Avoiding admissions:

The most cost effective delivery of acute care to residents of aged-care facilities in the Hutt Valley.

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Abstract

The highest annual costs of health care occur in the last one to two years of life. The most expensive part of health care provision during this period is aged-residential care. As residents of aged-care facilities are frail and suffer from chronic illness, periodic medical care is required. For residents of aged-care facilities in the Hutt Valley, this medical intervention is either provided on-site with the assistance of the contract general practitioner or the resident is acutely admitted to the Hutt Hospital. Such admissions incur a significant cost to the District Health Board, which continues to pay for the aged-residential care bed for up to 21 days in any one calendar year even if a bed is vacated for an acute hospitalisation. This study examined acute admission data of aged-care facility residents admitted into Hutt Hospital during 2003 from 1 Dec 2002 to 30 November 2003. This was compared the acute admission data to a census of 18 aged-care facilities in the Hutt Valley to identify the most cost effective delivery of acute care to the residents.

Analysis of data collected from the study supported a number of variables that impact on acute admission rates. These variables included attitude of the aged-care facility manager to acute admission, access to registered nursing, facility characteristics and contractual arrangements with general practitioners.

Five alternative models of acute care delivery were examined for possible impact on acute admission rates and cost effectiveness. The most cost effective delivery of acute care to residents of aged-care delivery is through a twenty-four hour contractual arrangement with a general practitioner.

However, variables such as contractual obligations of aged-care facilities, profit status, staffing configuration and whether a facility also offers other retirement options such as villas impact on acute admission rates and have implications in the development of older persons policy in New Zealand. Health researchers in New Zealand have not explored this area to date. Given the cost to the economy and the future fiscal risk with the increasing number of older people, this is an area that requires urgent research attention.

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Approval for this research was obtained from the Massey University Human Ethics Committee.

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New Zealand Legislation

The following legislation has been discussed in Chapter Two.

Health Act (1956)

An act to consolidate and amend the law relating to Public Health

Hospitals Act (1957)

An act outlining the law in relation to public hospitals (repealed by section 59(1) Health and Disability Services (Safety) Act (2001) on October 1, 2004.

Social Security Act (1964)

An act that outlines social welfare benefits.

Old Peoples Home Regulations (1987)

Regulations for old peoples homes (rest homes). Repealed by section 59 (3) Health and Disability (Safety) Act (2001) on October 1, 2004.

Hospitals Regulations (1993)

Regulations for private hospitals (including continuing-care hospitals) (repealed by section 59 (3) Health and Disability (Safety) Act 2001 on October 1, 2004.

Health and Disability Services Act (1993)

An act to reform the public funding and provision of health services, repealed by section 110 (1)(a) New Zealand Public Health and Disability Act (2000).

New Zealand Public Health and Disability Act (2000)

An act to provide for public funding and provision of personal health services, public health services and disability support services and to establish new publicly-owned health and disability organisations.

Health and Disability (Safety) Act (2001)

An act to promote the safe delivery of health and disability services to the Public.