Shifting care: GP opinions of hospital at home

SONJA HOOD

SHARON PARSONS

NAOMI J FULOP

SUMMARY

Hospital at home (HaH) has become an increasingly popular model of care over the past few years. However, there is little evidence to suggest that this is a superior form of care when compared with standard inpatient care in terms of cost, satisfaction, or clinical outcomes. Despite concerns that these schemes increase general practitioner (GP) workload, there is also no published evidence on the effect of HaH on GPs. As part of a broader study, a survey was undertaken of all GPs in an inner London health authority for their views of HaH. Overall, GPs felt that such schemes increased their workload, but GPs who had used HaH were more strongly in favour of these schemes for a range of conditions.

Keywords: hospital at home; inpatient care; GP workload.

Introduction

HOSPITAL at home (HaH), which replaces inpatient days with care in the patient's home, has become an increasingly popular model of care in the National Health Service (NHS) over the past five years. However, recently published research findings have not, on the whole, demonstrated a clear benefit of HaH over conventional inpatient care. In terms of cost, only one study suggested that HaH could save money compared with conventional inpatient care,[1] whereas other research shows that there is no saving to be made — indeed there is potential for increased cost.[2,3] In terms of patient outcome and satisfaction, HaH has generally been found to provide a similar level of care to inpatient care.[4,5] One recent study found a significant increase in GPs' costs for elderly medical patients and those with chronic obstructive airways disease.[2] Beyond this, however, there has been little published research on GPs' opinions and experiences of HaH.

Method

As part of a broader study of HaH in inner London, a short questionnaire was sent to all 183 GPs in a health authority, asking about their views and experiences of HaH. The questionnaire asked all GPs their opinion about the effect of HaH on their workload, and whether or not they were for or against the use of HaH for certain conditions. In addition, GPs who had had a patient on HaH were asked some questions about their experience with the scheme. GPs were asked to answer with regard to the most recent patient they had had on HaH.

General practitioners had access to one of two HaH schemes: an early discharge service catering mainly for postoperative orthopaedic patients, or a 'prevention of admission' service caring mainly for the frail elderly. Formally, the role of the GP was the same in both services; GPs were clinically responsible for their patient, who could only be admitted to the scheme with the GP's approval. Notably, GPs rarely referred patients directly to either service; referrals to the orthopaedic scheme were usually from wards, and to the prevention of admission scheme from district nurses. Both schemes provided nursing care through the district nursing service, and their own physiotherapy and occupational therapy.

Results

Results are summarized in Table 1. The majority of GPs favoured the use of HaH for terminal care, chest infections, cerebrovascular accident (CVA), hysterectomy, and haemorhoidectomy. However, the majority did not support the use of HaH for postoperative care of hip replacements, knee replacements, or fractured necks of the femur — an interesting finding, considering many HaH schemes are set up for postoperative orthopaedic care.

Of the 55 GPs who had used HaH, 21 (38%) did not know they could refuse to have a patient admitted to HaH. Four GPs (7%) did not know they were clinically responsible for the patient while on the scheme. Fourteen GPs (25%) rated the information they received from HaH about the services provided as less than or not at all adequate.

The reported rates of home visits to, and telephone calls from, the patient while on HaH were 49% and 56% respectively. This varied depending on the type of care given. GPs whose patients had been on the prevention of admission scheme were significantly more likely to have made a home visit than GPs whose patients had been on the early discharge scheme (68% versus

Table 1. Survey results (response rate = 141/183 [77%]).

Survey question	GPs' responses
Opinion or experience on effect of HaH on normal GP workload:	
Increases workload	81 (57%)
Decreases workload	9 (6%)
No effect on workload	19 (13%)
No opinion	29 (21%)
No answer	3 (2%)
GPs completely or somewhat in favour of HaH for the following conditions:	
Terminal care	108 (77%)
Chest infection	85 (60%)
CVA	83 (59%)
Hysterectomy	69 (50%)
Haemorhoidectomy	69 (50%)
Total hip replacement	68 (48%)
Total knee replacement	67 (48%)
Fractured neck of femur	63 (45%)
Transuretural resection of the prostate	56 (40%)
For GPs who have had a patient on HaH (n = 55):	
Aware they could refuse admission to HaH	34 (62%)
Aware they were clinically responsible for patient on HaH	51 (93%)
Thought HaH gave them adequate/more than adequate information about service	41 (75%)
Visited the patient at home at least once	27 (49%)
Received a telephone call from the patient	31 (56%)

S Hood, MSc, research project co-ordinator; and S Parsons, BSc, research officer, Kensington & Chelsea and Westminster Health Authority, London. N J Fulop, PhD, senior lecturer in health services management and policy, London School of Hygiene and Tropical Medicine.
Submitted: 5 June 1997; final acceptance: 11 November 1998.

33.3%; $P = 0.03$, not shown in Table 1). Notably, the majority of GPs surveyed felt that HaH would increase their workload.

Discussion

Although there are limitations to this study — most importantly, there is no comparison made between GPs with HaH patients and those receiving standard hospital care — it does highlight some concerns about the role of GPs in HaH schemes. If the NHS is to continue to encourage the development of HaH, it is imperative that the perceived shift in workload from the acute sector to primary care be closely monitored.

References

1. Coast J, Richards SH, Peters TJ, *et al*. Hospital at home or acute hospital care? A cost minimalisation analysis. *BMJ* 1998; **316:** 1802-1806.
2. Shepperd S, Harwood D, Gray A, *et al*. Randomised controlled trial comparing hospital at home care with inpatient hospital care. II. Cost minimalisation analysis. *BMJ* 1998; **316:** 1791-1795.
3. Hensher M, Fulop NJ, Hood S, Ujah S. Does hospital-at-home make economic sense? Early discharge versus standard care for orthopaedic patients. *J R Soc Med* 1996; **895:** 48-51.
4. Shepperd S, Harwood D, Jenkinson C, *et al*. Randomised controlled trial comparing hospital at home care with inpatient hospital care. I. Three month follow-up of health outcomes. *BMJ* 1998; **316:** 1786-1791.
5. Richards SH, Coast J, Gunnell DJ, *et al*. Randomised controlled trial comparing effectiveness and acceptability of an early discharge, hospital at home scheme with acute hospital care. *BMJ* 1998; **316:** 1796-1801.

Address for correspondence

Sonja Hood, Department of Public Health, Kensington and Chelsea & Westminster Health Authority, 50 Eastbourne Terrace, London W2 6LX.