Original Article

ASSESSMENT OF MEDICAL HOME CARE NEEDS IN TURKISH POPULATION

Saime Sahinoz[1], Turgut Sahinoz[2], Hasan Huseyin Eker[3], Suleyman Ersin Unlu[4]

ABSTRACT

Objective: To determine the home healthcare needs of the elderly so as to develop proper home Healthcare Services.

Methodology: This descriptive study was carried out in a county of Kocaeli province-Turkey. Data was collected through a specially designed questionnaire through face to face interview technique. The data were analyzed by the computer using the SPSS package program. Chi-square test was used for the statistical analysis.

Results: This study showed that 14.6% of the population had at least one diagnosed disease. Among them, 1.8% was disabled, 4.1% was elderly and 1.1% of the households were in need of home care services.

Conclusions: Home care needs were found to be low in this study. Its main cause was that elderly population was not aware of the availability of such a service in the country.

KEY WORDS: Home Care, Needs Assessment, Turkey.

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1. Saime Sahinoz,
2. Turgut Sahinoz,
3. Hasan Huseyin Eker,
4. Suleyman Ersin Unlu,
Specialist Dr., MD, Family Medicine Specialist,
Ministry of Health,
General Directorate of Primary Health Care,
Turkey.

1-3: Assist. Prof. Dr., MD,
Public Health Specialist, Department of Nursing,
Health College, Gumushane University, Turkey.

Correspondence

Sahinoz Saime,
Assist. Prof. Dr., MD,
Public Health Specialist,
Department of Nursing, Health College,
Gumushane University,
Gumushane, 29100,
TURKEY.
E-mail: drsahinoz@gmail.com

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INTRODUCTION

The increase of elderly population and chronic illnesses necessitate home care.[1] There is need for increased professional help to meet the fundemental health care of elderly population members. Home care provides the individual a more free life in the home mileu. In addition, home care can be provided for 24 hours and at the weekends also.

Specific plans can be developed to meet the specific needs of patients. Hospitalization always carries the risk of getting infectious diseases. Due to this risk, costs of home care may be more economical and convenient compared to hospitalization costs. Furthermore, home care services provide the opportunity for many treatment and monitoring of diseases like diabetes, asthma and cardiac problems.[2] In a randomized clinical experiment in two hospitals in Philadelphia, Naylor et al. determined that when a

patient is discharged and subjected to home care; re-admission to hospital as well as the cost of health care decreased.[3] This sector is growing in USA and the number of patients receiving home care is rapidly increasing. The provision of high tecnology care like intravenous infusion treatment, parental nutrition and home dialysis is compulsory in USA.[4]

There is not a well organized home care system in our country yet. There are provisions for providing diagnosis and treatment of infectious diseases at home, medical examination, and mother child monitoring in Law Number 1953. Socialization Law No. 224 which became effective in 1961 and the Directive 154 has given the responsibility of monitoring of the individuals with chronic diseases to community health nurses.[5-8]

In the Home Care Regulation promolgated by the Ministry of Health in 2005, the home care services were defined as "submitting health and care and follow-up services so that, they can fullfill the medical needs including rehabilitation, psysiotherapy and psychology treatment" of the patients. The objective of this study was to determine the home healthcare needs of the elderly population.

METHODOLOGY

This research is descriptive. It was carried out in a county of Kocaeli province-Turkey. Demographic data and other information (including residence, phone contact, socio economic status, gender, age, social security, health status and state of disability) was collected through a specially designed questionnaire. It was subjected to a pre-test and based on the feed back, necessary amendments were made in the questionnaire. The interviews were conducted by the graduates of the university who were earlier trained to conduct these interviews.

The interviewers were chosen from amongst the university graduates and theoretical and practical education was given to the interviewers about the questionnaire.

This study was conducted between February 15 and March 15 2005 by ten interviewers who visited each house and through face to face interviewing technique filled the questionnaire and recorded all the data onto the computers. When there was no one in the house, the house was re-visited on three different times. One of these visits was at the week-end. The data was analyzed by the SPSS package program and chi-square test was used for statistical evaluations.

RESULTS

Within the scope of this research, data from 25 211 individuals living in 7 217 houses was obtained. Fifty one percent of the 25,211 individuals were men (12, 852) and 49.0% (12, 359) were women. It was found out that in the study region the community's 14.6% had at least one disease, 1.8% were disabled, 1.1% were infants and 4.1% were elderly above the age of sixty five years.

The economic status of the majority of the families (82.1%) showed that they had moderate income. One percent of the families defined themselves as very poor and 10.1% as poor. Two percent of the families defined themselves as rich while only three families said they were very rich. Minimum wage in Turkey is about 330 US dollars. We used minimum wage as the base to classify the economic status of the families. If a family's average total monthly income was less than 330 US dollars it was classified as very poor. If average total monthly income was between US$ 330-660 we classified that family as poor. Families with total monthly income between US$661-1330 were classified as moderate. However, if the family average total monthly income was between US$ 1331-3300 it was classified as rich and families with monthly total income of more than that were classified as very rich.

When we investigated the social security status of individuals included in the study, we found that 51.0% were members of Social Security Institution, 26.5% were members of Retirement Fund, 5.7% had Occupational Pension Fund, 1.4% had Green Card, 1.3% had Private Security, 0.3% had other security programs and 13.8% had no social security at all. The most common disease was hypertension, 5.4%, diabetes and other cardio-vascular system diseases follow this by 2.4% and 2.2% respectively (Table-I).

Table-I: The distribution of diagnosed patients according to the diseases and gender

	Gender							
	Men		*Women*		*Total*			
Diseases	No.	%	No.	%	No.	%	x^2	p
Hypertension	496	3.9	858	6.9	1354	5.4	118.1	0.001
Diabetes Mellitus	258	2.0	338	2.7	596	2.4	14.5	0.001
Cardio-vascular system diseases	274	2.1	287	2.3	561	2.2	1.1	0.300
Rheumatic diseases	880.7	254	2.1	342	1.4	88.6	0.001	
Respiratory system diseases	234	1.8	231	1.9	465	1.8	0.1	0.760
Neurological diseases	990.8	175	1.4	274	1.1	24.5	0.001	
Uro-genital system diseases	110	0.9	155	1.3	265	1.1	9.7	0.001
Eye diseases	890.7	115	0.9	204	0.8	4.5	0.034	
Digestive system diseases	131	1.0	162	1.3	293	1.2	4.7	0.030
Cancers	400.3	33	0.3	73	0.3	0.4	0.516	
Psychological diseases	360.3	56	0.5	92	0.4	5.2	0.022	
Infectious diseases	260.2	14	0.1	40	0.2	3.1	0.076	
Diarrhoeal diseases	150.1	12	0.1	27	0.1	0.2	0.636	
Other	154	1.2	257	2.1	411	1.6	31.1	0.001
Existence of at least one chronic disease	1614	12.6	2026	16.4	3640	14.5	75.6	0.001

Other diseases prevalent in the study population included hypertension, diabetes, rheumatic diseases, neurological diseases, uro-genital diseases, eye diseases, digestive system diseases, psychological diseases etc. There was a statistically significant difference about the existence of at least one chronic disease and these diseases were significantly high in women (Table-I).

About 5.3% of the houses surveyed in this study declared that they had additional need for money, 4.4% needed food, 3.2% needed drug therapy; whereas, those who declared that they needed home care was only 1.1% (Table-II).

It was also observed that there was a significant relationship between the economic status of the families and the request of home care. In the very poor (9.3%) and poor (1.8%) families home care requests were significantly high. When these two groups were evaluated together, the request for home care was approximately 4.0% (Table-III).

Table-II: The needs of the individuals within the scope of the research that are not provided.

Needs	*No.*	*%*
Home care service	77	1.1
Food	320	4.4
Drug-Therapy	229	3.2
Cash	379	5.3
Shelter	20	0.3
Circumcision	17	0.2
Others	433	6.0
Total	1475	20.4

According to the family types a significant relation was determined for the request of home care (x^2= 15.6; p=0.001). The ratio of home care request was 1.0% (60 families) in the nuclear family, 3.0% (12 families) in large families and 1.0% (3 families) in broken families.

No significant relationship was established between the types of houses where the families live and violence within the family and the request for home care. (Respectively x^2= 5.8; p=0.32, x^2= 0.24; p=0.63).

DISCUSSION

Our study showed that 1.8% of the population was disabled as compared to the earlier Turkish Disabled Research study done in 2002 which had shown the prevalence of disabled population of 2.58%.[9] The majority of the population (51.0%) were members of Social Security Institution, while 13.8% of the population had no any social security at all.

Table-III: The home care demands of the families according to their economic status.

	Need		*Do not need*		*Total*	
Economic state	*No.*	*%*	*No.*	*%*	*No.*	*%*
Very poor	7	9.3	68	90.7	75	1.0
Poor	13	1.8	713	98.2	726	10.1
Medium	47	0.8	5875	99.2	5 922	82.1
Rich	0	0.0	142	100.0	142	2.0
Very rich	0	0.0	3	100.0	3	0.0

x^2= 69.3 p=0.0001

As regards the prevalence of diseases the study population was suffering from hypertension, diabetes, rheumatic diseases, neurological diseases, urea-genital diseases, eye diseases, digestive system diseases and psychological diseases. Most of them had at least one chronic disease. We also observed that these diseases were significantly high in women.

Naturally, as the elderly population increases in the community, burden of chronic diseases also increases. In the year 2000, 59% of the global deaths were due to chronic diseases.[1] Campen and Woittiez from Holland have reported that individuals who were elderly and having chronic diseases preferred home care as it was much more convenient.[10] In many countries like USA, Canada, England, Germany, France, Holland, Belgium, Luxembourg, Spain, Portugal, Denmark, Ireland, Italy, Greece, Japan, Saudi Arabia, Indonesia and Taiwan have now started home care services.[11]

Private firms were established in order to respond to the need of home care services in our country. But, as the finance of these firms' services are not within the current official security system, majority of the community cannot benefit from these services. Only those individuals who have taken home care insurance policy can avail the services of these private security firms. However the duration of service provided by the private social security firms generally cannot exceed two months.

The services of private home care institutions are limited to nursing services until to-day. After the legal regulations, private home care institutions having multi-disciplinary teams have been established. In the official Gazette notification No. 25751 dated March 10th 2005 the regulation of providing home care services were promulgated. Law No. 5378 about disabled and the amendment of some Laws and Decrees which were promulgated on July 1st 2005 it was recommended that the care of the disabled should be directed to home care as much as possible.[5] But study by Izgi et al. showed that "the directive of presenting home care services" was only focused on therapy services while preventive services were not taken into consideration.[12]

The fact that only 1.1% of the population surveyed requested for home care is an indicator that availability of such a service is not known very well known in the community. Among people above the age of sixty five years and elderly the ratios of diagnosed diabetes was 2.4%, hypertension 5.4% and the other cardio-vascular diseases 2.2%. Majority of these patients' are expected to request for home care services.

We also observed that there was a relationship between the economic status of the families and the request of home care. In the very poor (9.3%) and the poor (1.8%) families that requested home care was significantly high. When these two groups were considered together, the request of home care was 4%. The reason for the low level of this ratio can be partially explained by the existence of small number of very rich families. The main reason may be that home care services could be provided free of charge by the Municipalities.

CONCLUSIONS

Although the need for home care was found low in our study, its' main reason is that availability of home care services are not sufficiently known. This study also showed that policies extending home care services are needed. Moreover to educate the public services of print and electronic media can be utilized for creating awareness about the availability of home care services.

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