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Editorial

Home Health Services in Turkey: A Case Study based on Patient Survey of Home Health Services Users in the Province of Ankara

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Abstract: With the aging of the population, it is important to develop alternative models of providing medical as well as other support services related to psychological, social, economic, and legal needs of the elderly. Developing an effective and efficient home health system will be helpful in improving the quality of life of home health patients.

This study was conducted to understand the quality of home health services offered through the Ministry of Health (MoH) hospitals to the population in Ankara. Home health patients were randomly selected from the service users in eight MoH hospitals. Information was collected on socio-economic and demographic characteristics of patients and their satisfaction with the services received. Descriptive and multivariate analyses were carried out understand factors affecting patient satisfaction with home health services.

The results indicate that a significant proportion of home health service users are not elderly. Most of the users of the service belong to very low economic status. Average satisfaction score improves with age of the patient but declines with patient's economic status. Home health workers being skilled, being sensitive to the needs of the patients and not tired when they arrive for service provision, significantly improves reported satisfaction scores of patients. In general, satisfaction level with home health service is very high in the Ankara province
Home health service is a relatively new system in Turkey but the results indicate that the system is working well in general. The service, however, needs to be integrated with other social support mechanisms in place to improve quality of life of home health patients in a more effective manner.

Keywords: home healthcare services, patient satisfaction, health worker attributes, social services

Introduction

With the sustained improvements in medical knowledge and technology, global life expectancy at birth has reached 71 years in 2012 [Hsiao, 2000]. While the proportion of elderly (65 years and over) globally was 7.7% in 2013, this proportion will rise to 10.2% in 2023, 20.8% in 2050 and 27.7% in 2075. Three countries with the highest proportion of elderly in 2012 were Japan (with 24.4% of population), Germany (21.1%) and Italy (20.8%). Turkey's ranking in terms of proportion of population elderly was 91st in the world [Turkey Statistical Agency]. With declining fertility and increasing life expectancy, elderly population in Turkey will increase rapidly from about 7.5% of population now to about 10.2% in 2023, 20.8% in 2050 and 27.7% in 2075. Such a rapid increase in the number of elderly, from 5.7 million today to 19.5 million in 2050, will require significant amount of investments in health and social welfare of the elderly population [Turkey Statistical Agency]. Given the rapid increase in the number of elderly, addressing the needs of the elderly has become urgent.

The aging of the population is affecting not only the health system of the country but also the social and economic organizations like the social security system, family structure, economic activities, transportation systems, etc. Rapid increase in elderly is increasing the dependency ratio. With the changes in family structure, specifically the decline in traditional family units and extended families, it has become important to organize institutional mechanisms for taking care of the elderly. The reduction in the proportion of population living in extended and nuclear families (with two adults and children) implies that many elderly find themselves without any family support in both rural and urban areas. However, not much is known about the social and economic situations of elderly in Turkey, their needs in the community and mechanisms for delivering effective, efficient and timely medical and health care services for them. Most of the research studies on elderly focus on clinical aspects of care. Yet the concept of aging must be analyzed and viewed in a broader perspective. This study is an attempt to provide some information on home health in Turkey and the satisfaction levels of home health users.

To estimate the future need for long-term care, it is important to look beyond the increase in the number of elderly alone. The estimate of need should consider the following three aspects: (a) increased need for care due to increasing number of elderly population in the country

keeping the age-distribution of elderly constant, (b) increased need of care due to "aging" of the elderly, i.e., increasing average age of elderly population, and (c) changes in family structure that reduces the number of families able to take care of elderly at home. Since all these three components are working together to increase the need for care for the elderly, the demand for long term care is likely to increase at a much faster rate than the rate of growth of elderly population. In fact, the need for long-term care for non-elderly is also increasing making it critical to plan the long-term care needs of the population in general [Ülker et al, 1995; WHO, 1999; WHO, 2000a; WHO, 2000b]

Providing care by household members is another possible low-cost approach of delivering long-term care. In reality, this approach may imply provision of care in the households by women, who often have limited access to information and other resources needed to become effective caregivers. However, well-managed and supported home care systems can be very effective in improving quality of life of patients of any age. Well-designed and supported home care programs also improve satisfaction and quality of life of caregivers [WHO, 1999; WHO, 2000a; WHO, 2000b].

Home care services are referred to by different names in different countries of the world. The terms used ranges from home visit based healthcare services and home care to home health care, hospital at home, home hospitalization, medical home, hospital without walls, etc. [Bentur, 2001; Çoban, 2003]. In Turkey, home care is called *evde sağlık hizmeti* – which can roughly be translated as "home health services". The reason why we use the term "home health service" instead of homecare is the content of service only to give health services patient, cannot access hospital, not to care patient in their home.

History of Long Term Care in Turkey and the World

Institutionalized home care services started as a religious service for poor patients towards the end of the 18th century. In 1796, Boston Dispensary was established as the first home care institution in the US general [Benjamin, 1997]. The advent of 19th century saw high prevalence of infectious diseases and high number of deaths associated with the diseases, often triggered by population migration and rapid urbanization, especially in Europe and North America. Home care provided by trained nurses and providing health education

messages to families became some of the significant initiatives of the era. Preventing infant and maternal deaths also became an important objective of health programs and nurses visited homes of expectant mothers to provide information on prenatal, natal and postnatal care. In 1898 the Los Angeles Health Department started to hire professional nurses to visit poor patients at their homes. This constituted the foundation of state sponsored and organized home care services in the USA [Aydın, 2005]. The majority of the population sought medical help from nurses and during this period, many qualified and unqualified nurses, as well as visiting nurses, offered 24/7 home care services for acute and chronic conditions [Stanhope, 1996].

The years 1955 to 1964 may be considered as the birth of modern home health care. Higher prevalence of chronic diseases, rapid increase in the number of older people, and increasing cost of hospital care encouraged rethinking of home care as a low-cost alternative for providing longer-term care services. Home care system during this period took three different forms: hospital based home care, social based home care and home services [Karahan and Güven, 2002].

In the USA, National Home Care Association was established in 1982. The mission of the association is to improve quality of services provided through home care and hospice care, to protect the rights of care givers, to effectively represent all care givers in home care and hospices and to establish a central role for home care in the health care system. Since the association determined that only 18% of the population is aware of home care services, it adopted a campaign to inform the public about the availability of home care services. By 1992, almost 90% of the population became aware of the existence of home care services. Due to the wider knowledge and availability of services, only about nine percent of patients discharged from hospitals received home care services in 1981 but it reached 38% in 1985 [3,14-15]. Annex table 1 lists some of the important timelines in the USA in the development of home care services.

Annex Table 1: Historical Development of Home Care Services in the USA

1813 In South Carolina, the first women's organization named Benevolent Society was established in order to care for poor patients.
1832 Philadelphia Nursing Organization offers home care for the poor.
1877 New York City Church sends trained nurses to the homes of poor patients.
1898 The first municipal home care nurse is hired in order to serve poor patients.
1901 Total of 58 institutions offer public healthcare services with 130 nurses.
1909 The first professional journal, Visiting Nurse Quarterly, starts to be printed monthly.
1909 Metropolitan Life insurance company offers home care service to its policyholders for the first time.
1916 1922 public health institutions are serving with 5150 nurses.
1921 Government recognizes prenatal and newborn home.
1935 Formal home care services by healthcare department start with state financing.
1947 First organized home care program starts at Montefiore Hospital (New York).
1950 Number of public health nurses reach 25100.
1953 Life insurance policies exclude home care by nurses.
1960 Free home care for the elderly is approved by the government.
1966 Medicare and Medicaid recognize and offer home care services.
1982 National Home Care Organization is established.
1983 The state launches the new payment plan that reduces the duration of hospital stays.
1993 World home and rest home care organization is established.

In Germany, the cost of home care services is covered by contracts between the state, municipalities, NGO's and health insurance companies. Insurance agencies try to prevent patients from needing long-term care by prioritizing preventative treatments such as early diagnosis and medical rehabilitation. Care specialists visit people in their homes and inform them about the risk factors they face and how to mitigate the risks [Aksoy, 2011].

In the Netherlands, social care services are provided by health and health care companies, NGO's and freelance care givers chosen and supervised by the Ministry of Health. Palliative care is completely free. The cost of curative treatment is mostly paid by the disease funds and private insurance policies. Another form of long-term care service is the customer based home care service. Once the conditions are met, the insurance policy pays a specific amount to the patient and the patient chooses the service provider [Brodksy et al., 2010].

Scandinavian Countries have the highest proportion of elderly in Europe. In these countries, long-term care costs are mostly covered by state funding. The care for the elderly and disabled are offered at home, if possible. If the patient needs care in a rehabilitation center, the state pays most of the costs and the patient pays only a very small amount as copayment [Aksoy, 2011].

In Spain, approximately 14 million individuals receive home care services while in England about a sixth of elderly receive long-term care services. In Japan most of the older population are cared for by their family members. According to Jakopzode (2000), the proportion of elderly receiving home care services was 17% in Canada, 16% in the US, 11.7% in Australia, 11.2% in Sweden, 9.6% in Germany, 6.1% in France and 5% in Japan. In addition to these countries, Belgium, Luxemburg, Portugal, Denmark, Ireland, Italy, Greece, Indonesia, Taiwan and Saudi Arabia have established home care services [Özer and Santas, 2012].

Although the concept and practice of home care is not new, it was introduced in Turkey only recently. Home care has been mentioned by the Public Sanitation Law of 1930 and the Socialization Law of 1961 of Turkey but implementation of home care similar to the type introduced in developed western countries began only in 2005 with the adoption of "Healthcare Transformation Program". In 2005, Home Care Service Delivery Decree was published in the Official Gazette dated 10/03/2005. The decree regulates healthcare institutions that aim to provide home care services as one of their independent business activity or as an activity of a medical center, specialized center, polyclinic or private hospital. With the changes made to Disability Law and Other Statutory Decrees published on 01/07/2005, disability care is suggested to be carried out at home as much as possible. The state covers the cost of home care for disabilities that meet certain conditions.

The aim of the Directive on the Procedures and Principles of Home Healthcare Services of the Ministry of Health, published in 2010, is to provide examination, testing, treatment, and medical care and rehabilitation services at home within the family atmosphere and to provide social and psychological support for the patients and their family members as a whole. In this framework, home healthcare services are offered by educational and research hospitals, home healthcare service units within general or specialized hospitals, social health centers, family health centers and family doctors. The management of the service, communications and cooperation among units is provided by a coordination center established within the directorate and a healthcare associate director assigned by the director runs the coordination center.

In 2010 home healthcare services were offered in 7 provinces of Turkey and a total of 156,079 patients were reached and 99,027 patients were receiving home healthcare services in 81 provinces by 2012 (Ministry Of Health Turkey Public Hospitals Authority, 2012). The responsibility of the home healthcare service unit is not to diagnose but to conduct examination, testing, treatment, and medical care and rehabilitation services according to the diagnosis made by relevant specialist doctors. Home health service providers also provide medicines, assist in reporting the use of medical instruments and materials, inform patients and family members about their responsibilities in the home care process, and provide training and consultation on proper use of relevant medical instruments and equipment at home. Moreover, consultations are provided as needed with the assistants of specialists and/or trained nurses.

Patients or their family members can apply for home health services by completing the Home health Service Application Form, by calling the coordination center or relevant units within health care institutions or via family health centers or family doctors. All the applications are evaluated by home visits as soon as possible. If the patient is eligible for home health services, the patient is officially registered as a home health patient and starts receiving the services immediately.

In the province of Ankara, the Home Healthcare Service Coordination Center was established on August 16, 2011. Home Healthcare Services Coordination Center is the unit where the applications for home health services are received and registered. The center also acts as the communication and coordination agency between Home health Units, Health Group Directorates, Social Health Centers and Family Doctors. A Home Health Service Mobile Unit and mobile units in all Social Health Centers have also been established. Home Health Service Units have now been established in 18 States and in 15 educational and research Hospitals. The provincial organization of Home Health Services is shown in Figure 1.

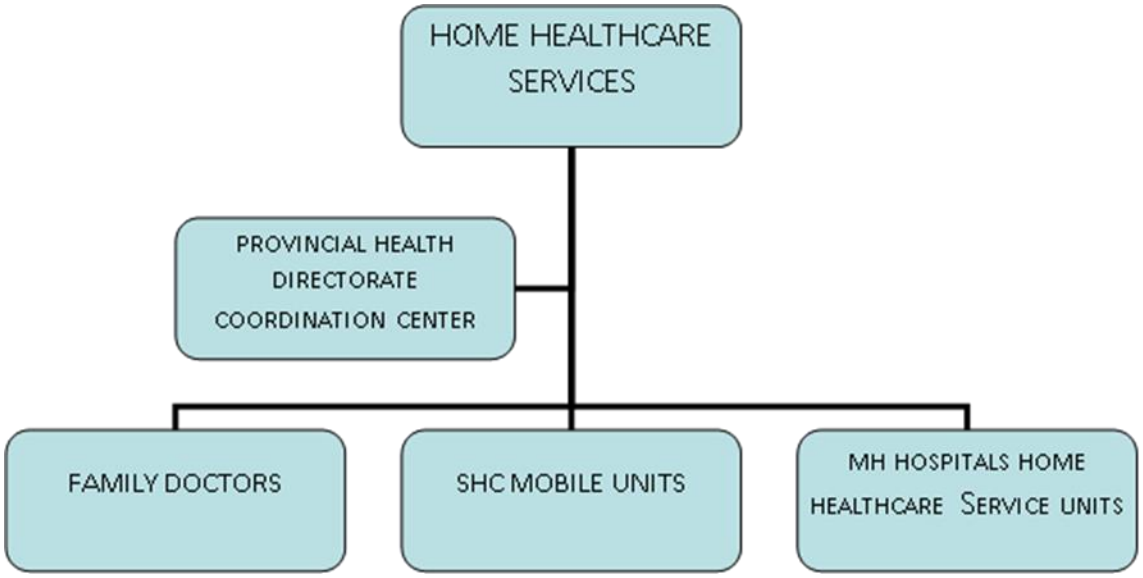

Figure 1: Organizational Structure of Home Health Service delivery at the Provincial Level in Turkey

The best way to explain the need for home care services is to point out the numerous advantages of home-based care. Although not recognized universally, effective provision of home care requires well-designed organization, trained personnel and financial resources. Effective home health service generates a number of significant advantages for the society and the health system [Akdemir, 2001; Çoban, 2003; Karamercan 2001; Spratt, 1997]. In general, the advantages of home health services can be listed as follows:

- Home care offers an alternative to institutional care and it allows the patients to live independently with considerable decision-making power on treatment choices. In

home health care, patient preferences are given priority and patients' own rules are valued.

- Home care service is more appealing to patients as they continue living in an environment known to them and in presence of family members and other people familiar to them.
- The fact that the patient is at home and participating in family life improves quality of living which often helps to improve recovery time, especially from short-term acute episodes.
- Since food is prepared specially for the patient at home, "hospital food" related complaints are not there in home care.
- Patients maintain their own identity better in the home setting rather than in a hospital or nursing home setting.
- While there is always infection risks associated with hospital stays, infection chances may be lower in home care.
- Long-term care is easier to carry out at home.
- Patients receive better psychological support at home.
- Home care costs are much lower than the alternatives, especially when compared to long term or short-term hospital stays.
- Services provided at home have become easier to manage with the advent of modern technology. Medical instruments are relatively easy to use and virtually any member of the family can be trained quickly on the proper use of the instruments and equipment.
- Home care services are potentially more reliable than hospital services as family members are more likely to be careful and sympathetic to the needs of the patient. This also makes the patient less prone to abuse and malpractice.
- Home care services reduce stress for the patient and the family members.
- Home care can be the only mechanism of providing healthcare services to some specific groups of people.
- Home care services improve accessibility to preventative healthcare.

Methodology

Objective of the Study

Since the home health service coordination center is relatively new in the province of Ankara, this study was designed to better understand the delivery of home health services and quality of service provision from the perspective of patients. This study collected information on various aspects of home service provision, quality of care and satisfaction by interviewing the users of home health services.

Population and Sample

The population includes persons receiving home health services in the central counties of Ankara province. The population consists of 9,757 persons (Ankara Home Healthcare Coordination Unit Data, April, 2012). A sample was drawn randomly from the home health service receivers who received services from eight hospitals located in the central counties of Ankara province. In this study, the aim is to reach whole universe therefore choosing the sample has not been preferred. However, to evaluate satisfaction rate accurately the survey has not been applied for the people who taken health services only one or two times. Moreover, the surveys applied based on voluntariness. We did not reach some people in their adresss. Table 1 reports the sample size for each of the hospitals. The sample size for the study was 265. The medical records of the patients were accessed in the hospitals through the Ankara Provincial Health care Directorate, Home health Coordination Center. The sample represents about 3% of the population and the sample size should be able to provide estimates of various parameters with 95% confidence level and +/- 6 confidence intervals.

Table 1: Number of Patients Surveyed by hospital providing home services in the Province of Ankara

Hospital Name	Territory	Number of Patients in the Sample	
		n	%
Numune Educational and Research Hospital	CANKAYA	81	31
Ankara Educational and Research Hospital	MAMAK	91	34
Dışkapı Yıldırım Beyazıt Educational and Research	ALTINDAG	20	8

Hospital			
Kecioren Educational and Research Hospital	KECİOREN	17	6
Ankara Ataturk Pulmonology and Pulmonary Surgery Educational and Research Hospital	KECİOREN	8	3
Ankara Abdurahman Yurtarslan Oncology Educational and Research Hospital	DEMETEVLER	11	4
Yenimahalle State Hospital	BATİKENT	19	7
Sincan State Hospital	SINCAN	18	7

Data Collection and Analysis Method

The data were collected using a structured questionnaire. This study has used the questionnaire developed by York University National Statistics (ONS) and Social Policy Research Unit (SPRU) in 2003 for the United Kingdom Ministry of Health (Jones K. et al. 2007). The instrument was designed to collect information on various aspects of home health service delivery, quality of care, perceptions about services received and health worker-patient interactions. The questionnaire has three sections. First section is designed to collect information on demographic characteristics of patients, the second section collects information on the services received and the third section is about the caregiver team. The reliability analysis of the questionnaire was completed. Its reliability is alpha=0,638.

The questionnaires were completed via face to face and phone interviews. A pilot survey was designed and conducted with 30 people receiving home health services from the 8 hospitals selected for the survey. The pilot survey indicated that the questionnaire was appropriate for use in Turkey and the questions did not pose any significant problem for the interviewers or the interviewees. In the survey, 81% of the respondents were relatives of patients and many of the relatives are also the informal care givers. 14% of the respondents were the patients and the remaining 5% were formal caregivers of the patient.

Data analysis was conducted by using SPSS 18.0 (Statistical Package for Social Sciences) and STATA 13 statistical programs and both descriptive analyses and to determine the variables that change satisfaction rate of patients chi-square, a linear regression, t-statistics were used during analysis.

Restrictions of the Study

Restriction of the study is the fact that the residences of the participants are dispersed within the province of Ankara, and the study is contained in the central counties of Ankara province due to budget and time constraints. Therefore the results cannot be generalized to Turkey.

Satisfaction levels and patient opinion on service providers

Table 2 shows demographic and social situation of the home health patients by subdividing the sample into elderly and non-elderly. Given the age-groups of patients, the elderly group was defined by 61 years of age or older. In the sample of home health users, about a quarter belonged to the non-elderly age group, indicating the importance of non-elderly group in the home health market. Turkey has no age restrictions on the utilization of home health services. 57% of all home health users in the sample belonged to the age group 81 years or more and another 43% were in the age group 61 to 80 years. Among the non-elderly, 58% of patients were male while for the elderly only 35% were male. Among elderly home health service users, only 4% reported having no children but among non-elderly 42% did not have any children.

Table 2: Social and Demographic Characteristics of Home Health Patients in the Survey (Province of Ankara, Turkey), 2014

Socio demographics	Older age group (61 years or older)		Non-elderly group (less than 61 years)	
	N	%	N	%
Gender				
Female	129	65	28	42
Male	69	35	39	58
Total	***198***	***100***	***67***	***100***
Age Group				
Below 20			7	11
21-40			15	22
41-60			45	67
61-80	113	57		
Above 80	85	43		
Marital Status				
Married	126	64	35	52
Single	72	36	32	48
Number of Children				
None	8	4	28	42
1 to 2	46	23	25	37

3 to 5	110	56	12	18
6 and above	34	17	2	3
Educational status				
Illiterate	66	33	15	22
Primary- Secondary	106	54	33	49
High school or similar	16	8	12	18
Higher	10	5	7	10
Monthly household income				
200-599 TL*	22	11	9	13
600-1099 TL*	145	73	42	63
1100-3099 TL*	25	13	15	22
3100 TL* and higher	6	3	1	1

- In the survey the monthly income data has been collected as Turkish Lira. But the data has been converted the current dollar exchange rate for to address all readers.

In terms of income and education, high proportions of home health service users belong to relatively low-income and low-education categories. 82% of participants reported their monthly income to be less than USD 533, compared to median disposable monthly income of USD $425 for Turkey as a whole and USD 483 for urban areas of Turkey. 83% of the sample had no education or less than high-school education.

A majority of home health participants, 68%, have been in the program for less than one year and almost 90% are in the program for less than two years. 41% of participants reported that health care providers visited them within two days of initial application while for 41% of elderly and 37% of non-elderly the first visit was five or more days after the first application. Patients waiting for five days or more since the application for home health may be considered an important problem and the coordination unit of the province should identify the bottlenecks in lowering the time gap.

The average number of visits received by participants in a month varied from less than one visit to more than seven visits. Wide variability of number of visits is not unusual as the number of visits required depends on the severity of medical conditions and need for health professionals in addressing the health issues or concerns. 85% of patients received less than 3 visits by health care providers a month. Among the elderly, 15% received more than two visits in a month while for non-elderly it was 17%.

In the interviews, the respondents were asked about their general satisfaction levels with the home healthcare services. Table 3 reports the frequency distribution of satisfaction levels. The

majority of the participants (77%) indicated that they are generally satisfied with the home care service. This high ratio can be associated with low expectations while the fact that it is not higher can indicate that a certain number of teams are offering substandard service.

Table 3: Overall satisfaction levels of participants with home healthcare services received

Satisfaction levels	N	%
Extremely satisfied	48	18
Very satisfied	32	12
Pretty Satisfied	125	47
Neither satisfied nor unsatisfied	43	16
Pretty Unsatisfied	3	1
Very Unsatisfied	5	2
Not satisfied at all	9	4

The survey also asked patients or their caregivers a series of questions on different aspects or characteristics of service providers. Table 4 reports the responses. All these questions used degree of agreement or disagreement with the statements based on four-level Likert scale (without the "neutral" option). The mean scores, therefore, varies from 1 to 4 with 4 being the highest level of agreement. In table 4, the average values are all above 3.0 for different attributes and characteristics of service providers. One of the questions asks about a "negative" attribute (Team workers have less knowledge and skill than I would like) and if we convert the variable into a positive attribute variable, the mean value would have become less than 1, about 0.6. About 11% of patients mentioned that the service providers were sometimes or never on time or they did not know when the team was supposed to come. In case of changes in schedule, 21% of patients were not informed about the changes and another 19% indicated that they were informed some of the times.

Table 4: Mean and SD of scale values for various provider attributes and characteristics based on four-level Likert Scale (ignoring the neutral category)

Provider attributes	N	Mean	SD
Team workers are very understanding.	265	3.585	0.5377
Team workers are not tired	265	3.328	0.6920
Team workers are kind	265	3.630	0.4991
Team workers are sincere	265	3.721	0.5767
As far as I know, team workers keep my personal information confidential	265	3.328	0.7892
Team workers do not gossip with me about other patients	265	3.796	0.4480
Team workers are good at their job	265	3.109	0.6737
Team workers have less knowledge and skill than I would like	265	3.362	0.7262
Team workers are respectful	265	3.668	0.5532
Team workers are gentle	265	3.683	0.4976
Team workers are not careless	265	3.581	0.6352
Team workers are honest	265	3.604	0.5200

Does the provider attributes affect the overall patient satisfaction? To analyze the potential effects of provider attributes on satisfaction scores, a linear regression was estimated by incorporating all the attributes (level 4 for each) as the explanatory variables. A number of demographic and socioeconomic variables were also included in the model. The estimated model indicates gender of patient have no effect on overall satisfaction scores. Satisfaction scores increase by about 13 to 17 points for patients with children compared to the satisfaction score of patients without any children. Higher level of income reduces satisfaction scores – compared to the patients belonging to the lowest income category, the highest income group reported a satisfaction score 17.6 points lower.

All the 12 provider attributes were also included in the model but most show no statistically significant impact on overall satisfaction. Providers being very understanding or not being tired increase the satisfaction scores by about 8 to 9 points. The only other attribute that shows statistically significant impact on patient satisfaction is the perception that the

providers are skilled (strongly agree). Other provider characteristics like being kind, sincere, confident, not being careless or being honest had no statistically significant impact on patient reported satisfaction scores.

Table 5: Factors affecting overall patient satisfaction with home care services in Ankara, Turkey

Attributes and other demographic and social variables	Coefficient	SE	t-statistics	P> | t|
Health worker attributes (level 4 in four-level Likert scale)				
Health care provider is understanding	9.36	3.48	2.69	0.01
Health care worker not tired	8.28	3.75	2.21	0.03
Health care worker sincere	4.54	3.38	1.34	0.18
Health care worker confident	-5.09	3.23	-1.57	0.12
Health care worker gossip with me about other patients	-2.13	3.53	-0.60	0.55
Health care worker does a good job	1.67	3.09	0.54	0.59
Health care worker is skilled in his/her job	7.52	2.72	2.76	0.01
Health care worker is respectful	3.14	3.08	1.02	0.31
Health care worker is careless	-5.29	3.14	-1.69	0.09
Marital Status (Married as reference)				
Single	7.21	2.86	2.52	0.01
Number of children (no children as reference)				
1-2 Children	12.93	4.48	2.88	0.00
3-5 children	16.91	4.15	4.07	0.00
6 or more children	14.03	4.80	2.92	0.00
Income levels (income TL 500 or less as reference)				
TL 600-1000	-5.46	3.92	-1.39	0.16
TL 1100-2000	-7.93	5.01	-1.58	0.12
TL 2100-3000	-17.64	7.65	-2.31	0.02
Constant	46.45	6.53	7.12	0.00

N=265, F(16, 248)=5.09, R-square=0.25

Problems encountered or Patient Suggestions on improving home health services

The participants were asked if they had any suggestions about the home healthcare service. The suggestions provided by the patients are reported in Table 6. The suggestions are reported for elderly and non-elderly patients separately because it is possible that patient age may affect the home health needs and therefore the suggestions they have on the home health delivery.

About a third of elderly and 39% of non-elderly patients had no suggestions at all on how to improve home health services. 42% of both elderly and non-elderly patients had one suggestion while 25% of elderly and 19% of non-elderly had two suggestions. Among all the suggestions received, 19% of suggestions from the elderly and 21% from non-elderly was on provision of "more frequent and regular visits". The second most common suggestions from elderly and elderly was to request various "social" services. About 11% of suggestions from elderly patients was to provide transportation assistance to go to the hospital. Non-elderly patients also suggested "transportation assistance" but they were relatively more concerned about obtaining medical supplies and medical treatment and examination than the elderly patients.

Table 6- Suggestions about Home Healthcare elderly and nonelderly groups

	elderly		**non-elderly**	
Suggestions	N	%	N	%
More Frequent and Regular Visits	47	19	19	21
Assistance in Transportation to the Hospital	27	11	5	6
Supplying Medical Materials	25	10	8	9
Social Provisions	32	13	8	9
Medical Treatment and Examination	19	8	6	7
Visits by other Health Professionals and Specialist Doctors	21	9	5	6
Appointment System and Arrival on Time	11	4	3	3
No Suggestions	65	26	35	39
Total	247	100	89	100

The patients were also asked about the problems they faced in home health services. More than 90% of patients reported that they have not faced any problems in the delivery of

home health services. Those who reported some problems or concerns, the main concerns were about too few visits or no visits and the providers not being accessible by phone.

Conclusion

The survey of home health patients carried out in the Province of Ankara indicates that a significant proportion of home health users are not elderly – about a quarter of patients were below the age of 61 years. About 65% of elderly and 42% of non-elderly patients were female. Half of the non-elderly patients were found to be not married or single. Since the medical needs of elderly and non-elderly patients may vary significantly, policy-makers should carefully evaluate how to address the differential needs of elderly and non-elderly patients. Majority of home health service recipients are relatively poor – more than 80% had income less than $412 per month. In 2013, GDP per capita of Turkey was about $11,000, more than $900 per capita per month. Therefore, the users of home health services in Ankara province are from relatively disadvantaged population groups and provision of better quality of home health services will help improve equity in health service delivery in Turkey. It will also be interesting to explore the reasons for the relatively better-off in the society not to participate in the home health services. It is possible that the relatively better-off section of the population prefer to arrange their own home health services because of perceived low quality of the services offered by the Home health Service department. Another explanation could be that the richer segment of the population has significantly lower need for home health services because of their relatively better health status.

In general, the users of home health services reported that they are quite satisfied with the services received. More than 90% of the surveyed users mentioned that they did not face any problems at all with the home health services and most by more effective delivery of home health services. About 30% of home health service users in Ankara province were very satisfied or extremely satisfied with the services received. The satisfaction scores, however, decline with higher economic status of patients. This implies that many of the patients receiving home health services have low expectations about service quality because of their relatively lower socioeconomic status. Since most of the participants in the program are from low-income categories, the reason for high satisfaction rate with the service could be due to provision of medicine and medical supplies free of charge. In Turkey, supplying medicines to home health patients is a new policy and implementation of this policy may have improved

patient perception of quality of care, especially among the very poor segments of the population.

Since such a high proportion of home health service users (77% of all users) reported their general satisfaction with the services received, we can conclude that recently adopted home health program in Turkey has been quite successful in the provision of needed services to the participants. About 95% of patients reported their satisfaction with the treatment they received and most indicated their satisfaction with the skills and knowledge of home health workers. In general, patients reported their satisfaction with the home health workers. 97% reported that the home health workers arrive on time, 99% thought they are very kind can caring and more than 95% reported that the workers are caring, gentle, sincere, respectful and careful. Such positive opinions possibly reflect adoption of appropriate and effective organizational and management structure of home health delivery in Turkey, even though it is a relatively new service. In the survey area, the Ankara province, applications for home healthcare service are quite high due to high population density of the area. Despite this high level of new applications, home health department arranged the first visit to patients' homes usually within five days of application. This indicates high degree of responsiveness of the system to the needs of home health applicants. In addition, almost 100% of patients mentioned that the health care workers arrive in their houses on time, again indicating excellent administrative structure in place for the provision of services.

The results of the study suggests that home health services play a very important role in providing social and mental support to patients and depending upon the family situation of the patient, the system should identify alternative social support mechanisms in absence of children or other family support. Only a few health-worker related variables are found important in the model explaining the factors affecting satisfaction levels of patients. These variables are: health care workers are skilled in the work they do, they show concern and understanding of the needs of patients, and not tired. Therefore, from patient's point of view, they would like to see health care workers being sensitive to the needs of patients, and skilled in their profession or jobs.

Home health system has its own especial requirements for successful implementation of quality health care program. Often, home health requires significant hours beyond the usual working hours and dedicated efforts and patience of health care workers like the providers in

intensive care unit or emergency health care services. Home health workers not being tired when they show up for work is an important consideration and the system should identify strategies for fair work-load distribution. For ensure fair work-load distribution as well as to improve motivation and efficiency of home health service staff, the system may consider hiring health care providers assigned to home health services alone. It should allow specialization in home health needs and help standardize home healthcare services.

The suggestions patients have on how to improve the provision of quality home health should also be considered carefully. About 17% of the suggestions from patients are related to housing, heating, food, clothing, and social activity. Clearly, the needs of patients in home health is more than the medical care needs and unless these social aspects are improved, quality of life of patients may not improve significantly. The system should also consider on how to integrate other social support with the medical care delivery. In Turkey, medical care, social care and provision of daily necessities are given separately by various institutions like the ministries and their agencies; municipalities and associations. To improve home health system, it is important to improve coordination among these various agencies.

Home health services are predominantly provided by the service units created in various hospitals. Even though home health is currently designed as a mechanism of providing medical care, the role of family doctors in the system has remained very limited. From the experiences of other western European countries, it is clear that to ensure quality home care it is important to adopt a holistic approach of service provision by incorporating both preventative and therapeutical services. Therefore, the role of the family doctors in home health service should be clearly defined in order to improve efficiency and effectiveness of care provided through the home health system.

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