

The Economics of Long-term Care

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Compared to many other walks of life, long-term care (LTC) poses special challenges to economic analysis (and by implication, policy). This can be seen by using the decision tree that organizes the textbook by ZWEIFEL and BREYER (1997) on health economics as the benchmark. There, a patient goes through a stylized sickness episode. Influenced by especially health insurance parameters, he or she first decides whether or not to see a physician. Next, the physician in turn decides whether or not to provide the services needed using her own time, ancillary services provided by the practice, outside resources such as drugs, or whether to refer the patient elsewhere altogether, in particular to a hospital. The management of the hospital then faces the question of whether to provide the services in a capital or a labor (and human capital) intensive way. Finally, the whole sequence is very much influenced by regulation, which may be used by politicians to secure their re-election.

In the case of LTC, the sequence is much more complicated. First of all, the individual concerned must decide whether to disclose its helplessness, which may be of two types. One type is a reduced productivity in nonmarket work due to physical limitations. The other is mental, the inability to take decisions oneself anymore. Alzheimer disease is especially threatening in this regard in that it combines these two incapacities. The responses of the spouse, relatives, and friends to disclosure is likely to differ strongly between these two types.

However, potential caregivers pursue their own objectives. Without negating altruism, providing LTC care has a high opportunity cost in terms of leisure and/or labor income. As most of the informal care is provided by female spouses and daughters, the closing of the gender gap in terms of wages cannot but create an increased incentive to call on LTC insurance or public welfare, depending on the system in place.

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Caregivers may also enlist the help of a physician. Here, the decision situation is again more complicated than in general health care. When weighing her objectives in terms of leisure and income against professional ethics, the physician must not only take into account the welfare of the patient but that of the burdened caregiver as well. Moreover, the question of what type of outside resources to rely upon (and their location, since admission to a nursing home likely is permanent, so travel time plays an important role) becomes even more relevant than in the context of a hospital stay. Depending on insurance parameters, the physician may also be under pressure to ‘medicalize’ the problem, i.e. to disguise to the insurer that she is dealing with a LTC patient.

Finally, the objectives of the nursing home who admits the LTC patient need to be known. In particular, the issue is of whether its for profit status makes a difference. One might expect that financial incentives work in a very similar manner regardless of whether or not the institution has nonprofit status.

All these agents interact, determining the outcome of the decision sequence in terms of health status and remaining life expectancy of the patient, health status of informal caregivers, labor participation of caregivers, physician fees, and prices and costs of nursing homes. They result in moral hazard effects impinging on LTC insurance and/or the public purse, which must be taken into due account when designing a public LTC policy.

References

ZWEIFEL, PETER and FRIEDRICH BREYER (1997), *Health Economics*, New York: Oxford University Press.