HOSPITAL AT HOME – Who should provide it? A SWOT analysis of managers' attitudes to HOSPITAL AT HOME

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The home environment is considered better for the patient's recovery, outcomes, and higher satisfaction among both patients and family members. For the healthcare system, hospital-at-home seems beneficial as it: 1. Prevents hospital overcrowding, especially in internal medicine departments; 2. Decreases costs by reducing the length of hospital stays & emergency room stays, thus optimizing costs for the healthcare system. Oddly enough, being a win-win healthcare solution known for decades, the hospital-at-home model is adopted slowly and often reluctantly – which begs the question as to what is holding it up. We believe that hospital-at-home can be beneficial to the health system in general and to the patient.

A study we conducted tried to understand the attitudes to hospital-at-home among two categories of healthcare providers in Israel: HMO's and hospitals. Israel has a public, universal healthcare system financed through state income-related health tax. Its service base is Health Management Organizations (HMOs – Kupot Holim) which insure, purchase, and provide health services from cradle to grave. The HMO's have a vast network of community clinics and offer nighttime and telehealth

response and minor trauma services. Hospital services are purchased for the patient by the HMO. There are also second and third-tier complementary health services and private vendors. Acute hospital-at-home (AHaH) has been incentivized by the Ministry of Health to be the responsibility of the HMO's, either directly or through outsourcing. Some hospitals choose to provide AHaH themselves, despite not being the MOH preferred or incentivized supplier.

In order to explore the adoption of the hospital-at-home model, we interviewed key operational figures in the Israeli hospital-at-home system. Choosing the SWOT (Strengths, Weaknesses, Opportunities, and Threats) framework seemed like a natural choice for our interview. This way, we could hear the operators' first-hand accounts of 'the good, the bad and the ugly' of hospital-at-home, and gain a deeper insight into this phenomenon as well as compare the attitudes of senior management of these two providers.

Our findings were divided into four categories: Patient care; Organizational aspects; Staff issues; Macro-health system issues. Whereas all participants perceived AHaH as a move that is beneficial for patients, it was also seen as a potential

extra burden on carers. Other disadvantages included safety concerns, concerns about standards of care, concerns about added expense and the need for substantial financial investment, and insufficient home testing. Our findings did not show significant differences between the two stakeholders, demonstrating instead a common desire to proceed and design more tools.

CONCLUSION

We believe that for promoting hospital-at-home, it is necessary to:

1. Establish clear criteria of which cases are suitable for the HaH, and which should go to the hospital.
2. Distribute risks by deciding which of the two providers will be responsible for patient safety within the HaH system. Additionally, we need to think of a system measuring patient safety and the risks involved.
3. Decide who gets the incentive from the Ministry of Health – the HMO’s or hospitals. HMO’s are interested in providing services at home and within the community. Hospitals, on the other hand, see the HaH as a new service that involves new technologies.
4. Encourage the provider responsible for HaH to develop training programs for caregivers at home.

FURTHER RESEARCH

Further research can focus on comparing the effectiveness of hospital-at-home and caregiver burden, as well as on effective new medical technologies that can change healthcare delivery in Israel and the European Union. We hope to design a pan-European comparative research and development project of HaH and homecare within the Horizon Europe framework.

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