

questions

d'économie de la santé

Issues in health economics
analysis

Background

This document examines the appropriateness and ways of developing home health care as an alternative to standard hospitalisation. By analysing experiences in other countries, it aims to understand why and how other countries have set up this type of services, what difficulties have been encountered and the incentives created to promote their development. The information used mainly stems from a review of the literature and Internet research, sometimes enhanced by contacts with institutions in various countries. An evaluation of the medical costs of these alternatives, extending to other countries, was also carried out, in parallel. While those results are not presented in this document, they have been used to feed our analysis. The entire project was financed by the DHOS (French Department of Hospital and Health Care Organisation) and DSS (French National Health Department) under the Ministry of Health, the Family and Disabled Persons.

The development of hospital care at home: an investigation of Australian, British and Canadian experiences

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In France, the development of hospital care at home (abbreviated by French acronym SHAD) offering an alternative to traditional hospital-based care does not measure up to the scope of its possibilities, such as enhancing the quality of the care and improving the coordination between the ambulatory and hospital care. Examination of experiences in other countries of these modes of care would help to understand their context and the factors which facilitate or hinder their development. The aim of this analysis is to contribute to the debate on the appropriateness of maintaining and extending this type of services in France.

Three countries were chosen for their large amount of available literature on the subject of home health care: Australia, Canada and the UK. Their experiences show that the type of pressure exerted on the supply of hospital services determines the development and characteristics of home health care. Nevertheless, their development must be encouraged by an assertive policy which creates the right incentives, in terms of financing, inter-sectoral coordination and the organisation of the care as well as the acceptability of the programmes.

Context of the development of hospital care at home

	Australia	Canada	UK	France
Population	19,663, 000	31,414,000	59,232,000	59,486,000
People aged 65 and over	12.7%	12.7%	15.9%	16.3%
Density (per./km ²)	2.4	3.1	243	110
Percentage in urban areas	65%	80%	92%	80%
Acute hospital care				
Density in terms of beds & places (nbr/1,000 people)	3.9	3.2	2.3	4.2
Occupancy rate ⁽ⁱ⁾	80%	89%	84% ⁽ⁱⁱ⁾	78%
Average length of stay (in days), including 1-day stays	3.5	7.3 ⁽ⁱⁱⁱ⁾	5.4	4.5

Sources : OCDE and IRDES estimates drawn from national statistics: DREES, Australian Institute of Health and Welfare, OHE Compendium of Statistics, Canadian Institute for Health Information. Years 2001 to 2003, according to availability.

(i) Occupancy rate = number of beds occupied per 100 beds available.

(ii) Not limited to acute care due to data unavailability.

(iii) Including patients on long stays occupying acute-care beds.

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The study presented here focuses on the development of hospital care at home in three foreign countries: Australia, Canada and the UK. It is essentially based on a review of the literature available in 2003 and therefore has a few limitations, described in the paragraphs that follow. Nevertheless, the analysis unveils the major trends concerning the ways in which these services are developing in the three countries, the type of home care services provided and the factors which promoted their development: legislative measures, modes of financing, inter-sectoral coordination and acceptability for health care professionals.

Definition of hospital care at home: substitution, type of care and coordination

On the international scale, the alternatives to health care services traditionally provided in the hospital present some dissimilarities. For the purpose of this study, the definition used for hospital care at home is the following: hospital care provided to the patient in his/her own home, involving technical care of a more or less complex or intensive nature, without which hospitalisation would be required.

This definition puts emphasis on the notions of substitution, type of care and coordination (see box opposite). In France, it essentially corresponds to the Hospital At Home programme (abbreviated by French acronym HAD). It may also include other types of health care structures such as palliative care networks.

Highly variable availability of information reflects the development level

In Australia, «hospital in the home» (HITH) is particularly well documented. Data is available at national level on the characteristics of the services: modes of organisation, activity, information on the patients and reasons

Definition of hospital care at home (HITH)

For the purpose of this study, the definition used for hospital care at home (or hospital in the home - HITH) is the following:

Hospital care provided to the patient in his/her own home, involving technical care of a more or less complex or intensive nature, without which hospitalisation would be required.

This definition puts emphasis on the notions of substitution, type of care and coordination.

These services may be provided as total substitutes (admission avoided) or partial substitutes (early check-out or delayed admission) to hospitalisation.

They can offer a wide range of health care services: short-term medical treatments in response to acute clinical situations, continuous care in the case of chronic illnesses, palliative care, rehabilitation or functional therapies – all these services being identical to those provided at the hospital.

The scope of the service is that of medical care, characterised by the compulsory participation of health personnel in HITH services (doctors, nurses and paramedical personnel). However, other professional categories, such as health workers and home helps, are also involved in the process in order to provide the patient with comprehensive care.

The notion of coordination of the services is thus essential, differentiating HITH services from standard outpatient services. It is in keeping with the intensity and/or complexity of the care, as well as the number of staff involved.

Beyond these three consistent notions in all HITH service, the types of services provided are variable. While all of these services must be the same as those provided in hospital, their scope may be different from one patient to another, from one experience or structure to another, from one country to another and also from one period to another.

for calling on HITH services. The decentralised organisation of health care and the variety of local situations have given rise to a great diversity of modes of organisation and financing of local health care systems. In this respect, the Australian experience may be considered as a natural experimentation of different forms of home health care organisation and financing.

The literature concerning HITH services in Canada and the UK offers extensive information on home health care in general, which includes some HITH services such as rehabilitative care. In contrast, the information is fragmentary concerning alternatives to traditional acute hospital care (extra-mural hospital, hospital at home) and there is no easily accessible centralised information making it possible to assess the extent of these service offers.

We were unable to come up with a precise indicator of the development

of HITH services in all countries. In the UK and Canada, there is no national record on HITH activity. The data available in Australia is incomplete as it does not take all States into account.

These variations in the information available is not insignificant. In fact, the countries with the least information offer the vision of more limited HITH development in the field of acute and intensive hospital care.

The nature of the HITH services provided depends on the type of pressure on the supply of hospital services

The scope given to HITH services in terms of their degree of technicality and acuity varies from one country to another. Several factors seem to influence the development of HITH services: the ageing of the population, its spread over the territory and

the characteristics of the pressure exerted on the supply of hospital services.

Everywhere, the ageing of the population is presented as an incentive to develop home health care services, particularly in the fields of chronic or long-term care. However, rural and/or remote areas are generally considered as unfavourable to the development of HITH services due to the cost of transport for the health care personnel. Given the geographic and demographic characteristics of France and the three countries studied (see chart on page 1), we could expect France and the UK to develop HITH services in a similar way, while Canada and Australia would follow a different course. Yet, such is not the case: in this respect, France is much closer to Australia while the UK shows more similarities with Canada.

In fact, the pressure exerted on hospital beds stands out as the key factor to the development of HITH services. In the four countries, the problem of availability of hospital beds does not have the same intensity and is not of the same order. The insufficient availability of hospital care is often pinpointed as a key factor in HITH services as it determines both the target population and the degree of technicality of the health care services transferred from the hospital to the outpatient sector.

Every winter, the UK has to cope with the problem of hospitalisation requirements beyond its capacities. According to NHS officials, this pressure is due to an insufficient community service offering, which results in the clogging up of acute care beds by patients whose condition would only require rehabilitative care, either in their own homes or in appropriate institutions. Emphasis is thus put on HITH services liable to offset insufficiencies in outpatient care. These so-called «intermediate services» provided either

in institutions or at home are generally of a low technicality level. They are defined as an alternative to an «unnecessarily long» or «avoidable» hospital stay. In this respect, they are not a true alternative to hospitalisation. Hospital care at home as defined herein is also present, but it is less visible.

In Canada, historically, the home care services provided are also of a low technicality level: they consist of «routine» care provided to disabled patients or those suffering from chronic diseases and «long-term» care replacing the services provided in institutions. However, as a result of the drastic hospital bed closures which took place in the 90s, their function was extended to the replacement of acute hospital care. A survey recently conducted in Quebec on the technologies used by the home health care personnel clearly indicates that most Local Community Care Centres (CLSC) had to provide complex services in patients' homes (intravenous therapy, dialysis, etc.). This trend was indeed confirmed by a survey of home health care providers in 2001, revealing that 90 % of them estimated that the services had become increasingly complex over the last three years.

Australia also has a waiting-list problem, but it is not linked to the non-clinically justified clogging-up of hospital beds like in the UK. The pressure exerted on hospital capacities is to a larger extent attributable to the insufficient supply of hospital services rather than to unjustified demand. The transfer of services from the hospital to the outpatient sector thus developed right from the start with highly technical health care.

In France, the situation with respect to the emergence of HITH services is close to that of Australia. They were created following the overload of certain services. The first services concerned were highly technical,

short-term treatments aimed at cancer patients. They were subsequently extended to other patients, initially in the form of acute or limited treatments, then to a lesser extent, as continuous care, follow-up care and rehabilitative care, this time for reasons similar to those of the UK.

In conclusion, the literature and data available suggest that the French and Australian systems offer acute health care services at home, in partial or total replacement of short hospital stays, while the Canadian and British systems offer home health care focused on continuous treatments, in the form of routine care for chronically-ill or elderly patients or treatments to enable them to return home. However, the information available on the Canadian and British situations is incomplete and does not allow any real conclusion.

Australia displays a strong political will to develop HITH services

Since the 90s, Australia has shown its determination to develop nationwide HITH services. It has been supporting experiments, issuing recommendations, financing assessment studies and compiling an annual information repository on HITH services. Australia was also quick to make the required legal changes for the development of these services: measures, laws and amendments aimed at lifting impediments to the development of HITH services were rapidly implemented. For instance, before 2003, «private» patients admitted to a public hospital were not eligible for HITH services, even if the hospital offered those services, because their private insurance could not cover them. A law put an end to that problem by broadening the definition of the «hospital treatment» which could be insured by private operators, so as to include hospital care in the home.

This political will is also displayed in the ongoing provision of HITH services in remote rural areas, even though the distances travelled and low recruiting levels make them more costly than traditional hospital care. They thus favour the patient's satisfaction and increased quality of life over cost control objectives.

The State of Victoria, which displays the highest ambitions and dedicates considerable resources to the development of HITH services, is where those services are the most developed. HITH days account for over 4 % of hospital days in acute care, which is a fairly high percentage. In comparison, in France the number of HAD days accounts for 2.3 % of all full hospitalisation days in short-term care.

While in Australia the development of HITH services seems to be prompted by the objective of providing the population with that service, in the other two countries studied, it appears to a greater extent as a response to the constraints imposed by the system. In Canada, HITH services provided as an alternative to acute hospital care developed under the constraint imposed by bed closures, in conditions sometimes deemed difficult by health care personnel and carers. Only the health department of the province of New Brunswick set up, manages and finances a genuine programme of HITH services, which incidentally dates back to before the budget cutbacks and bed closures.

In the UK, there seems to be no political will directly aimed at promoting the development of HITH services, as defined herein. Yet, HITH services sparked the interest of the NHS and researchers from the middle of the 70s to the end of the 90s. However, while this type of programme still exists, particularly in the field of chemotherapy, the development of "intermediate home health care" seems to be the current priority.

The NHS has thus allocated additional resources to local authorities to give them the means to release the winter pressure on hospital beds. In return, since the spring of 2003, they are financially respon-

sible for the unjustified use of hospital beds: they have to refund the National Health Service for "unnecessary" hospital days attributable to insufficient community-based services.

Organisation of Hospital In The Home (HITH): the Australian example

Decentralised development

At the beginning of the 90s, a large number of HITH services (Hospital in the Home - HITH) were set up in Australia. Mainly stemming from local initiatives, they did not develop in the same way throughout the territory. Like in most countries, they were organised in response to variable local needs, around different pathologies or modes of treatment, with a variety of organisation and financing structures (Haas *et al.*, 1999; Montalto, 2002).

At the federal level, there is currently no legislation aimed at formalising the set up of HITH services. However, over the past five years, the Commonwealth Department of Health and Family Services has focused its attention on the development of these structures, with the main objective of reducing waiting lists. More general objectives aimed at improving the quality of the system (efficiency, patient satisfaction, etc.) also spurred this interest.

Great diversity in terms of organisation

Throughout Australia, there are major differences in the spread of the population and modes of financing of hospitals and community health care services. These characteristics affect the functioning and success of HITH programmes. Added to the fact that the set-up of HITH services was initially the fruit of local initiatives, this explains why the Australian experience comprises a great variety of situations.

The numerous forms of organisation of HITH programmes existing in Australia can be divided into four models¹. In actual fact, the modes of organisation encountered are often close to one of those models but can also consist of a combination of several of them or be on the border-line between two of them.

Australian organisation models:

- A. Hospital-based organisation², the treatments are connected to a specific field and are provided by members of the hospital personnel;
- B. Hospital-based organisation, the treatments are not connected to a specific field; they are provided by members of the hospital personnel
- C. Hospital-based organisation, the treatments are not connected to a specific field; they can either be provided by members of the hospital personnel or by service providers from the outpatient sector (GPs, district nurses, etc.).
- D. Organisation not based at the hospital, the treatments are not connected to a specific field.

In the last case, the patients are under the responsibility of the institution organising the programme (community health care centre, local health authority, group of doctors, etc.) and the treatments are primarily provided by outpatient sector personnel.

Thus, three out of those four models are managed by a hospital. In theory, in Australia, a HITH programme can either be managed by a hospital (public or private), another organisation unrelated to the hospital (group of GPs, health care association, etc.), a local/regional health authority, the central/territorial government, any combination of the above or a private enterprise. However, the vast majority of HITH services stem from hospitals (69 out of 74 programmes studied in 1998 (Haas *et al.*, 1999).

¹ This categorisation stems from a study conducted for the federal government in 1998 (Haas *et al.*, 1999) and a study conducted in 2001 for the government of New South Wales (Vinay *et al.*, 2001b).

² The patients remain under the responsibility of the hospital.

In France, where HITH services essentially cover the hospital at home programme (HAD), questions had been raised as to whether there was a real political will to promote the development of HITH services before the recent changes which removed major impediments and set up incentives. For instance, the exchange rate imposing the closure of two standard hospital beds to create one home health care bed was abolished; the transition to the per-service pricing of HAD days has introduced a pricing method which allows fairer remuneration per type of service and remedies the non-inclusion of HAD services in the PMSI database; additional resources have been allocated such as the 1.6 million euro package aimed at covering the cost of home nurses for the care of highly dependent patients and palliative HAD care. Moreover, the development of HAD services will mandatorily have to be integrated in the upcoming Regional Health Organisation Schemes (SROS 3).

The modes of financing of HITH services are crucial for their success

Initial financing facilitates the set-up of HITH programmes: they allow to cover the investment costs at the programme creation and service development phase during which the number of patients is often insufficient to be economically viable. Nevertheless, this financing is not a guarantee of the long-term survival of the HITH service, which must subsequently obtain a suitable mode of financing.

The financing of HITH services cannot be considered in isolation; it raises questions on the coherence of the financing of the health care system: do HITH services give rise to a transfer of expenditures from the hospital sector to the outpatient sector, from the health sector to the

The diversity in the organisation of hospital care at home (HITH) in the UK

Hensher (2000) explains the diversity of British HITH services by characterising them according to seven criteria:

- first of all their objective: the HITH service may be aimed at allowing early hospital check-outs or avoiding admissions;
- pathology: certain HITH services are aimed at a specific pathology while others handle several pathologies in a target population (elderly people, for example);
- institutional anchoring: the service may be dependent on a community trust or hospital trust;
- the team may be "comprehensive", i.e. include nurses, auxiliaries, etc., or "reduced", i.e. composed of district nurses and community personnel;

- the clinical responsibility for the patient may be entrusted to the hospital specialist or to a GP;
- the frequency and nature of the medical consultations, which may be scheduled on a regular basis, or on the contrary, reserved for emergency needs;
- the provision or non-provision of social services in addition to health care services;
- and lastly the eligibility criteria linked to the patient's environment: according to Hensher, while certain HITH services accept patients living in isolation, others require the availability of informal carers.

All of these aspects intermingle and give rise to numerous types of services.

social sector and finally, from the public sector to the private sector? Should there be a transfer between the budget dedicated to traditional activities and that dedicated to HITH services?

The financing of HITH services must correspond to the chosen objective. When these services are set up to reduce the pressure on hospital services, they are not implemented as a substitute to another offering but rather as an additional offering. It would be incoherent to envisage a mode of financing based on a transfer of funds from the hospital sector to HITH services. On the other hand, when a service provided outside the hospital makes it possible to reduce in-hospital activity, certain authors claim that we have to carry that substitution reasoning through to its logical conclusion, through a budget transfer and the closure of the beds dedicated to that service. However, this reasoning implies that the objectives have been clearly defined right from the start and that

the change takes place without any transition or adjustment cost.

When HITH services are tied to a hospital, their inclusion in the financing of the hospital's activity is crucial. Whether the hospital is financed through a comprehensive budget or on a pathology basis, two different cases are possible: either the HITH activity is included as such in the activity assessment and remuneration, either it is not. Where the HITH activity is remunerated separately, the respective remunerations for full hospitalisation and HITH services must be defined so as not to incite hospitals to develop opportunistic behaviours of under- or over-development of HITH services. When HITH services are not remunerated as such or are not taken into account in the assessment of the activity used as a basis for the remuneration, the financial incentive to develop them only exists if they are a less costly alternative to hospitalisation. However, medical cost assessment studies are not all favourable to HITH

services concerning costs. In the case of chemotherapy for example, while direct daily costs are on average lower for HITH than hospital care, the analysis in terms of marginal cost is sometimes favourable to hospital care as it is less costly to care for an additional patient in an existing structure than to set up an alternative HITH structure. However, the results are highly dependent on the context, protocols and organisational aspects which cannot be transposed to the French situation. Consequently, it is impossible to draw a conclusion in favour of either of the alternatives.

The Australian experiences show a great diversity in their modes of financing, in keeping with the various types of organisation and functions of the HITH services. An analysis of these experiences (Shanahan *et al.*, 2001) suggests that there is no ideal or “optimal” model for all HITH services, but rather that the mode of financing must be suited to the organisation of each HITH service and its specific objectives.

Likewise, the remuneration of the personnel, when they are not all employed by the institution which provides the HITH services, must be attractive in order to secure their involvement. For example, Australian observers noted that the per-service remuneration of health care personnel working in private HITH services didn't have any component covering supervision tasks during the period of care, which hinted that there were limits to their participation.

Moreover, the tasks left up to the patients and their families can also limit the development of HITH services. In the three systems studied, HITH services are generally more expensive for the patient than the hospital care they replace, without taking into account the work of

carers. In Canada, contrary to hospitalisation, HITH services are not part of the so-called “essential” services, i.e. fully covered under Canadian health law. They are therefore more or less well covered, depending on the home health care programmes set up by the provinces. Moreover, like in the UK, numerous medical goods (equipment and medication), which are fully covered when the patient is hospitalised, are poorly or not covered when the patient is cared for at home. These impediments have already been identified by the governments: in September 2004, Australia laid down laws to remove these financial obstacles to the development of private HITH services, while Canada's provincial prime ministers have undertaken to cover “to the first dollar” the “acute care” provided in the patient's home by 2006.

However, the patients' financial input is not limited to the financing of medical goods and treatments. Very often, social-sector services like home help are added to the patient's expenses. When these are publicly financed, they are often income-linked. Such is the case in the UK and France. Moreover, the cost of informal home help (family and voluntary carers) is never taken into account in the financing of HITH services. In this respect, in all systems, HITH services inevitably contribute to the transfer of part of the public health care expenses to the private sphere and to the creation of inequalities in accessing the health care they offer.

The inter-sectoral coordination of health care services and their financing is primordial

HITH services often call on personnel from the hospital and out-patient sectors as well as social sector personnel. The proper operation of the services thus rests on the coordina-

tion of services and appropriate financing methods.

Like France for HAD, the three foreign countries studied have set up a «one-stop» system: a single person is in charge of assessing the patient's needs and mobilising the appropriate personnel to meet those needs¹. However, the lack of communication and coordination is sometimes denounced by the personnel. For instance, in Quebec, an analysis of the provision of these services by the Local Community Care Centres (CLSC) showed that the hospital assessed the HITH eligibility criteria solely on the basis of clinical criteria, without any reference to the resources available at the patients' homes. Moreover, the professional health workers, like the patients and their carers often have little or no training on the care requirements.

Beyond the organisational aspects of the inter-sectoral coordination of health care services, is the question of financing. In that respect, the trend observed also points to the joint financing of health and social services. Thus, in Australia, in the State of Victoria, a single body remunerates all health and social services provided by the HITH programme. In Canada, routine “community” health care and social services are frequently combined, which facilitates their provision.

In the UK, the local NHS authorities and the local authorities in charge of the social sector were encouraged, starting in 2000, to pool human resources and budgets to cover the health care and social needs of the patients cared for at home and thereby promote greater cooperation.

¹ In France, this function is performed by the co-ordinating nurse and/or the social worker of the HAD service which identifies eligible patients and organises their care, once they have been admitted to the programme by the co-ordinating doctor.

Three modes of cooperation were offered to them: pooled budgets, the delegation of the management and purchase of services (lead commissioning: a principle according to which one of the two authorities delegates to the other the responsibility of managing the programmes and, if applicable, choosing the service providers) and lastly, the creation of a single organisation, linked to the NHS (the Care Trust). In that case, financial and human resources are allocated to this organisation which takes full charge of the management and provision of the services. The first mode of cooperation is the one most frequently opted for and a single co-ordinator is often appointed in charge of intermediate care.

In France, HAD services are tasked with handling all aspects of patient care. Yet, the consensus according to which the services of a home helper, when prompted by the health care period, should be financed by the Health Insurance while it traditionally stems from the social sector, is not always obvious.

Institutional anchoring is not insignificant from the point of view of programme acceptability

The institutional anchoring of HITH services (their connection to a hospital or community health care service) is very different depending on countries and sometimes even regions. In certain cases, it may affect the development of HITH services.

The Australian HITH programmes show great variety in this respect (see box page 4). Several Australian studies conclude that the programme's feasibility depends, amongst other factors, on its acceptability by hospital personnel and that it gets a higher rating when the head of the programme is a hospital doctor with a certain prestige.

In the UK, various modes of organisation coexist. A survey conducted in 1996 showed that, at the time, HITH services for adults were most often offered by community trusts, while patients remained under the hospital's responsibility. On the other hand, paediatric HITH services were mainly the responsibility of hospital trusts. Analyses identified several obstacles to the development of HITH services when these were independent from the hospital. Poor knowledge of HITH services on the part of the hospital and a lack of communication result in these services being tasked with the appraisal of the patients' eligibility while it would be more logical for the hospital to make that appraisal. In addition, in the British context, competition exists between the various players: the hospital may fear that the transfer of the patients' responsibility to the community sector may be accompanied by a transfer of funds.

In Canada, the handling of HITH services by community services also poses coordination problems. On the other hand, the external health care programme developed by the province of New Brunswick is original as it constitutes a new entity within the health care system. It is totally autonomous: it has its own financing and its personnel is employed by the programme, except for doctors. It directly recruits over half its patients eligible for HITH services, without going through the hospital; it is therefore less dependent on the hospital teams' endorsement.

In fact, in itself, institutional anchoring is not an impediment to development. This issue becomes significant when the choice of institutional anchoring induces competition between players and/or when it implies a transfer of responsibility from one professional to another.

* * *

In conclusion, it is important to recall that this work stems from a review of the literature available and that, depending on the nature of the documents, we are not always sure of having a faithful image of the actual situation. As an example, the information gathered on the pooling of resources by community and social sectors in the UK mainly stems from official documents, from the NHS or other government bodies, and it is difficult to know how these alliances are actually implemented.

In the end, what can be drawn from these analyses to enlighten the debate on the development of hospital care at home in France ?

In the three countries studied, HITH services developed to increase the health care capacity, either in acute care or in follow-up care, in the context of rationing of hospital services and sometimes their forced redeployment to the outpatient sector. France's situation differs in this respect. On the whole, the supply of hospital services is not deemed insufficient, and the HITH offering currently responds to two objectives: on the one hand, continuing to reduce the length of hospital stays and hospital capacities, and on the other, complying with the patients' wishes (and/or those of their families) to be cared for at home. Its development is a way of reconciling the increasing concentration of technical facilities, due to many factors, and the user's desire to be treated locally. This is indeed one of the orientations of the third-generation SROS (regional health organisation schemes).

In theory, the home health care offering should replace the traditional hospital care offering and benefit from a redeployment of resources. Until now, numerous administrative obstacles (exchange rate for example) and financial obstacles (inappropriate modes of financing) have stood in the

way. The recently adopted measures and the set-up of per-service pricing should facilitate things.

These measures do not solve all problems. The organising of HITH services requires perfect coordination among the various players involved. In France, a certain ignorance of the set-up and the lack of communication between the hospital and the city impede the development of HITH services. Foreign experiences also emphasise this phenomenon without providing any answer in terms of ideal model: while on the whole, Australian set-ups advocate hospital anchoring, the two other countries do not favour that option. On the other hand, the "one-stop" approach is *unanimously* espoused: it must be implemented not only to facilitate the patient's admission (finding eligible patients) but also to allow comprehensive care throughout the care period, by co-ordinating all medical and social personnel and obtaining all related financing.

The specific training of HITH personnel, the patients themselves and their families is a primordial factor in the quality of the care. In this respect, the French situation seems more favourable than the Canadian or British situations, even though general practitioners do not always feel suitably equipped to care for seriously ill patients at home.

Given all of these coordination difficulties, no spontaneous development of HITH services is possible without strong political will. Among foreign experiences, it seems that the most favourable contexts for the development of HITH services are those characterised by a clear political stance followed by a set of actions: assessment of the situation - decision (creation of HITH services) - evaluation, adaptation of legislation to lift the impediments identified.

However, while legislation can promote the development of HITH services, it can also restrict it. In France, the scope of HAD is very clearly defined by regulations. Questions may be raised on the pertinence of laying down too rigid of contours. In other countries, HITH services are often provided by bodies which also handle long-term

home care. Provided the health care personnel is well trained and the financing of the various types of services is in keeping with the resources mobilised, this approach could increase the flexibility of the progressive patient care system and cater in real time to the needs expressed and possibilities offered by therapeutic progress.

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