The Past, Present, and Future of House Calls

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• House calls • Home visits • Home-based medical care

ORIGIN OF HOUSE CALLS

The classic image of a doctor up through the mid-20th century was that of a community physician, black bag in hand, traveling to a patient's home where he would provide care. Physician house calls were once the primary mode of health care delivery in the United States and Europe. Before World War II, every tool a physician had available to diagnose and treat a patient could be packed into the black bag. The practice of house calls was prevalent in this earlier era before most individuals lived in compact cities. Physicians were more likely than patients to have access to means of transportation, whether horse or automobile, making health care most efficiently delivered in the home by the traveling doctor.

EVOLUTION OVER TIME

During the 20th century, dramatic changes in health care affected the way health care was delivered. House calls dropped from 40% of physician encounters in 1930 to 10% by 1950 and less than 1% by 1980.[1,2] As the number of physicians making house calls fell, the nature of house calls also changed. Through the early 20th century, house calls were the primary mode of medical care. However, as technology, physician specialization, and payment systems changed, primary care moved into clinics, and house calls largely became a relic of the past. Primary care physicians focused on office encounters and rarely made home visits, generally doing so only to visit a long-term patient who had become too frail or homebound to come to the office.

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By the turn of the 21st century, physicians were divided into those who never or rarely made house calls and the few who continued to make regular house calls. In 2001, less than 18% of US physicians made house calls. Those physicians who did make house calls averaged 5 house calls per week.[3] The small cadre of physicians who have made house calls a major focus is so small that they are not well represented in these statistics. In contrast, most primary care physicians in Europe and Canada continue to make substantial numbers of house calls as a routine aspect of home and community-based care. Physicians in England make 10 times the number of house calls per 1,000 patients per year compared with US physicians and 100 times as many to persons older than 85 years.[4,5]

With the growing availability of medical and transportation technology, medical care became housed in medical institutions. Diagnostic and therapeutic technology required increasing space and maintenance, and specialization of practitioners was such that medical care came to be based in hospitals and clinics. Car ownership also became commonplace, and public transportation systems sprang up in urban centers enabling patients to visit physicians more easily. Physicians' specialization and subspecialization in medicine have also been greatly influenced by hospital-based diagnostic and therapeutic advances in technology.[6,7] The exceptions to this trend are geriatrics and palliative care. While many palliative care services remain hospital-based, the growth of home hospice programs supported by the Medicare hospice benefit has allowed many individuals to receive end-of-life care in their home. Likewise, geriatric specialists, by nature of caring for frail elders, have kept attention on access to care for homebound elders.

The economics of medical care has also influenced the decline of house calls. The growth of managed care and overhead burden created increasing pressure for "productivity" and forced primary care physicians to provide care as efficiently as possible—generally meaning abandoning house calls and exclusively practicing in clinics, pushing daily patient encounter volumes to the highest safe level to offset their overhead. Although there has been very little litigation in home care, concerns over medical liability also contributed to the shift of care from home to hospitals and clinics.[8] As more advanced technology was used for diagnosis and treatment of illness, physicians and patients alike came to expect high-technology medicine.[9] With this expectation was the association of "good medicine" with hospitals and clinics.[10] House calls became "old fashioned."

Physicians who do make house calls are now almost exclusively practicing in a primary care field providing comprehensive care. A survey of Virginia Medicaid providers found that physicians who make routine house calls to patients (compared with those who never or only emergently made house calls) were more likely to be family physicians than internists. Physicians who make house calls were more likely to use and collaborate with home health agencies. These physicians were also significantly more likely to consider the following as indications for home visits: chronic disease management, acute illness, end-of-life care, death pronouncement, difficulty transporting patient, and personal satisfaction from home visits.[11] Physicians often cite terminal care as a reason for making house calls.[11]

During this shift in primary care from home to office, the availability of Medicare-supported home health agencies has been vital. The growth of home health care agencies, discussed in an article by Murkofsky and colleagues, elsewhere in this issue, has helped improve health outcomes of homebound individuals. In the 1990s, skilled home health care was the fastest growing component of the Medicare budget.[12] Yet, while home health agency care has enabled homebound patients to live at home and recover there from serious illness, historically, there has been