5.6. Unplanned hospital re-admissions for mental disorders

The burden of mental illness is substantial. Schizophrenia and bipolar disorder are among the top ten causes of years lost due to disability at the global level (WHO, 2001).

Mental health care has become a policy priority in many OECD countries, coinciding with dramatic changes in the delivery of mental health services, especially for severe disorders such as schizophrenia and bipolar disorder. Starting with de-institutionalisation in the 1970s, care has shifted from large psychiatric hospitals towards community-based care. Paradoxically, the shift has made it harder to track mental health care at the population level, as few countries have a health information infrastructure suitable for following patients across a variety of delivery settings.

Unplanned hospital re-admission rates are commonly used as an indicator of insufficient care co-ordination following an inpatient stay for psychiatric disorders. Longer lengths of stay, appropriate discharge planning, and follow-up visits after discharge contribute to fewer re-admissions, indicating that re-admission rates reflect the overall functioning of mental health services rather than the quality of hospital care (Lien, 2002). Thirty-day hospital re-admission rates are part of mental health performance monitoring systems in many countries, such as the Care Quality Commission in the United Kingdom and the National Mental Health Performance Monitoring System in the United States.

Figure 5.6.1 shows the variation in unplanned re-admission rates for schizophrenia, with Nordic countries at the higher end and the Slovak Republic, the United Kingdom, Spain and Italy at the lower end. The pattern of re-admission rates for bipolar disorders (Figure 5.6.2) is similar, with the Nordic countries well above average. Most countries have similar rates for men and women, however, male patients with schizophrenia have higher rates in Italy while female patients are more likely to be re-admitted in Canada and Denmark. Regarding bipolar disorder patients, women have higher re-admission rates in Finland, Sweden, Ireland, Canada and Belgium. These numbers may reflect differences in care seeking behaviours or management related to a patient's gender.

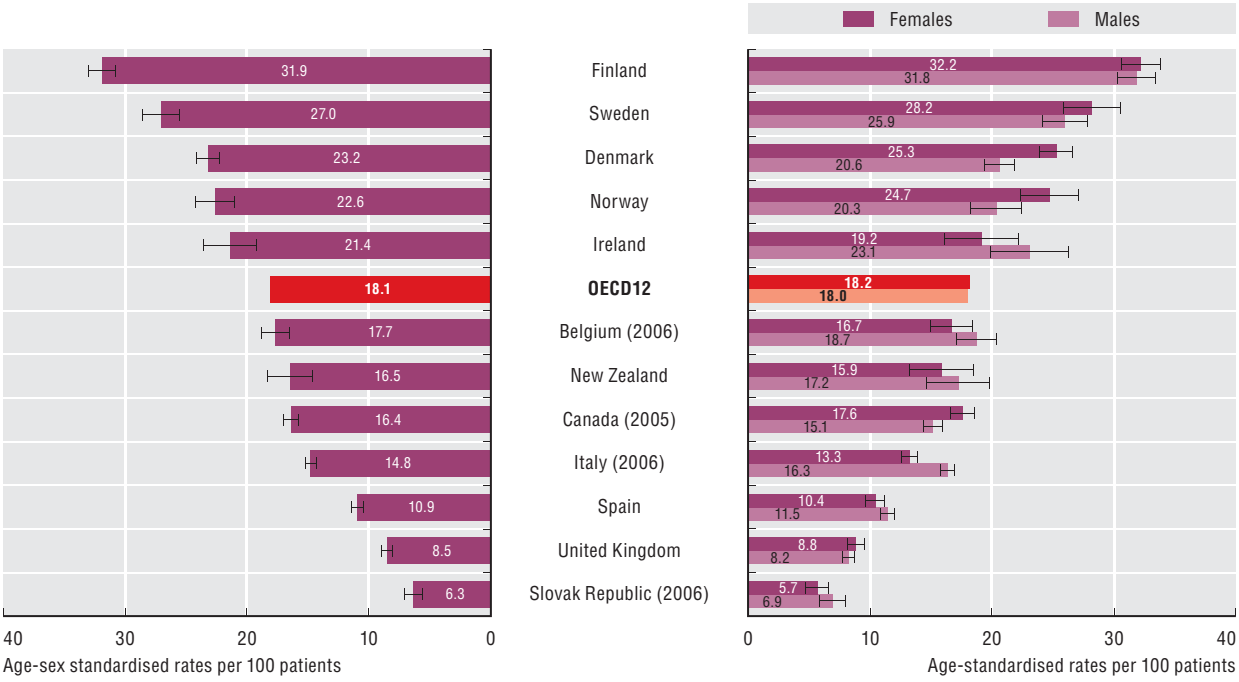
Supply factors such as the availability of hospitals beds (psychiatric and total), and the profile of in-patient facilities (percentage of in-patient care provided in psychiatric hospitals, general acute hospitals or residential facilities) cannot explain the variation in re-admission rates. The average length of stay for patients with schizophrenia or bipolar disorder does not seem to be associated with variations in re-admission rates. Anecdotal evidence suggests that different approaches to crisis management might play a part. For example, some countries with lower re-admission rates, such as the United Kingdom, Spain and Italy, use community-based "crisis teams" to stabilise patients on an outpatient basis. Other countries with high rates, such as Finland and Denmark, use interval care protocols to place unstable patients into hospital care for short periods. While there is broad consensus that community-based care is preferable to in-hospital care where possible, in certain countries the practice seems to be shifting towards supplementing or substituting community-based devices with in-hospital care. In the absence of a comparable measure of outcomes across countries, the benefits of this alternative approach are difficult to assess. The enhancement of mental health related information systems will be necessary to make this type of comparative information readily available.

Definition and deviations

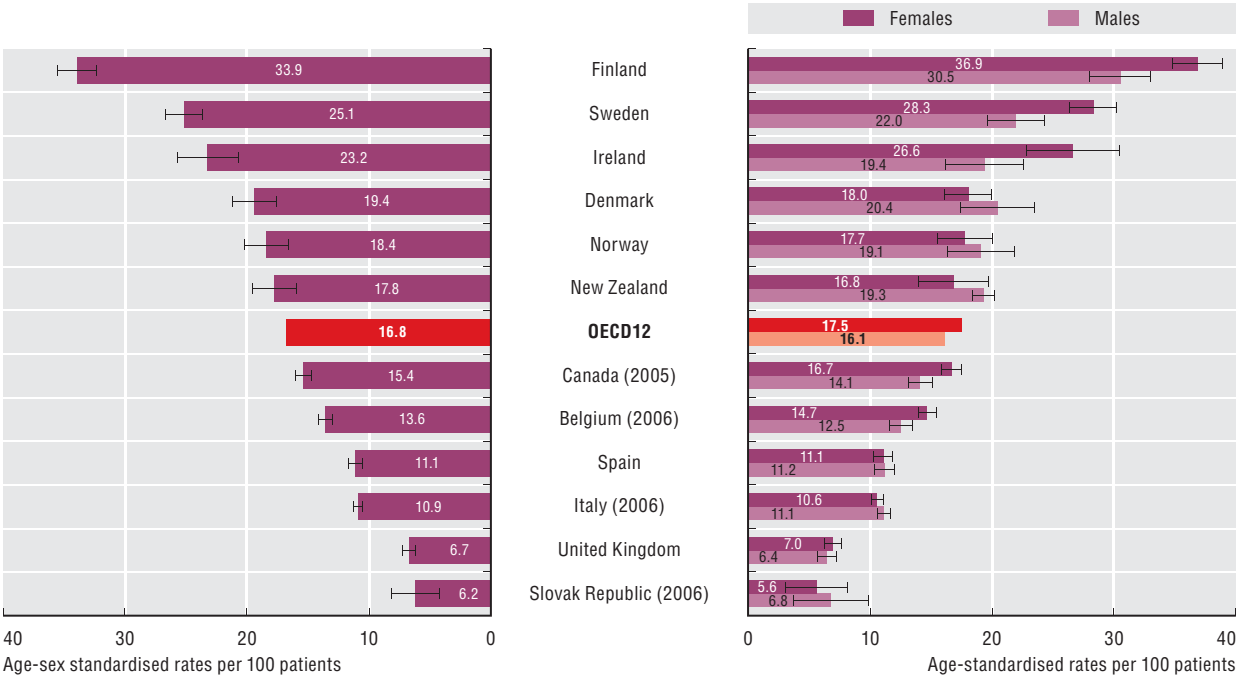
The indicator is defined as the number of unplanned re-admissions per 100 patients with a diagnosis of schizophrenia and bipolar disorder per year. The denominator is comprised of all patients with at least one admission during the year for the condition. A re-admission is considered unplanned when the patient is admitted for any mental disorder to the same hospital within 30 days of discharge. Same-day admissions (less than 24 hours) are excluded.

The absence of unique patient identifiers in many countries does not allow the tracking of patients across facilities. Rates are therefore biased downwards as re-admissions to a different facility cannot be observed. However, the eight countries which were able to estimate re-admission rates to the same or other hospitals, show that rates based on the two different specifications were closely correlated and ranking of countries was similar, suggesting that re-admissions to the same hospital can be used as a valid approximation.

5.6.1 Unplanned schizophrenia re-admissions to the same hospital, 2007

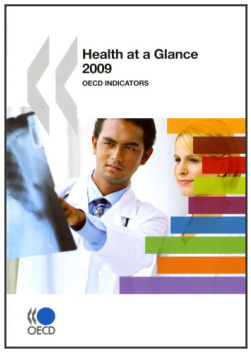


5.6.2 Unplanned bipolar disorder re-admissions to the same hospital, 2007



Source: OECD Health Care Quality Indicators Data 2009. Rates are age-sex standardised to 2005 OECD population. 95% confidence intervals are represented by ⊢⊣.

StatLink http://dx.doi.org/10.1787/718800331705



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