



Ricardo Rodrigues is Head of “Health and Care”, *Kai Leichsenring* and *Juliane Winkelmann* are Researchers at the European Centre for Social Welfare Policy and Research, Vienna
<http://www.euro.centre.org/rodrigues>
<http://www.euro.centre.org/leichsenring>
<http://www.euro.centre.org/winkelmann>

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Series Editor is *Pieter Vanhuysse*, Deputy Director and Head of Research
vanhuysse@euro.centre.org

To Make or to Buy Long-term Care? Part I: Learning from Theory

Ricardo Rodrigues, Kai Leichsenring, Juliane Winkelmann

Introduction

The past decades have witnessed an increased reliance on market mechanisms for the delivery of public services, among these long-term care services. This development coincided with a time of welfare retrenchment and calls for more efficiency. The shift towards market mechanisms can be understood in light of the relevance that several streams of thought gained in mainstream economics during the 1980s, namely ‘government failure’ (Vining & Weimer 1990) and New Public Management (Hood 1995). The explanations for the introduction of market mechanisms for the delivery of welfare included also increased consumerist values, erosion of trust in professionals, louder clamour for the empowerment of users, and changes in prevailing ideas about the limits and appropriate size of the state (Greener 2008). Nowadays, different types of market mechanisms are a staple of welfare provision in many European countries.

Against this backdrop this Policy Brief is the first part of a trilogy dedicated to the reliance on markets for the delivery of long-term care or, in other words, to the ‘make or buy’ decision in long-term care. Each Policy Brief in this trilogy will address specific issues pertaining to the topic. This first Policy Brief will focus on the policy lessons that can be derived from the theoretical literature, while the second will empirically review the actual implementation of market mechanisms in selected European countries and the third will address mechanisms to assess and manage quality in long-term care. These Policy Briefs draw from the Report ‘“Make or Buy” – Long-term Care Services in Sweden: Lessons for Policy’, edited by the European Centre, that is a result of research funded under a grant from the Swedish Ministry of Health and Social Affairs.

Market mechanisms for long-term care

Markets are characterised by private ownership, choice, competition and price signals. Markets for long-term care tend to share some of these characteristics but not all as long-term care is a derived demand and inhibits a potential risk of imperfect information, which is why they are usually highly regulated and termed 'quasi-markets' (Le Grand 1991, Bartlett & Le Grand 1993). The decision to make or buy is also a decision on which and how much of these market characteristics should be used to provide public services. Several market mechanisms can be put in place for the provision of public services, in particular in the context of long-term care (Savas 2005, Blöchlinger 2008):

- **Tendering (public procurement):** whole public service provision is contracted-out with competition between providers taking place at the bidding stage. It is usually employed for services where integrated networks are important, or where there is potential for monopolies (e.g. provision of long-term care in sparsely populated areas).
- **Outsourcing:** only support tasks are contracted-out (e.g. catering), with core tasks continuing to be produced in-house.
- **Public-Private Partnerships (PPP):** construction, funding and (sometimes) the operation of facilities are carried out by a private provider in exchange for a periodic annual subsidy. It has the advantage of spreading high capital costs over time.
- **Competition:** this has the potential to improve production efficiency, i.e. to drive production costs down as providers seek to gain advantage over competitors. A pre-condition is inexistence of barriers to entry and exit the market, such as limited market size (e.g. provision of long-term care in rural areas), economies of scale (e.g. hospitals) and/or high sunk costs (e.g. building or adapting facilities to function as nursing homes that cannot be easily used for other purposes).
- **User choice:** allowing the end user of services to choose providers is meant to enhance allocative efficiency by improving providers' responsiveness, since care commissioners acting as single purchasers may not always know users' preferences or have the incentive to pursue them.
- **User fees:** users may be required to pay for part or the full cost of public services, thus replicating some of the effects of prices in conventional markets. User fees, however, may price poorer users out of the market (equity issues) and may have a limited impact on expenditure if fixed costs are high.
- **Vouchers:** payments are linked to actual demand, while allowing for user choice and for user fees to more closely reflect costs. Vouchers can be used to selectively increase the purchasing power of less affluent users, while still allowing for well-off users to pay for the full

cost of care (i.e. it is akin to price discrimination). Vouchers are also considered as a steering mechanism to address potential 'misuse' inherent to cash benefits. Vouchers, however, may lead to price increases if there are barriers to entry; they may be prone to problems of asymmetric information (i.e. providers have better information on quality than users and may shirk) unless information on quality is available; and require users to have the resources, time and ability to search for information.

Lesson #1: Understand the limits of markets

Users of social services may not always behave like typical consumers in other markets.

The underlying assumption behind markets is that users have perfect information and act rationally. A growing body of literature has questioned the validity of this assumption in real world choices by pointing out the role played by perceptions, the way information is presented, prevailing social norms and by seeking instant gratification rather than future rewards (hyperbolic discounting) (Kahneman & Tversky 1979, Granovetter 1985, Kahneman et al. 1991, Frey & Stutzer 2005, McFadden 1999, McFadden 2006). This is arguably even more pertinent in long-term care where decisions are often made under conditions of duress and in moments of crisis, e.g. following loss of a family carer, where uncertainty about future needs is high (Glendinning 2008). Under these circumstances one might plausibly conjecture that choices are often driven by instant gratification or deeply influenced by how options are presented. Moral norms, e.g. regarding what is admissible to pay for, can also have a profound impact on how markets are set up.

Market mechanisms can affect the inherent motivations of those providing long-term care. The 'cash nexus' could thus turn *knights* – providers acting on the users' best interests – into *knaves* – providers that have their own self-interest in mind (Le Grand 1997). Altruism and trust can ultimately replace expensive mechanisms that would otherwise have to be in place to deliver long-term care or manage and monitor contractual relationships. Therefore the impact of financial incentives on motivations should not be overlooked.

One of the key features in current debates about long-term care is the need to improve the coordination and integration of fragmented services to more user-centred service systems (Leichsenring, Billings & Nies 2013). This could however clash with many features and outcomes of markets, e.g. in relation to choice if users and/or public purchasers buy individual services rather than 'packages' of care; if competition between

providers prevails over cooperation and transparent sharing of information; or if funding mechanisms are linked to different budget lines or government levels (yet another issue of governance). Similarly, better coordination and integration of care pathways might impact competition, e.g. by creating networks that in theory provide incumbent providers with an advantage over competitors, as well as contracting practices and quality measurement. However, the challenge remains how to measure quality and to assess performance when outcomes depend on the intervention of different supplementary providers along the continuum of care.

Lesson #2: Market outcomes depend on having sufficient information and resources

Information is key to the functioning of care markets, especially since quality in long-term care is multi-dimensional and not easy to assess.

Long-term care differs from other personal services in a number of ways that are liable to affect the outcomes of markets. The textbook examples of competitive markets apply to homogeneous services. Yet long-term care services are not homogenous, either because of the geographical location of providers (e.g. nursing homes) or because providers deliver different types of services. In fact, variety of services is a desirable characteristic of long-term care as it allows for different needs and preferences to be addressed. When providers can differentiate services, the impact of competition on variety and quality of services is no longer straightforward (Proper & Leckie 2011). On the one hand, providers may offer too little variety of services if they stand to gain little or nothing in terms of revenues from the increased variety. On the other hand, providers may also produce too much variety if they believe they can deviate demand from other competitors.

With service differentiation, having information on price and quality becomes paramount for those purchasing long-term care. If information on quality and/or price is imperfect – which is often the case with long-term care since quality is multidimensional and difficult to assess – competition may also produce undesired outcomes (Dranove & Satterthwaite 2000). Users react to what they can measure and if prices can be easily assessed but quality cannot be, providers may compete on prices (what users react to) at the expense of quality (that users cannot really observe in advance). In the opposite case, providers may engage in an ‘arms race’ for quality, which in turn leads to higher costs and higher prices. Furthermore, if only some dimensions of quality are easily observable, e.g. if public reporting of quality indicators only includes staff ratios or room size, providers may seek to comply with those quality indicators and neglect other quality dimensions that are equally or more important but not easily observable.

People demand long-term care not because they want it but because they need it in order to live independently, i.e. long-term care is a derived demand (Baxter, Glendinning & Greener 2011). Even if competition may increase efficiency, long-term care may still be too costly for many to be able to afford it. Indeed, those most in need of long-term care are also usually poorer and this could create an undesired and socially unacceptable socio-economic gradient in access to services. If sufficient resources are not allocated to those in need, markets could produce inequitable outcomes.

Markets may also lead to inequitable outcomes in other ways. In theory, choice gives users the possibility to 'vote with their feet' and change to a better provider. This might be more equitable than expressing complaints, because these are more likely to be heard when those complaining are affluent, well articulated or have influential roles in society, i.e. social capital (Le Grand 2007). Making the correct choices, however, also requires information, which, in turn, requires resources, whether it is time, money, cognitive skills or social capital that are not equally spread among different user groups. Lack of access to information is therefore also likely to produce inequitable outcomes (Greve 2009).

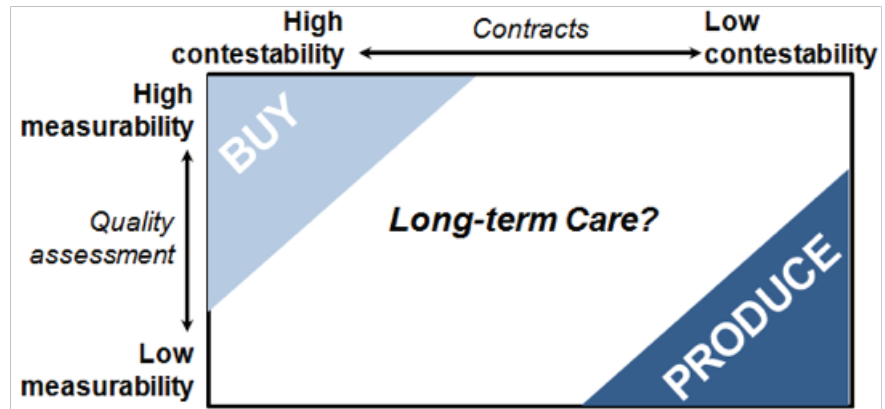
Finally, if payments do not reflect needs or costs, providers may be tempted to cream-skim, i.e. to select users that are more amenable or easier to care for, or those whose care is less expensive (Bartlett & Le Grand 1993, Glendinning 2008). This in turn may also produce inequitable outcomes.

Lesson #3: Transaction costs matter

Competition coupled with user choice can lower production costs, but contracting-out long-term care services also incurs transaction costs. Figure 1 depicts the theoretical general conditions for contracting-out services or producing them internally. If markets are contestable and outcomes are easy to measure, transaction costs will likely be low and buying long-term care would be preferred. If markets are not contestable and outcomes are difficult to assess, transaction costs will likely be high and offset efficiency gains derived from contracting-out. Making rather than buying long-term care would thus be preferred. It is important to bear in mind that the position that different types of services occupy in the make or buy matrix can change with time, e.g. advances in quality measurement may move a service from low to high measurability.

The process of setting up care markets has costs (e.g. contracting) that could offset efficiency gains from markets.

Figure 1:
Make or buy decision matrix



Source:

Adapted from Preker et al. 2000, p. 784.

In theoretical terms, how suitable is long-term care to be contracted-out according to transaction costs theory? Table I provides an overview of the theoretical conditions to contract-out services in general (Kelman 2002) applied to long-term care. To each question, 'yes' means that long-term care is in theory suitable to be contracted out:

Table I:
Applying transaction costs economics to long-term care

Theory-driven questions	Answer	Caveats applicable to long-term care
Fundamental conditions		
Tasks can be detailed <i>ex ante</i> ?	Yes, but...	There is scope to define in advance which tasks are to be delivered. There is, however, the risk that, as tasks become more detailed, this will lead to a standardisation – with a potentially negative impact on quality of services.
Compliance with objectives is easily monitored?	Difficult, but expanding	It is possible to monitor compliance but this requires sophisticated quality assessment mechanisms and/or that end-users of services are able to choose and assess quality of care. Some outcomes may also depend on network functioning of several providers along the continuum of care.
The market is competitive or contestable?	Yes	Certain geographic locations might be too sparsely populated and constitute natural monopolies – this can be mitigated, e.g. leasing contracts for nursing homes, but requires mechanisms to address provider failure.
Tasks are not central to the state's mission?	Debatable	This should ultimately reflect societal preferences. However, even if provision of adequate means to compensate for the risk of dependency may be a central mission of the state, some specific services may still be contracted out (e.g. meals).

Source:
authors' compilation.

Secondary conditions		
Demand is irregular?	No	It is nonetheless possible to lease the operation of the service and make only the capital investments.
Production involves economies of scale?	No	Limited scope for economies of scale without seriously compromising quality, even in nursing homes. Leasing the operation of the service and making the capital investment can contravene possible economies of scale.
Private providers can better hire specialised staff?	Not salient	Operating staff costs of private providers may be lower due to reduced unionisation or lower benefits or pay of private employees <i>vis-à-vis</i> civil servants. This could, however, have detrimental effects on staff turnover and compromise quality.

On the one hand, long-term care is not the typical example of a public service that can be easily contracted-out, at least not in comparison with other examples such as telecommunication. On the other hand, there are no fundamental obstacles to contracting-out long-term care, at least not from the theoretical point of view. For instance, while irregular demand usually makes contracting-out more appealing, with the reasoning being that costly resources are not tied up to respond only to occasional demand, regular demand is not necessarily an obstacle to successfully contracting-out (e.g. garbage collection has a regular demand and yet it has been successfully contracted-out).

Lesson #4: Bear in mind the specificities of public services and voluntary organisations

Public services are an important factor for generating social cohesion in the local context. The need for cooperation and coordination of various service providers and institutions to guarantee ‘seamless service provision’ might easily clash with claims for the free choice of providers and competition between them. Public services are a fundamental component of the welfare state and have therefore other aims beyond efficiency such as social justice, equality of access and social inclusion based on a broader political debate on individual rights and obligations. The replacement of this debate and ensuing social planning by purely market-oriented governance could jeopardise the provision of equal access due to informational and regional asymmetries.

In reality, the introduction of market mechanisms in long-term care has changed the governance structure of existing public organisations, including the breaking-up of larger organisations into smaller units to foster intra-organisational competition and management (purchaser-provider-

Public services produce intangibles such as social cohesion that must be considered beyond efficiency.

split); an emphasis on contracting and performance measurement and less discretionary decision-making; and the adoption of private-sector management rules and paradigms (Hood 1995). In practice, this has produced a 'hybridisation' of all types of organisations providing public services in terms of a mutual exchange of values, practices and guiding rationales (Evers 2005).

Voluntary charities and non-profits play an important role in care markets, namely by serving as benchmarks for quality.

Voluntary charities or similar non-profit organisations have a long story in the provision of social assistance from where long-term care eventually evolved in many countries. These voluntary organisations have developed their own identities by emphasising that their role extends well beyond the mere provision of services as they contribute to foster intangible assets such as solidarity, voluntarism, democracy and participation. It has therefore been argued that market-oriented governance might undermine 'the very specificity of the social contribution of civil society organisations' (Enjolras 2009: 289). In line with this argument, voluntary organisations are mainly driven by motivations other than profit-maximising, with important implications for contracting-out long-term care. For example, voluntary organisations may have less of an incentive to cream-skim, they may provide a useful benchmark against which to assess quality of for-profit providers when quality is not easily observable and the trust relations on which voluntary organisations are based may reduce contracting costs (Forder 1997, Steinberg 1997).

Lesson #5: Consider all the advantages of choice

Choice can be important as an outcome of care linked to autonomy and control.

Thus far, choice has been debated in the context of market-based mechanisms in long-term care for what it can bring or contribute to – i.e. for its instrumental value in bringing about increased efficiency. In assessing the pros and cons of market mechanisms and the arguments whether to make or buy long-term care it is important also to assess the intrinsic value of choice. Disability rights movements have often questioned the role and power of bureaucrats in defining needs and allocating social services, as well as the 'one-size-fits-all' view of social services (Clarke, Newman & Westmarland 2007). Instead, they have claimed self-determination, independence and autonomy of users, arguing that disabled and older dependent people may be limited in their capacity to self-care, but they retain their capacity to decide over their own lives (Collopy 1995). In this context, user choice came to be viewed as an essential tool to empower users with agency to choose the services that best fitted their heterogeneous needs and preferences and to be in control over services they receive (Clarke, Smith & Vidler, 2005). The ability to choose can thus be an outcome of care in its own right.

The distinction between choice as an instrument and choice as an outcome has important implications for markets in long-term care. For example, choices made on behalf of users by public officials may produce desired outcomes in terms of efficiency or responsiveness of providers, while failing to address the issue of agency for end-users of long-term care. Empowering users with agency also has implications for how markets are organised, e.g. instead of single purchasing by care managers this calls for a market based on many individual users acting as purchasers themselves.

Conclusions

The decision whether to make or buy long-term care is one that is probably best addressed empirically, but policy-makers that ignore insights offered by different strands of theory do it at their own peril. The theoretical considerations reviewed in this Policy Brief provide important clues about a wide range of subjects to be considered when designing and setting up care markets, but also about the wide range of resources necessary for care markets to produce the desired outcomes. This can help avoid mistakes and prevent rather than correct unintended outcomes of regulatory frameworks that are needed as long-term care is dissimilar to other sectors of public services where market-based mechanisms were introduced. Social services have a broader range of objectives, including contributing to social cohesion or ensuring equity. These objectives may not preclude the contracting of long-term care services with different types of providers, but raise issues that are not present in other services and therefore may impose additional transaction costs through investment in specific skills and training for the very process of contracting and monitoring these services.

Further reading

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European Centre
for Social Welfare
Policy and Research

Berggasse 17
A – 1090 Vienna

Tel: +43 / 1 / 319 45 05 - 0
Fax: +43 / 1 / 319 45 05 - 19
Email: ec@euro.centre.org

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