient's ability to voice his interests. The design of complaint procedures internally in the organization and

to outsiders is also important. They should be well known, simple to follow and difficult to manipulate by the provider or by shirking monitors. On a general basis, not taking account of the type of service and the resources of the service recipient, it is difficult to be more specific.

6.3 Facilitating the outside monitoring by able groups or individuals

The need for monitoring arises because the recipients themselves are unable to sanction low quality service. Through institutional design there is ample scope to adapt consumer choice and voice channels so that they can serve as quality enhancing mechanisms even in circumstances where consumer sovereignty is weak. This is likely to save on outside monitoring costs, but unlikely to eliminate the necessity of outside monitoring as the ultimate guarantee for quality. In particular this is so for services directed at the most vulnerable recipients.

Given the fundamental incentive problem in outside monitoring, the institutionalized monitoring by the authorities must be complemented by additional measures. One such measure has been mentioned, that of ensuring transparency. Modern democratic societies recognize the virtues of making information public, or facilitating information gathering. This allows for others – individuals, organization and the media – to monitor the service provider and the publicly appointed monitor.

Another measure would be 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 with the capacity to monitor. Many of those with a strong commitment are also in some regards better informed than the service provider. Thus, monitoring may therefore also entail cooperating with the service provider to improve service quality.

One obvious resource in that respect is service recipients' family. However, family members do not always represent the interest of the recipient, but may have their own agendas, consciously or subconsciously. Furthermore, they may be better informed than the provider in some respects, but not in others. It is therefore not straightforward to let family members (or any individual or organization) unconditionally represent the interest of a recipient who is unable to do so himself.

Family, and past and present service recipients, is however also an important resource collectively, through interest group organizations. Policies that enable

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 much resources personally or through their family being better to take care of their interest. Involvement that goes through collective channels will contribute to even out such differences, so that those recipients with the least personal resources are those that benefit the most from collective monitoring action.

Collective monitoring may therefore be very valuable. Also groups or individuals not directly affected themselves by the service can have a strong moral commitment to high quality. The partnership between the Boston Police Department and a group of black inner-city ministers exemplify the large gains that can be had from facilitating that kind of monitoring. The following exposition is based on Berrien and Winship (1999) and Winship (2002).

Boston has a history of racial antagonism and polarization that has also marked police-community relations in the black inner cities. In the late 1980s, the police responded with aggressive law enforcement policies in response to a sharp increase in drug related crime. Crime rates went down, but the resentment towards the police in these communities increased. That was not without reason. Several serious police scandals revealing poor police investigation and racial discrimination emerged in the press.

Additional to the press, several black inner-city ministers criticized the police fiercely. From 1992, in part by incidence and in part because new leaders in the police department put greater emphasis on community relations, a partnership between these ministers and the Boston Police Department emerged.

The ministers were in some respect better informed about crime in the community than the police. To illustrate, a group of 20 young men can all look like gang members to the police. A minister having walked the streets, talked to the kids, knowing their families, may know that only a subgroup of these are gang members, and only a few of those are real trouble makers with whom the police should be concerned. Getting those few kids off the street could prevent others from becoming delinquent. The partnership improved the information available to the police, which in itself increased service quality. Furthermore, the ministers were given more information about the police activities, and the police became more attentive to

their views. Through that the ministers, having both a strong commitment and the ability to check on quality, were allowed to do so.

How these relationships emerged is a story of its own, see Berrien and Winship (1999). My concern here is with its function once established. The black ministers serve as non-governmental monitors of police services affecting recipients with particularly low quality-effective demand: Black young men in particular, and the black, poor inner-city communities more generally.

In economic terminology, this evolving partnership resembles relational contracting, however, without monetary incentives involved (certainly, the ministers have little to gain materially). This entailed a recognition of some shared interests (crime prevention) and that gains could be realized through cooperation, for example, the sharing of information.

Through the 1990s homicide rates in Boston declined by 80 per cent (Winship 2002). At the same time police complaints also went down. The "Boston miracle" as it has been called, contrasts with the high criminality, fierce public criticism and the strong resentment in the black communities in Boston in the early 90s. It is also a contrast to the situation in New York City over the last decade. Both in Boston and New York the police has spent much resources in fighting crime in its poor inner-city communities, and crime rates have come down considerably in both cities. However, in New York the cost seemed to be strained relations between the police and the city's black inner-city population, with many citizens feeling that their civil rights are not respected. Serious allegations of police misconduct and discrimination have been voiced and sometimes substantiated.

7 Gathering the threads

Quality-effective demand is low when the party to whom quality really matters is unable to enforce the agreed upon quality level even if he has the financial means to pay for the service and even if the quality standards in principle are well-defined. In the absence of fully effective outside monitoring low quality-effective demand results in an entitlement failure, however, of a somewhat different kind than that introduced by Sen (see Sen (1982)). The problem is not insufficient legal entitlements (though that may also be true), but that the service recipient lacks the means to enforce the quality level that he is legally entitled to. His commandable (or enforceable)

entitlements are weaker than those laid down by laws and regulations.

Asymmetric information and weak consumer sovereignty both lead to low quality-effective demand. Moreover, many service contexts are characterized by both weak consumer sovereignty and information asymmetries, and it is often difficult in practice to separate one effect from the other. Economic research has focused on the problems of asymmetric information. I have argued that weak consumer sovereignty is an important additional reason for the frequent occurrence of low quality within parts of the human services. In some service situations the service recipient does not have the ability to evaluate the quality level or act rationally upon it. For example, this is so for much psychiatric care, care for the intellectually disabled, and nursing home care, although to varying degree. Typically, the higher care needs, the more is this ability impaired. Or the service recipient does not have the authority to do so. Within large parts of law enforcement, such as in the police, service providers are by nature of the service given extensive authority. This often precludes consumer choice. Voice is then important to guard own interest. Recipients with limited consumer choice and weak voices therefore tend to have low quality-effective demand.

The pressure for high quality that providers face can either come from consumers' quality-effective demand $f(S)$, or from outside monitoring.

$$Q^D = f(S) + M. \tag{1}$$

M is the effective outside monitoring when consumer sovereignty, S, is 0. By assumption, $S \geq 0$. The pressure for quality increases with quality-effective demand, the latter increasing with consumer sovereignty, $f' > 0$. The more effective consumer choice or voice, the higher is S, and the higher is $f(S)$. Stronger voice strengthens the recipient's capacity to monitor the provider directly, as well as his ability to monitor the performance of outside monitors. For no consumer sovereignty there is no quality-effective demand, $f(0) = 0$. The only remaining quality pressure is then M, which is generated by external factors alone, that is, factors not influenced by recipients' voice or choice. More severe information asymmetries shift $f(S)$ downwards as analyzed below.

Quality in the human services is, however, likely to affect consumer sovereignty, particularly when the need for the service is substantial. An important objective in

most human services is to increase the service recipient's functional ability, and the success of such efforts is closely related to the quality of service (Eika (2003)). For example, nursing homes are not only supposed to assist residents in the activities of daily living, but an important element in professional care is also to rehabilitate residents. Equation (2) captures this causation.

$$S = g(Q), \text{where } g' > 0. \tag{2}$$

The police-minister partnership in Boston represents yet another example of a positive dynamic from Q to S. The partnership increased service quality, which reduced crime rates. Though more effective enforcement, increasing the expected cost of criminal activity, may have partly accounted for this, better police-community relations, inducing cooperation and trust have probably influenced behavior at a more fundamental level. One consequence of this was that fewer youth got into serious trouble. At an individual level, less social and criminal problems are likely to increase voice. This comes in addition to the direct effect of trust on the efficiency of voice (the police becoming more attentive) and thus on consumer sovereignty.

Combining the two mechanisms described by (1) and (2) allows a sketch of the interaction between consumer sovereignty and human service quality.

$$Q^D = h(Q) + M, \tag{3}$$

where $h(Q) = f(g(Q))$. (1) and (2) imply that $h(0) \geq 0$, and $h' = f'g' > 0$. Higher actual quality increases the effective pressure for quality. It seems reasonable to assume that Q^D increases by less than Q, that is, $h' < 1$.

In long run equilibrium the realized quality level may be higher than that which follows from the quality pressure facing providers, that is, $Q \geq Q^D$. Providers can be intrinsically motivated to high quality service, cf. footnote 2. If this motivation is sufficiently strong, then $Q > Q^D$. Though this may be true in some situations, the more typical case is that quality is predominantly determined by demand pressure (including outside monitoring). I assume therefore that $Q = Q^D$ in equilibrium.

The determination of the long run equilibrium is shown in figure 1 a. M is the minimum quality level determined by the level of monitoring efforts. $Q_0 > M$

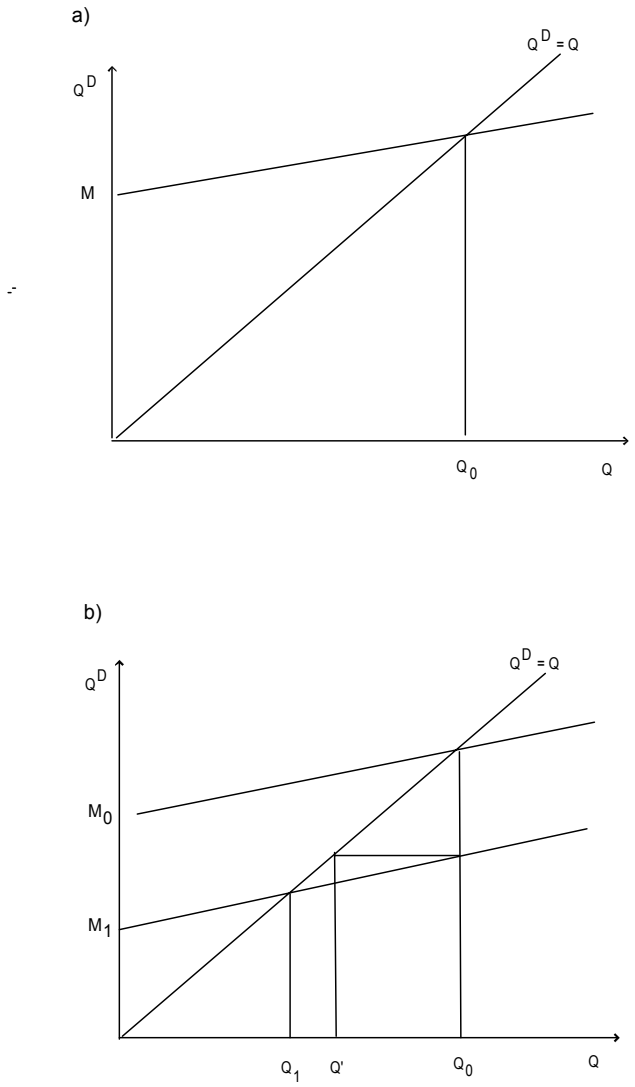

Figure 1: a) The determination of the long run equilibrium quality level. b) The effect of a permanent reduction in monitoring efforts.

is a stable long run equilibrium. To see this, let $Q = M$ initially. Consumer sovereignty is then low and given by $S = g(M)$. However, the pressure for higher quality that providers face given M and S is higher than that which is required to sustain the present low level of consumer sovereignty. That is, $Q^D > g^{-1}(S) = M$. Therefore, quality increases until Q_0 is reached. On the other hand, if $Q > Q_0$, $Q^D < g^{-1}(S) = Q$. The quality pressure that providers face is lower than the level that is required to sustain the present degree of consumer sovereignty. Consumer sovereignty therefore falls, which in turn reduces quality-effective demand and thus Q^D. Over time quality is brought down to Q_0.

What happens to the long run quality level if monitoring efforts are permanently reduced? As illustrated in figure 1 b the fall in quality is larger than that which follows directly from lower outside monitoring. The direct effect on quality is given by equation (1). There is first an immediate drop in Q^D, corresponding to the fall in M from M_0 to M_1. The pressure for quality that providers face is reduced, which in turn also lowers actual quality. However, this reduction in quality indirectly reduces quality-effective demand by weakening consumer sovereignty (cf. equation 2). Rather than a reduction in quality from Q_0 to Q' (the direct effect), there is therefore an additional reduction over time that brings quality down to Q_1.

An alternative interpretation of figure 1 b is that the shift in the curve reflects a worsening of exogenous conditions that affects the effectiveness of outside monitoring, or consumer sovereignty. An example of the latter is institutional restrictions that make voice (respectively, choice) less effective for services where voice (choice) is the most important quality-demanding mechanism. The opportunity for voice and choice and their effectiveness are often defined as a part of the quality of service (and incorporated in g'). To the extent that it is not, restrictions on voice or choice are reflected in a downward shift in g and thus in h, for example of the kind displayed in figure 1 b. Figure 1 b can also represent a change towards more severe information asymmetries which reduces the effectiveness in outside monitoring. Outside monitoring becomes more demanding when information is more costly to obtain. For an unchanged level of monitoring efforts, the effectiveness of those efforts are reduced, that is, M is lowered (from M_0 to M_1). However, quality-effective demand $f(S)$ is also likely to be directly affected. I have previously argued that the combination of weak consumer sovereignty and information asymmetries is particularly worrisome, for example, in the case of dement nursing home residents. That situation is better

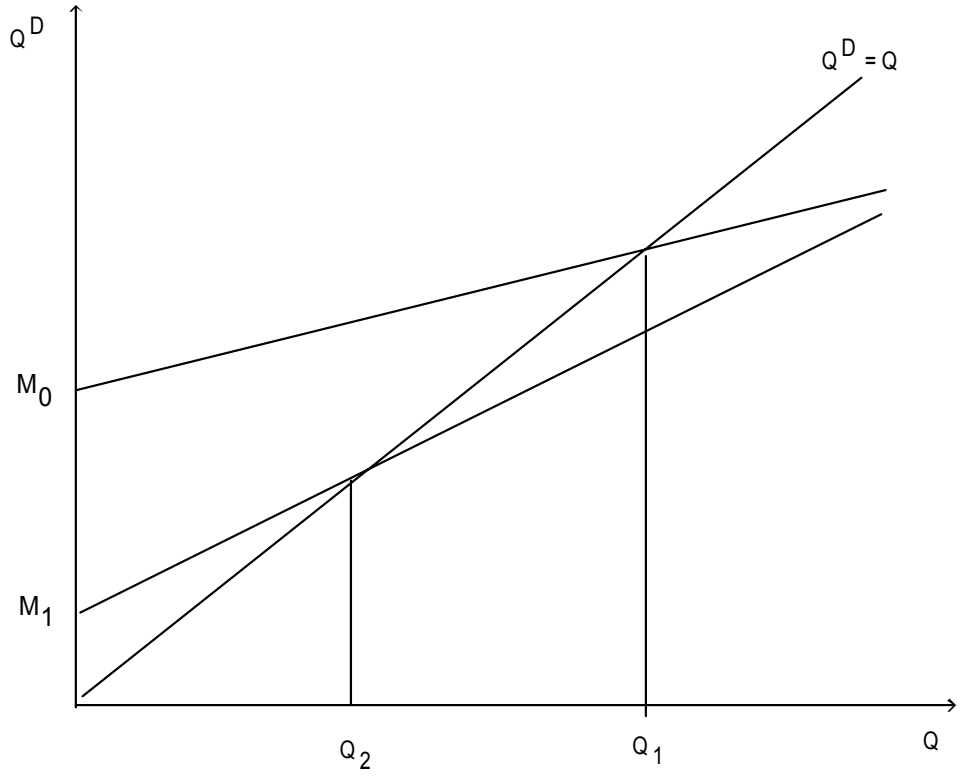

Figure 2: The effect on equilibrium quality of more severe information asymmetries.

described by figure 2, where the shift entails both lower M and higher f'. The drop in quality-effective demand is then higher for low levels of consumer sovereignty. The lower is S, the more difficult it is for the service recipient to acquire and evaluate quality information (for example a dement nursing home resident) or to convey such information to outside monitors (for example, a prisoner with very restricted voice, or a dement resident). The downward shift in Q^D is larger the lower is S. Therefore, if the initial long run equilibrium level is relatively low, poorer information leads to a more dramatic permanent reduction in quality than if the equilibrium level at the outset was "high".

Asymmetric information and weak consumer sovereignty as causes of low quality are in important respects analytically distinct. Weak consumer sovereignty leads to a fundamental incentive problem in the monitoring of the service, which is not equally present when service recipients can act rationally although with inferior information to the provider. In service situations with weak consumer sovereignty,

outside monitoring is crucial for quality since recipients are without sufficient ability or authority to do so themselves. However, given non-observable monitoring efforts, the outside monitor has insufficient incentives to undertake that task, not being the one that benefits from high quality service. This is the fundamental incentive problem. Substandard service quality in human service contexts where consumer sovereignty is weak can often be traced back to inadequate outside monitoring.

In contrast, a poorly informed but sovereign recipient has full incentives to monitor quality at the best of his capacity. She can monitor the service provider directly, and she can monitor any outside monitor. The latter is typically an agent with professional knowledge about the specific service and to whom the authorities have assigned the task of monitoring service quality.

Poorly informed consumers often learn the true quality after some time. They are then capable of voicing their complaints. This may afflict direct costs upon the provider, reduce demand and improve the efforts of the outside monitor. Service recipients with weak consumer sovereignty have both limited or no consumer choice *and* weak voices. The lack of the latter resource is important. Hirschman (1970) argues that both exit and voice are important quality-enhancing mechanisms in the market. Individuals with low consumer sovereignty may not be able to voice complaints, however, well informed. Consistent with this, many scandals in the human services do not become public, or known only after a long time. For example, the neglect and abuse of children in some post-war Norwegian children's homes were disclosed only after 30-50 years.

Though not substantiated empirically in the paper, I contend that weak consumer sovereignty often cause quality problems by order of magnitude much greater than that caused by information asymmetries.

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