

Configuration of Palliative Care Clinics and Integration with Home Health Care Services: Current Practice in Turkey

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BACKGROUND/AIMS

The establishment of palliative care clinics (PCCs) and the integration between PCCs and home health care are important for both patient comfort and disease-related cost reduction. We aimed to analyze PCC distribution and structure of state hospitals along with human resources, and to evaluate the integration of PCCs with home health care services in Turkey.

MATERIAL and METHODS

Data of PCCs started between January 2015 and February 2017 were analyzed in this study with the help of data obtained from the Turkish Ministry of Health.

RESULTS

PCCs are available in 28.9% of state hospitals active in Turkey. Of the total 2957 staff working in PCCs, 77.6% are health care professionals, with 99% being doctors. Home health care service (HHCS) units are available in 76.3% of hospitals with PCCs. Service was offered to 48,953 patients in PCCs, 5.7% of whom were transferred to HHCS in an integrational manner.

CONCLUSION

Integration between PCCs and HHCS remains at an inadequate level. We believe that the benefits of integration should be observed by patients, relatives, and health personnel, thereby increasing awareness and accelerating integration. In addition, we believe that hospital information management systems can be used for this purpose and software programs can be developed to accelerate integration between these 2 units.

Keywords: Coordination, home health care, health professionals, integration, palliative care

INTRODUCTION

Palliative care is the comprehensive and integrated care of patients and their families who are facing problems related to life-threatening diseases. It used to be a care philosophy of approach organized and structured at a high level with multi-disciplinary health care providers (1). In palliative care units, symptom control is targetted rather than treating the primary disease to enhance the patient's quality of life. In addition to the symptom control of the primary disease, the physical, social, psychological, and moral requirements of the patients are focused

The need for palliative care has increased worldwide owing to prolonged life expectancies and an increasing aging population, as well as an increase in the frequency of noninfectious diseases and cancer. Approximately 40 million people need palliative care annually (2). According to estimations, worldwide, 377 of 100,000 individuals older than the age of 15 years and 63 100,000 individuals younger than 15 years will need palliative care at the end of their life (1). However, only 14% of the people worldwide in need of palliative care are able to obtain it (2).

In 2011, it was stated that advanced integration of palliative care services with the primary services was available in only 20 (8.5%) out of 234 countries. Only limited and isolated palliative care services are available in 75 countries (31.6%), and no palliative care services are available in 98 countries (42%) (3). In 2011, 136 (58%) out of 234 countries implemented palliative care services in 1 or more hospitals (1). To integrate evidence-based, cost effective, and equitable palliative care services to health services at every level, palliative care policies to support extensive consolidation of health systems have to be developed, empowered, and applied (4).

At the beginning of the 1990s, it was noticed that there was a need for a palliative care program in Turkey, but it could not go beyond providing pain management to cancer patients. A 5-year national cancer control program, including palliative care, was declared in 2009, and palliative care was acknowledged as medical discipline through the "Palya Turk" project in 2010 (5). The legislation for the opening of palliative care clinics (PCCs) in Turkey was issued in 2014. PCC bed capacity was planned to be half of the bed capacity of the intensive care unit available in the same hospital, with such planning limited to the state hospitals (6). Palliative care and home health care services (HHCS) became integrated services, and the cooperation of these 2 disciplines was essential. After completing treatment of the patients in PCCs, their follow-up period is managed at home by HHCS units for their medical, psychological, and social needs to provide the maximum possibility of achievement of better quality of life. Legislative studies have been made for this goal and HHCSs, which began in 2011 has been integrated with PCC in 2015 (6).

The aims of the current study were to analyze PCC distribution and locations within the structure of state hospitals in Turkey, along with human resources, and to evaluate the integration of PCCs with HHCSs.

MATERIAL and METHODS

Data of PCCs between January 2015 and February 2017 were analyzed in this study. Written consent of the T.R. Ministry of Health was provided to acquire and use data for this study. Therefore, ethics committee approval was not required. The

Main Points:

- PCCs are available in 28.9% of the hospitals in Turkey, and 76.3% of the hospitals with a PCC has an HHCS unit. There are 2429 beds in PCCs, 63.3% of which are qualitative.
- Integration between PCCs and HHCS remains at an inadequate level.
- The benefits of integration should be observed by patients, relatives, and health personnel, thereby increasing awareness and accelerating integration.
- Hospital information management systems can be used for the purpose of integration and software programs can be developed to accelerate integration between PCCs and HHCS units. Future studies are also needed in order to analyze the effect of integration between PCCs and HHCSs on morbidity and mortality.

appropriate forms have been officially submitted to all hospitals linked to the Ministry that have registered PCCs within their structure. The roles of the hospitals having PCCs, the number of beds in these clinics, the number of qualitative beds, the number of health care professionals, and the integration of the PCC with HHCSs were questioned using the prepared form. Forms were completed by the appropriate individuals in charge. The database from the Ministry and all acquired data were compared to determine correctness of the information. After evaluation, any inconsistencies were eliminated.

Statistical Analysis

SPSS software (version 24.0; IBM SPSS Corp.; Armonk, NY, USA) was used for descriptive statistical analysis of the data.

Definitions

Role of the Hospital and Classification

The role of the state hospitals and their classification are defined with a circular (7). According to this classification:

- (1) Group A-I General Hospitals: Treatment institutions with general beds that are authorized to provide training in a minimum of 5 medical specialities completed training personnel are grouped accordingly, and where third level treatment and rehabilitation service are given, training and research activities are conducted, and specialists are trained and fellowships are given.
- (2) Group A-II General Hospitals: General hospitals that do not have active training and research in the provinces, with a health center or the province linked to those centers.
- (3) Group B General Hospitals: General hospitals those are located in the provinces, other than the A-I and A-II hospitals, which are located or in the improved districts.
- (4) Group C General Hospitals: Hospitals that are active in the improved districts or the districts linked to the centers improved within the content of health region planning regarding health services offered, with specialists providing care in the 4 main specialities (internal diseases, general surgery, gynecology and obstetrics, and pediatrics). In addition, specialists are available at least in 2 other specialties and with at least a first step intensive care unit and first level emergency service.
- (5) Group D General Hospitals: Hospitals having at least 1 specialist, including a primary care physician (family doctor) and active in the districts linked to the improved districts and those having at least 25 patient beds.
- (6) Group E General Hospitals: Hospitals having fewer than 25 patient beds and those where diagnosis and treatment services are offered along with health services at the first step given in the same structure.

Qualitative Bed

Defines the bed where a bath and toilet are located inside the room, and a television, telephone, dining table, and companion sofa bed are provided.

RESULTS

According to our study, among all government hospitals (8) 27% of PCCs are located in Group B hospitals, 24% in Group C hospitals, 21% in Group A-II hospitals, and 19% in Group A-I hospitals. PCCs are not available in Group E hospitals. PCCs are available in 28.9% of state hospitals active countrywide (Table 1). There are 2429 patient beds in PCCs countrywide, and 63.3% of the beds in PCCs are qualitative (Table 2). There are 2957 total staff working in PCCs, 77.6% of whom are health care professionals. Of these, 99% are doctors (Table 3). HHCS units are available in 76.3% (n=152) of the hospitals with PCCs (Table 4). This service is offered to 48,953 patients in PCCs, and 5.7% (n=2837) of these patients are transferred to HHCSs (Table 5).

DISCUSSION

PCCs are available in 28.9% of the hospitals in Turkey, and 76.3% of the hospitals with a PCC has an HHCS unit. There are 2429 beds in PCCs, 63.3% of which are qualitative. This constitutes 1.8% of all public beds. A total of 5.7% of patients are transferred to HHCSs from PCCs. There are 0.61 nurses per palliative care bed and 1.14 doctors per PCC.

In our study, the number of beds in PCCs was increased by 1.87, whereas the number of qualitative beds was increased by 2.03. Although PCCs are generally available in Group A-I, A-II, and B hospitals located in the province centers, they are rapidly expanding to Group C and D hospitals located in districts as well. Policies of the Ministry are considered to be effective in light of such rapid expansion and increases. The number of beds recommended for hospice and palliative care in Europe is 80 to 100 per 1,000,000 population (9, 10).

According to our data, 30.4 beds are currently serving each 1,000,000 population countrywide, which is far below the recommendation. PCCs are available in 28.9% of the state hospitals, a rate that has to be increased. In addition, we believe that the target may come closer together if private and university hospitals were included in the planning. A total of 2957 personnel currently work in PCCs countrywide, of whom 77.6% are health personnel. Of these, 99% are doctors and 65% are nurses. The recommendation according to international standards is 1 nurse per bed (9, 10). Currently in Turkey, our study found the number of nurses per bed is 0.61, which is quite low.

The integration of palliative care with home care and having transfers made in harmony will assure that patients receive the proper health and care service easily (1, 11). Such integration and harmony would also provide support to the health economy through the economical use of resources (6). According to our study, 76.3% of PCCs countrywide are integrated with HHCs. However, the rate of patients transferred to HHCs is very low at 5.7%. Factors causing this situation must be examined first and the integration setup should be reevaluated. PCCs receive most of their patients from intensive care clinics. Along with an increase in the number of beds in PCCs, the tendency for increase for beds in intensive care units, especially in state hospitals, is expected to drop. However, this expectation was not reflected as of 2017 (Figure 1). It is believed that an increase in the number of intensive care beds continues, as the palliative care field had just started in 2015 and needs in this field are very high. Studies conducted in this field are necessary, as PCCs will affect occupation rates and the number of admission dates of intensive care beds.

Implementation of palliative care services have an important role, especially in the management of end-of-life patients. As HHCs run by state hospitals attached to the Ministry of Health cover the entire population free of charge, this is an important development in the field of social medicine. Implementations aligned with health policies are rapidly extended countrywide. Although both units are localized in the same hospital, integration between PCCs and HHCSs remains at an inadequate level.

TABLE 1. Distribution of State Hospitals and Palliative Care Clinics in 2017 According to the Role of the Hospitals

Hospital Role	Hospital (*), n	Palliative Care Clinic, n (%)	Rate of Availability of Palliative Care Clinic Within the Structure, %
A1	86	38 (19%)	44.2%
A2	107	41 (21%)	38.3%
B	123	54 (27%)	43.9%
C	163	48 (24%)	29.4%
D	123	18 (9%)	14.6%
E	86	0	0
Total	688	199	28.9%

*(8)

TABLE 2. Bed and Qualitative Bed Situation in Palliative Care Clinics

	Number of Recently Activated PCCs, n	Number of beds in PCCs, n	Number of Qualitative Beds and Rate, n (%)
2015	98	1.294	757 (58.5%)
2016	79	865	559 (64.6%)
2017 (January-February)	22	270	222 (82.2%)
Total	199	2.429	1.538 (63.3%)

TABLE 3. Number of the Health Care Professionals working in Palliative Care Clinics in Turkey, February 2017

Healthcare Professionals						
Medical Doctor	Nurse	Psychologist	Social Worker	Physiotherapist	Dietician	Total
228	1,492	149	127	150	150	2,296
Other Personnel						
Spiritual Care Staff	Clinical Support	Other				
67	91	503				661

TABLE 4. Integration of Palliative Care Clinics with Home Health Care Services

	Recently Activated PCCs, n	Hospitals with PCC and HHCS Units, n (%)
2015	98	75 (76.5%)
2016	79	58 (73.4%)
2017 (January-February)	22	19 (86.3%)
Total	199	152 (76.3%)

HHCS, home health care services; PCC, palliative care clinics.

TABLE 5. Rate of the Patients Transferred to Home Health Care Services from Palliative Care Clinics in Turkey

	Number of Patients (n)	Number and Rate of Patients Transferred to HHCS Units, n (%)
2015	8,815	452 (5.1%)
2016	31,958	1,952 (5.9%)
2017 (January-February)	8,180	433 (5.2%)
Total	48,953	2,837 (5.7%)

HHCS, home health care services

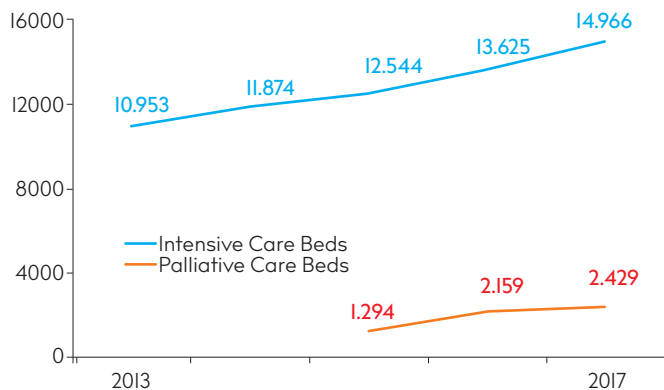


FIGURE 1. Increase Tendency of the Number of Intensive Care Beds and Palliative Care Beds

We believe that benefits of such integration would be observed by the patients, their relatives, and health care professionals, increasing awareness and accelerating integration in long-term implementations. If short-term positive feedback is expected concerning the satisfactory quantitative interaction between PCCs and HHCSs, some applications are provided and should be developed. These applications must be independent of demand of patients and reference of health care professionals. We believe hospital information management systems can be used for this purpose and that software programs can be developed to help accelerate the integration between these two units. We also believe that there is a need for future studies analyzing the

effect of integration between PCCs and HHCSs on morbidity and mortality.

Ethics Committee Approval: Written consent of the T.R. Ministry of Health was provided to acquire and use data for this study, therefore local ethics committee approval was not recieved. Written consent was obtained from the Ministry of Health by official correspondence (number 326933113-622.03)

Informed Consent: Written consent was obtained from the Ministry of Health by official correspondence.

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