Clinician's Commentary on Mohammed et al.¹

Mohammed and colleagues¹ highlight an issue that is vital to the health and well-being of Ontarians: the lack of access to publicly funded community-based physiotherapy services. Their article describes the decision-making processes that underpin the use of physiotherapy services in home care, based on key informant interviews the authors conducted with case managers and directors from four home-care regions in Ontario. The data presented in the article make clear that many of the most important decisions about eligibility for in-home physiotherapy have already been made long before the home-care decision makers even begin their decision-making process. The health care policies that govern home-care services in Ontario make many people ineligible for in-home physiotherapy services: anyone capable of getting out of their home to attend outpatient physiotherapy is not eligible for publicly funded in-home physiotherapy services, which immediately eliminates a large number of people who could benefit from such services.

This policy is based on the false assumption that those who are not eligible for publicly funded in-home physiotherapy can actually find and readily access outpatient physiotherapy services. In fact, we know that there are very few publicly funded options for physiotherapy in the community and that these options grow fewer every year as more and more hospitals close their outpatient physiotherapy departments to address budget constraints. There are fewer than 90 Designated Physiotherapy Clinics in Ontario, and they are disproportionately located in larger urban settings in the south of the province.² New provincial initiatives to enhance primary health care do not include physiotherapy services.³ Further, even for those who have publicly funded options for physiotherapy services in their community, inevitably the wait lists for services are a major obstacle to receiving timely physiotherapy care; moreover, the available outpatient clinics tend to focus on short-term acute musculoskeletal conditions, not on patients with long-term chronic conditions.⁴

Those eligible for home-care physiotherapy services frequently have complex medical and social care needs, and it is often the functional performance issues they confront that make their care needs so complicated. Yet the home-care decision makers whom Mohammed and colleagues interviewed report that even those who do qualify to receive in-home physiotherapy services are limited to two assessment visits and two treatment visits, with the vague possibility of perhaps receiving another two or three sessions; once they are "safe in the home," physiotherapy services are withdrawn.¹ The unintended consequence of this policy is that people with chronic illness and disability are warehoused in their homes, receiving care primarily from informal caregivers such as family and friends. Ironically, the reduction in physiotherapy home-care services over time has been attributed to the implementation of "managed competition," an Ontario provincial policy intended to reduce health costs through competitive market forces that has actually led to increased per-visit physiotherapy costs and thus to a substantial decrease in the number of visits any one client can receive and to fewer clients being assessed as needing physiotherapy services.⁵

The main factor in determining what physiotherapy home-care services a person receives is cost containment, not need.

Although we may think of home care as providing services to maintain people in their homes and the community, the focus is actually on medical necessities rather than rehabilitation. Shortened lengths of stay in acute care mean that home-care services are now being called on to address the needs of more acutely ill people who have been discharged home from hospital "quicker and sicker."⁵ The drive to discharge patients more quickly from acute care to decrease health care costs has not been matched by the promised reinvestment of these savings into home care and community-based services. As a result, there are more people in the community requiring services but no concomitant increase in service capacity; the costs of caring for these people have simply been shifted from the public sector to families, who are increasingly expected to fill the gaps in care that cannot be provided by home-care services.

How could this happen in a country that prides itself on its universal health care? The answer is that our universal health care is really universal hospital and physician care, not health care. The Canada Health Act stipulates that medically necessary services are comprehensively covered, but only when those services are provided in hospitals or by physicians.⁶ So if you are in hospital, your access to "health services" such as physiotherapy is ensured by the Canada Health Act; as soon as you are outside the hospital setting, however, your eligibility to receive publicly funded physiotherapy services falls under the jurisdiction of the provincial government, which decides what home and community-based services are publicly funded. The provinces are mandated only to provide publicly funded physician services in the community. In tough economic times, therefore, community-based non-physician services are an easy target as provinces look for ways to contain costs. This is a huge challenge for our profession. On the one hand, in Ontario we have recently gained important changes to our legislated scope of practice; on the other hand, these advances are balanced by the continuing erosion of access to publicly funded home- and community-based physiotherapy services for Ontarians. This insight, in my opinion, is the major contribution of Mohammed and colleagues' study.

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