Measuring the Change in Consumer Benefits

One measure of the change in consumer benefits is the change in consumer surplus. Consumer surplus is defined as the total valuation of the quantity of goods that are chosen minus the total expenditure that consumers must pay. The change in consumer benefits is equal to the change in the benefits received by consumers from the policy change.

If hospital patients had to pay for their own meals, their willingness to pay for hospital meals could be illustrated by a demand curve for hospital food of the usual shape. The downward sloping demand curve can be thought of as an ordering of willingness to pay by patients from the highest to the lowest. At higher prices, fewer meals would be chosen. The willingness to pay for hospital meals is undoubtedly a function of the quality of the meals. A higher quality of food would increase the willingness of patients to pay for meals, a lower quality would reduce their willingness to pay.

A difficulty in analysing the net benefits from the hospital meals is that hospital patients do not choose their food service provider, the

hospital decides, on the menu and allows the patient to choose from among the set of meals (subject to dietary restrictions). Thus, what we have to estimate is the value that patients would place on the meals, which may differ from what it costs the hospitals to provide the meals. For example, if a patient had to pay for his or her own meal, which costs the hospital say $5.00 to provide, only those patients valuing the meal at $5.00 or more would purchase the hospital food, if there was a choice of food services. However, if there is no choice then the patient would consume the food which costs $5.00 which is valued at say $4.50, thus we have a social loss of $.50 on that meal, assuming competitive supply of the hospital meals.

Suppose we feel that we have a reasonable estimate of the willingness to pay for hospital meals, then to measure the net social benefits, we subtract from the total willingness to pay for a given quantity and quality of meals, the total social costs of providing those meals, to measure the net social benefits. In aggregating the net social benefits we may want to weight the social benefits differently depending on who receives them. For example, it may be considered more important that low income individuals receive the consumer benefits then do higher

income individuals, therefore we might set a higher weight on those benefits in aggregating the net social benefits. Or we might weight the consumer benefits received by children higher than older individuals. One can imagine a number of ways in which distributional issues would enter the calculation. It is important to realize that lower quality of meals would result in a reduction in the aggregate willingness to pay and hence a reduction in the net social benefits of any given quality of meals.

[redacted]

There is considerable controversy regarding the quality of meals under the status quo versus the Shared Services Contract. In the initial period of operation, residents of Deer Lodge Hospital lodged numerous complaints over the food service from the new system. USSC confirmed they had been flooded with complaints over poor quality. USSC claims that the status quo system was "marginal at best" and that as far as the new system is concerned, "based on taste-panel results for the period Oct. 10-29, cleanliness has improved to 85 per cent, taste has improved to 70 per cent and the final score has improved to 81 per cent, or an A."

[redacted]

It has been reported that in some cases, food service systems that had been centralized were subsequently changed back to the old system. For example, the British Columbia psychiatric facility in Port Coquitlam reverted back to the system of in-house preparation at the request of the ombudsman after numerous complaints. In other cases, for example, the Atlantic Health Sciences Corp. (AHSC) who had switched over to serving reheated food at its 12 hospitals and health centres in 1995, maintains that its system, after a barrage of complaints, has improved and AHSC has no intentions of reverting to in-house preparation.

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Other evidence comes from the Canadian Union of Public Employees, CUPE Research Branch (1996, 1998). Their most recent research seems to indicate that the shared food services system in New Brunswick and Ontario are incurring significant operational and financial difficulties. For example, the poor quality of food has made headlines in New Brunswick papers, with the research branch concluding that "the shared system is no doubt proving extremely costly". In Ontario, they argue that "since switching from conventional to cook-chill and shared food production, Toronto hospital has had its first ever deficit in their dietary budget ($2 million)." These examples suggest that the shared services system might be

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more difficult to operate than its proponents suggest. (ii) Measuring the Change in Government Receipts	[redacted]