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Elder Care at Home

Current status analysis in Turkey, Italy and Poland

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INTRODUCTION

COMPARATIVE ANALYSIS ABOUT ELDER CARE AT HOME

The structure of presentation is divided into 4 parts:
1) Firstly, the main kinds and providers of elder home care in Turkey; Italy and Poland;
2) Secondly, a set of data and indicators about demographic and social changes reguarding to 3 countries analysed;
3) Thirdly, an overview of national system of elder care at home
4) In conclusion, the main qualitative results we have taken from your SWOT analysis.

What is the Home care? and what is elder care at home?
Definition of Home Care is very similar in the three Countries, even if there are different services in each one of the Countries analysed. Home Care is a nursing model, containing psycho-social, physiological, medical support and social services, which are provided both for the individuals with disability and/or with chronic illnesses, and their family for the purpose of promoting, maintaining, or restoring health.
The general strategy includes a shift of focus from hospital to home.
In the specific, Elder Home care can be defined as any care provided with reference to services enabling elderly people to remain living in their home environment.
Each of these services necessitates a different providers mix, level of care and need, for health management in the home.
And so we can distinguish between at least two care sistems: formal and informal and two kinds of services: health care and social care.

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This is a scheme which we can use for focalize the complex system of elder care at home.

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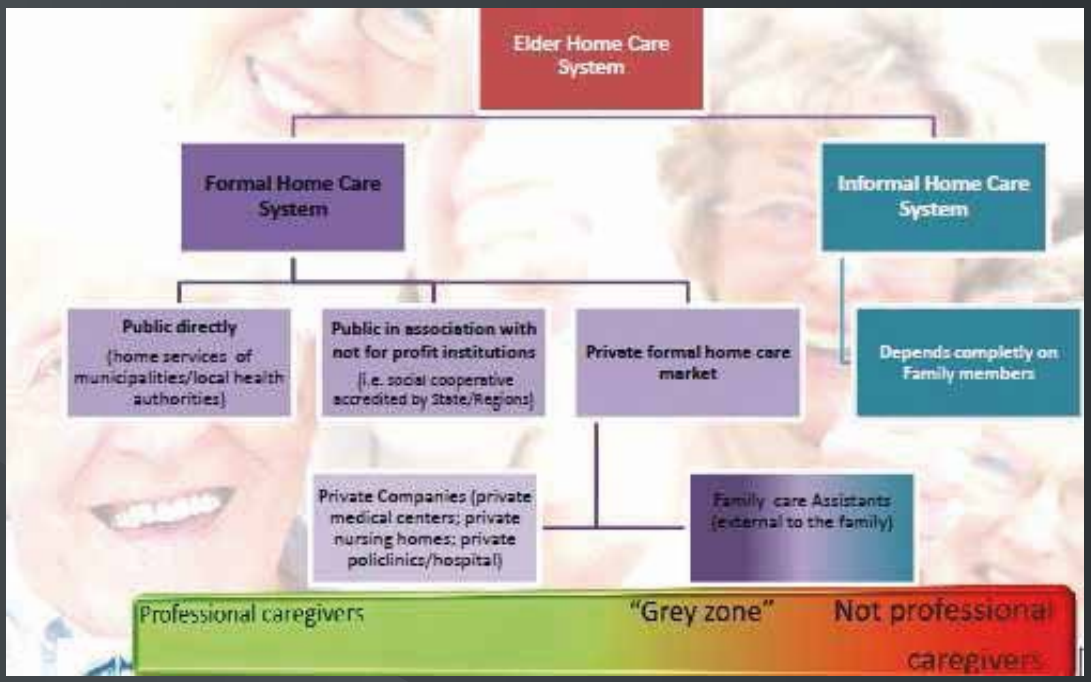

The sistem can be formal and informal.
Starting from the formal system we can see that is mainly provided by public entities directly, or by not-for-profit institutions , and private formal home care market.
In the system of home care services provided directly by public, the providers/the palyers are Municipalities and Local Health Authorities..
The services can be provided also in form of association between public and not for profit organitazions, such as social cooperatives accredited by State/Regions).
And again, always in the formal home care system, there is private home care market.
The private formal home care market is growing much (above all in Italy and Turkey.)
The players are the private companies(- such as private medical centers; private nursing home and so on which provided also services at home).

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Always in the field of private market, there is as another performer that is family care assistant, who isn't a familiy's members. This phenomen is common above all in Italy, where there are caregivers above all women who come from Easter or Nord Europe (Romania; Bulgaria; Ukrain) or, less, from Africa.

The Informal home care is provided by relatives who are responsabilities of care family.

As regards the type of services, home care may refer to care given:

The formal home care system is provided by professianals caregivers who work for pay (like nurses; doctors, nursing assistance, social workers, phisioterapists ec..).

Informal care givers' are family and friends who are not paid for the services that they provide and they haven't specific care skills.

And then there is a grey zone there are family elder care assistants who could be either (IDER) skilled or unskilled, with regular employment contract or not (in which case they are called `irregular caregivers. And this phenomen is enough common in Italy).

Reguarding the nature of home services in three Countries analyzed it'is possible to distinguish between Social Care and Health care.

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Elder Home Care: nature and typologies of services

Current status analysis in Turkey, Italy and Poland

The health care mainly involves services addressed health needs such us: riabilitation; monitoring of pressure or other phisical parameters; needs linked to stroke or asthma or cronic illnesses or terminal illnesses; or psicological problems... and so on...
The social care involves services of social assistance such as preparing meal, company for the elder people, special trasport services; telerescue/telearm; cleaning of rooms; and so on..

AN EMERGING NEED OF ELDERLY HOME CARE: Demographic and social changes

Many factors drive the need and demand for home care. Some of the most important factors are demographic trends and related social changes.
And below we can see some data and indicators about this trends in Turkey, Poland and Italy.

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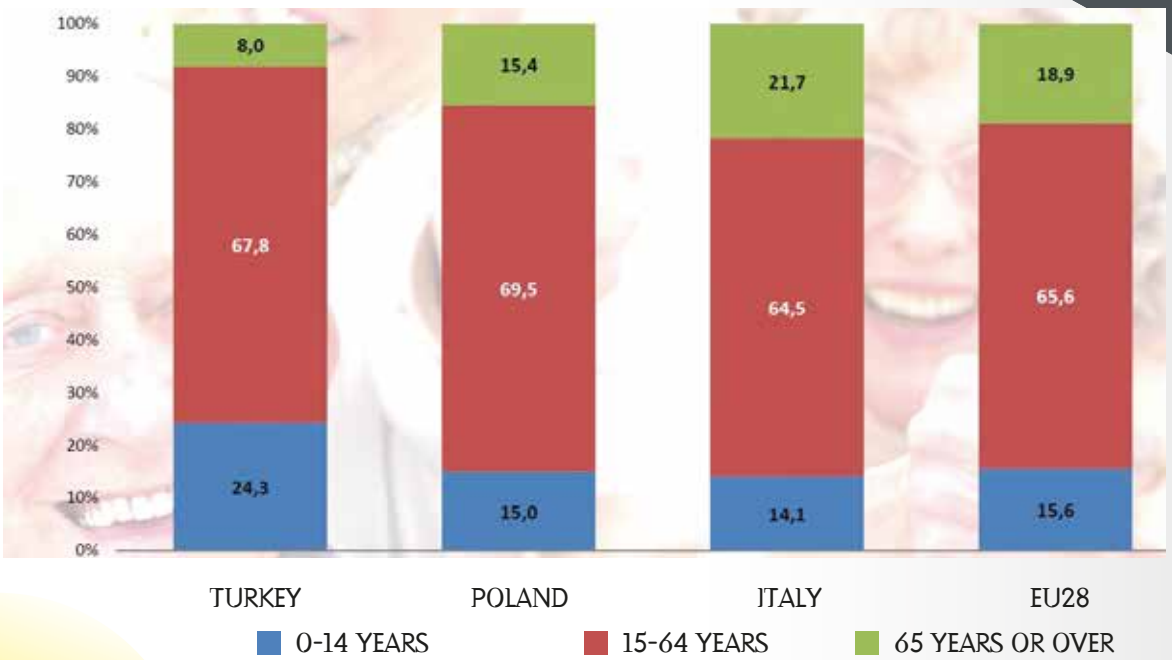
This bargraph shows the population age structure by major age groups.

Population age structure by major age groups, 2015 (% of the total population)



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Each bar rappresents the country of TC-Pl-IT and EU. We can see the blue represents the population from 0-14 years old; the red shows the population 15-64 years old; the green shows population 65 and over years old. We can see that the 65 and over population is 8% in TK; 15,4% in PL; 21,7% in IT; and the average in EU is 18.9%. We can see that in Italy the percentage of 65 and over population is more than double that of Turkey's. And slightly (SLAITLI) less than a third grater than of Poland's.

Current status analysis in Turkey, Italy and Poland

These percentages will drammatically increase in each country in the years to come.
For Turkey the percentage increase will be even more drammatic if only because now
it is significantly lower in respect to Poland and Italy.
Another question is that the population in active age, that is in 15-64 age group, is
steadly decrease in all Countries.

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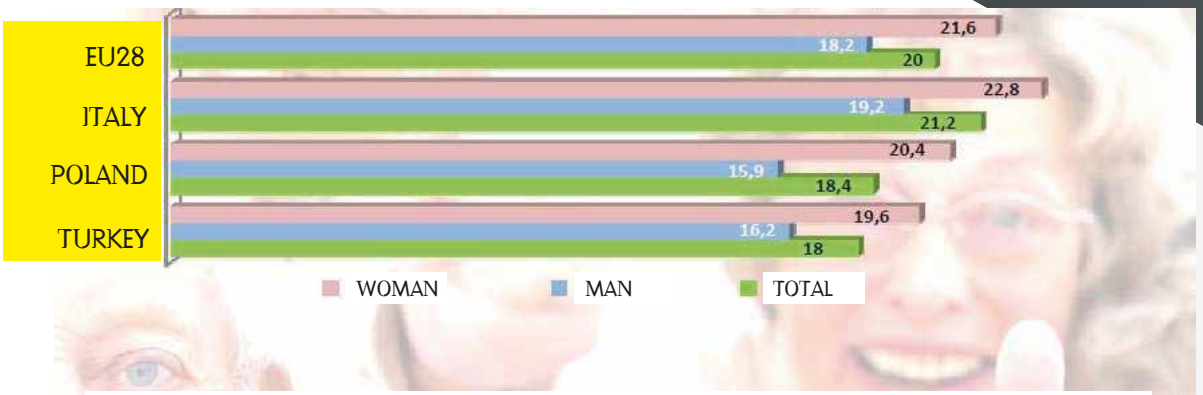
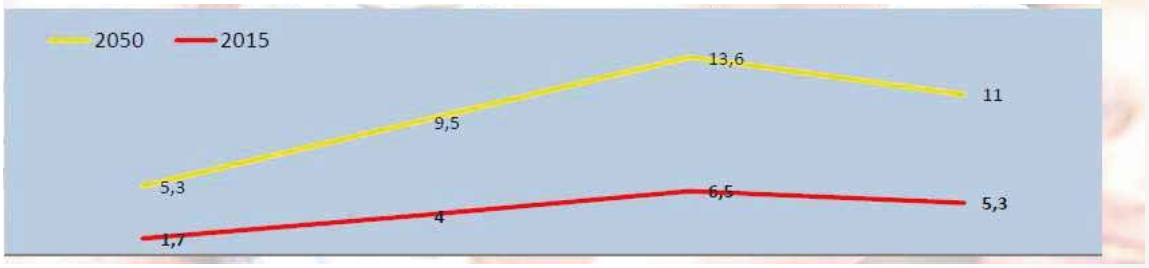
Life expectancy at age, 2014 (years)



Share of population aged 80 or over (% on total population)



TURKEY POLAND ITALY EU28

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The first bargraph shows life expectancy beyond age 65 (approximatly the usual age of reteriment). In TK and in Poland the life expectancy of 18 and 18.4 years for the total elderly population is almost the same. In Itali it is 21 years, higher than the EU average of 20 years. In each Country the elderly woman have a higher expectancy age the elderly man. The second graph shows what will happen to the population structure in 2050. The red line represents the actual percentages of the population aged 80 and over.

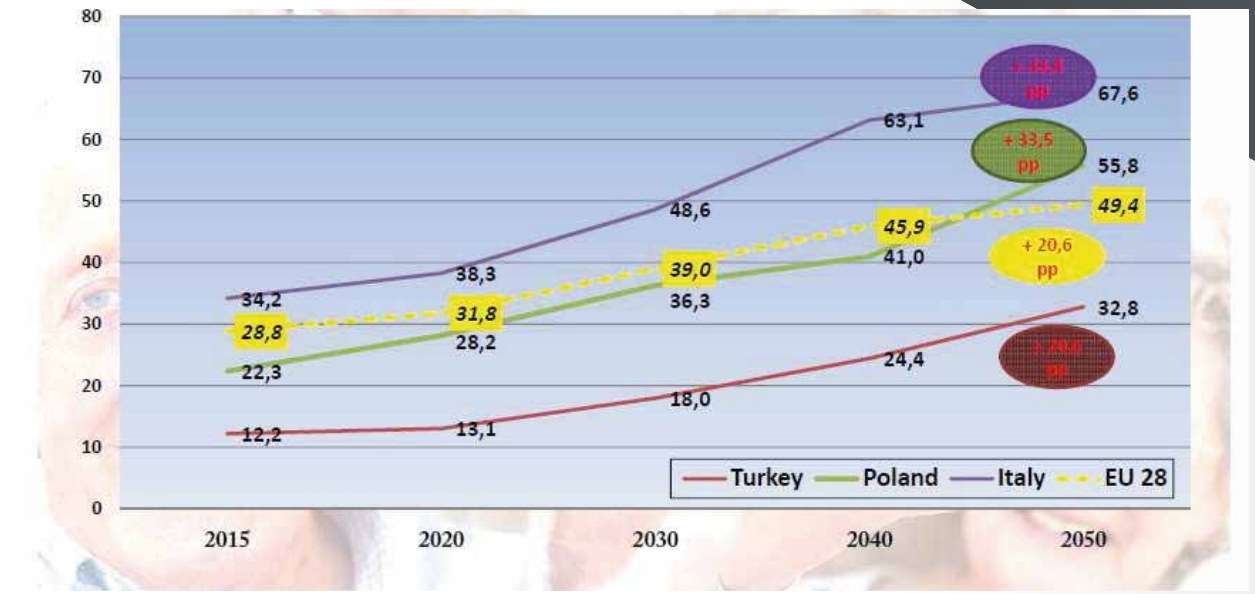
The yellow line shows whath will happen in 2050. In particular we can see that if in PL and Italy the percentage share of population aged 80 and over will increase to more than double the 2015 level, in TK this share of population will increase more than three times.

Current status analysis in Turkey, Italy and Poland

And so it shows that those people will need care, at quantitative and qualitative level. This also means that in the future the demand of long-term care will increase exponentially. Given that the active age group is decreasing also means that ultimately elderly people will be cared by caregivers equally elder. The next two graphs show the changes of two important indicators of the dependency ageing population.

Elder Care at Home

Projected Old-age dependency ratio 2015-2050
(65+ per 100 population 15-64)



The first indicator is Old-age dependency ratio (that is the ratio of population in notactive age -65 and over years old- per 100 population in active age-15-64 years old). In 2015, in Italy per 1 hundred people in active age there were 34 people in not-active age. In Poland they were 22.3%; In TK 12.2%. The projections show the changes from 2015 to 2050. In each country, the curve increases.

In particular in PL and In Italy the growth will be of 33 percentage points, and so it means that people potentially dependent (67.6% or 55.8%) will be more than people who are active.

In TK it will be in line with EU, at 20 percentage points.

The second socio-demographic indicator is the potential support ratio. The potential support ratio (PSR) is the number of people age 15-64 per one older person aged 65 or older.

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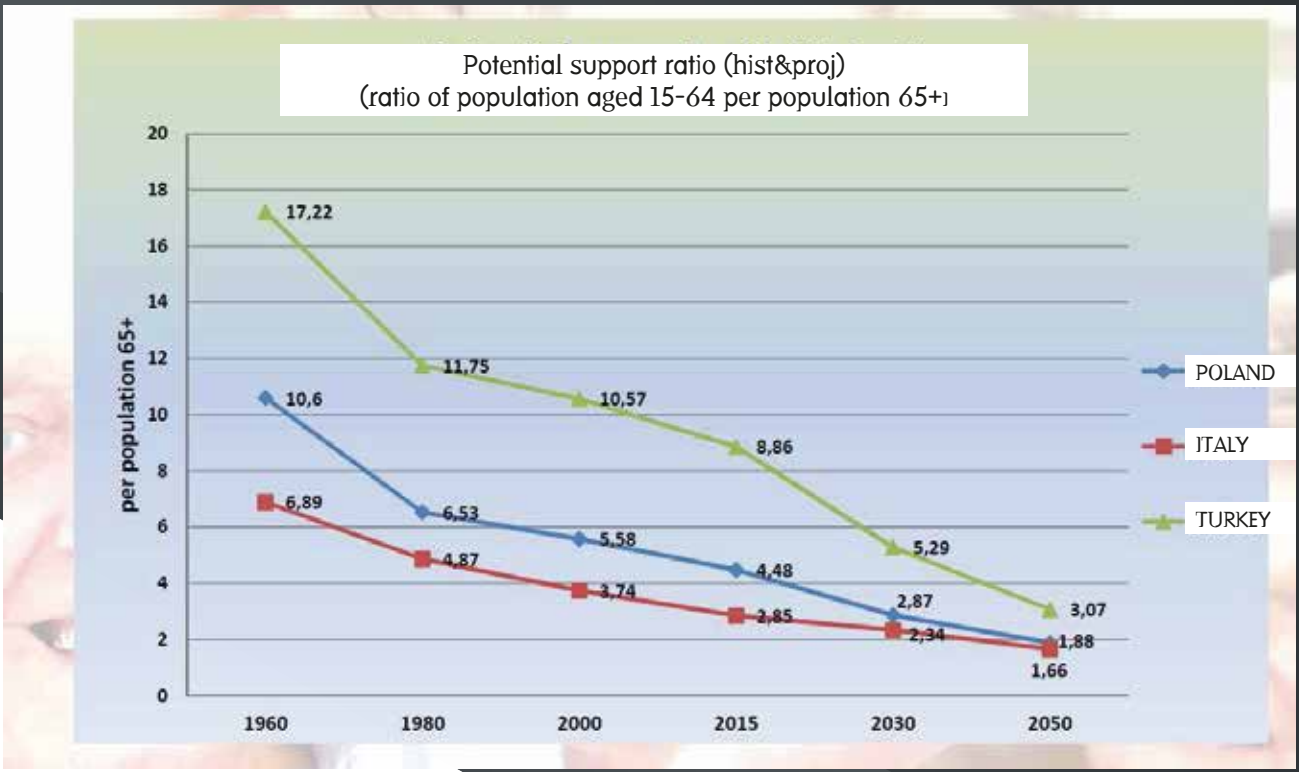
Current status analysis in Turkey, Italy and Poland



The graph shows how the PSR is changed from 1960 to now. And how it will change in 2050. Like we can see, the capacity of family to care their elderly will be stretched to the limit.
For example, In Turkey in 1960 there were 17 people(15-64 aged) who gave care to 1 elderly person. In 2050 there will be only 3 people (15- 64 aged) who will care for 1 elderly person. Now they are less than 9.In Poland it will pass from less than 5 people in 2015 to less than 2 people in 2015. In Italy , the situation is already worrying because already now the number of potential care givers is low- less than 5 people in active age for 1 elderly people. In 2050, they will be less than 2.

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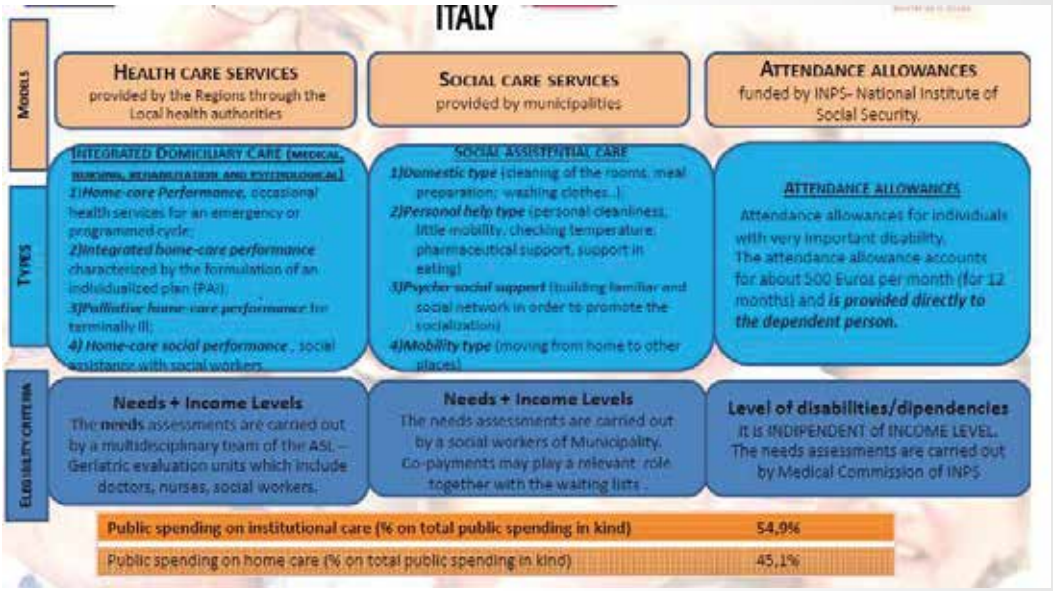
An overview of national system of elder care at home
In the three Countries analyzed exist different national system of elder care at home .
Following for each Country we present a scheme divided in three levels:
- in the first level, we can see the models of home care in the country;
- in the second level, we can see the types of services within the particular model of care;
- in the third level, we can see some eligibility criteria for accessing to services.



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Current status analysis in Turkey, Italy and Poland

In Italy there is a distinction between three intervention models : social care services;social-health care services; Attendance allowances. Health care services are provided by the Regions through the Local health authorities Social care services are provided by municipalities. While, attendance allowances are funded by INPS- National Institute of Social Security. The Health care service at home is the Integrated Domiciliary Care (medical, nursing, rehabilitation and psychological services), called ADI ("Assistenza Domiciliare Integrata") in italian language. ADI services mean social-assistance services and health services (such as medical sevice, nursing service, rehabilitation and psychological service. These services are multi-disciplinary and multi-professional. In ADI service, there are not only home-care workers, but also health professionals: nurses, doctors.

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The services can be divided into 4 different profiles assistance:
1. Home-care performance, characterized by occasional health services - even once, only one or two hour.
2. Integrated home-care performance , characterized by the formulation of an individualized plan (PAI), prepared according to the global multi-dimensional evaluation
3. Palliative home-care performance for terminally ill
4. Home-care social performance, that is a social assistance with support of social workers. The elegibility criteria concern income levels and needs. The needs assessments are carried out by a multi-disciplinary team of the ASL – Geriatric evaluation units which include doctors, nurses, social workers.

Services can be:
1) Domestic type: consisting in take care of hygienical conditions of main rooms, main household services, meal preparation, assistance in managing domestic activities.
2) Personal-help type: personal cleanliness of person immobilised, little mobility, checking temperature, pharmaceutical support, support in eating
3) Psycho-social support: consisting in activities such promoting familiar and social network in cooperation with other local services in order to promote the socialisation
4) Mobility type: moving from home to hospital, to administrative offices The needs assessments are carried out by social workers of Municipality. For Accessing to the service may be necessary to contribute with a co-payments, which is set in according to income brackets. Also the waiting lists are important for the access.About the system cash for care, there is an attendance allowance for individuals with very important disability.

The attendance allowance accounts for about 500 Euros per month (for 12 months) and is provided directly to the dependent person. It is indipendent of income level. The needs assessments are carried out by Medical Commission of INPS

Finally, we can see like in Italy the public spending on home care (on total public spending in kind) is less than the public spending on institutional care.

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Current status analysis in Turkey, Italy and Poland

POLAND

Also in Poland there is a distinction between three intervention models : social care services; social-health care services; Attendance allowances.

Also in Poland there is a distinction between three intervention models : social care services;social-health care services; Attendance allowances.

Health care services are financed by the National Health Fund
Social care services are provided by municipalities and financed by the Ministry of Family and Social Policy
Attendance allowances are funded by Social Security System.

Elder Care at Home

Also regarding the types of health and social care, the services are similar at those we have already seen in Italy sistem but there are some intersting things:
- the first is that the elegibility criteria for accessing to health care services are very selective and so the services cover only a minum part of the domand. The exception is represented for the people over 75 age, which have right to riceive nursing benefit regardless of their state of health (but the coverage is extremely low)

Regarding at system cash for care, we can see two particular Kinds of economical support:
- the Attendance allowance for people 75 aged, to cover costs for paying another person in supporting an elder person.
-and, a very intersting cash-based intervention is the Carer's allowance in the form of paying social security contributions for the carer. This benefit can be given to people who doesn't start employment or who stops working because of the need to provide care.

The elegibility criteria concern Income Levels. It' s also necessary a medical certificate attesting to the necessity of exercising direct personal care over the sick person.

The public spending on home care (on total public spending in kind) is less than the fourth part of public spending on institutional care.

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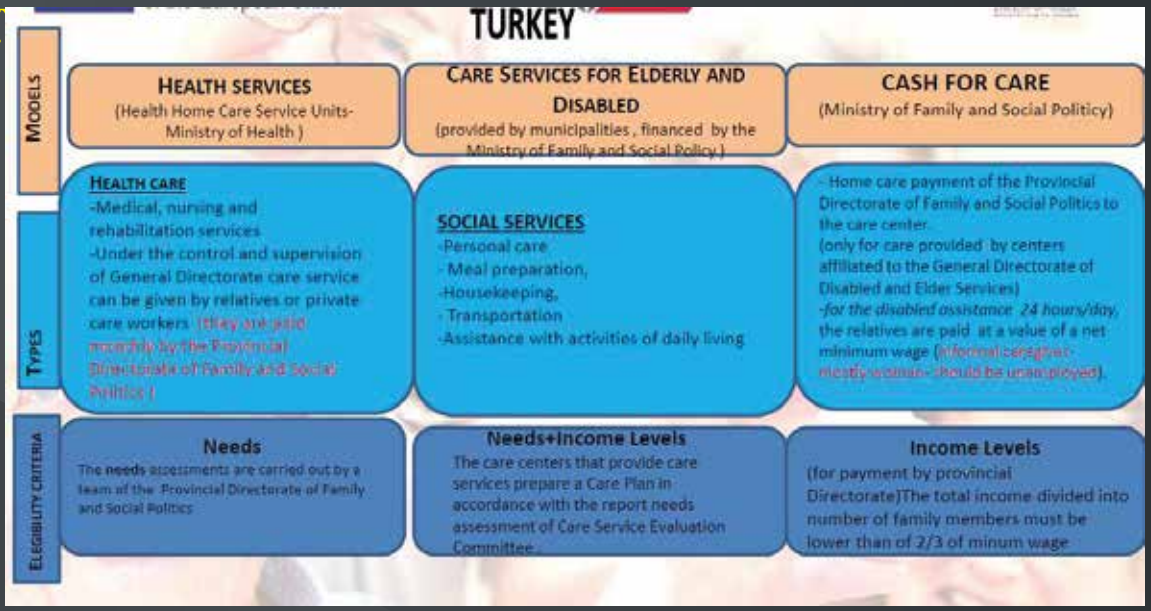
Current status analysis in Turkey, Italy and Poland

TURKE

In Turkey, services are distinct between Health Home Care Service and Care Services for Elderly and Disabled. There is also a cash for care system.



Health services is provided By Health Home Care Service Units, and funded by Ministry of Health;
Care services provided by Municipalities, financed by Ministry of Family and Social Policy, as well as cash gfor care system
We can underline some aspects like:
1)In case of health care services given by relatives, who are supervised by General Dircetorate, those relatives can be paid monthly by Provincial Directorate;
2) The need assessment for accessing to the service is carried out by multiprofessionals
team of Provincial Directorate of Family and Social Politics .
3) The third intesting aspect is the system cash for care.
It's provided a form of payment by Provincial directorate for the care at home provided only by accreditated centres. The elegibility criteria are based on income levels.
The total income of family must be lower than two third of minimun wage

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4) For the disabled assistance , 24 hours for a day, the relatives are paid at a value of a net minimum wage. But, and this in important because open reflection about employment of women, the informal caregivers-who are mostly woman- should beunemployed.

Comparing 3 SWOT Analysis

In the last part we have reported the main elements which are emerged from 3 SWOT analysis carried out .
The Swot analysis was focused on the informal caregiving addressed to older people.

STRENGTHS	WEAKNESSES
Care at home is preferred by people in need.	Lack of skills of informal caregivers
Care at home is cheaper than services given by institutions.	The age of caregivers (who are often elderly themselves)
Reinforcement of emotional dimension/sentimental relationship between the caregiver and the person who receives help.	Caregivers are more likely to have physical and psychological illnessess
Elder people feel better in staying at home (great feeling of indentity and security).	Not all houses are adeguate in term of facilities (spaces and equipment) and general environment.
	The lack of support to the caregiver (above all women) from other family members.
Great relationship of informal caregivers with services and formal caregivers .	The lack of trust in institutions on the part of caregivers.
Valorisation and recognition of the role of informal caregiver	Lack of social value of the role/work of informal caregiver
Increasing of women employment	Decreasing of number of women informal caregiver employed (because they have to leave their jobs)
Incomes from elder person (in help in economy of the family)	Attendance allowances as salary

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Current status analysis in Turkey, Italy and Poland

OPPORTUNITIES	THREATS
Training for informal carers (for providing highest quality of informal home care)	Increasing elder population
Provide psychological support for carers	Increasing average life expectancy
New forms of obtaining information (i.e e-consultancy) or provide care (i.e e-health technologies)	Increasing of chronic illnesses
Organize *network of proximity* and *social volunteer networks* that can help informal caregivers in their work	Shortage of professional training courses for caregivers and/or relatives. Few training courses available are very expensive
Educating volunteers on supporting older people	Changes in the family model (economic migration, the weakening of family ties).
Reinforce cooperation between NGOs, local governments, schools, hospitals and social assistance in terms of services for the elderly	Lack of data on informal caregivers
Improve the Awareness of healthy old age	Reduced level of care for the elderly by family members.
Presence of database	Inaccessability to data about services for elder people

The main strengts are:
- care at home is preferred by people in need;
- reinforcement of emotional dimension/sentimental relationship between the caregiver and the person who receives help; 13
- care at home is cheaper than services given by institution;
- elder people feel better in staying at home (great feeling of indentity and security).

However some aspect are identified both strengths and weaknesses, for example:
If the increasing of women employment is a strength, at the same time there is the decreasing of number of women informal caregiver employed (because they have to leave their jobs). And also, if incomes from elder people can help family economy, the risk is that the attendance could be used as salary for relative with gives home care.
Among main opportunities and of informal caregiving we can see:

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PART 1 - HOME CARE CONCEPT AND SCOPE

1 What is Home Care?

Definition of Elder Home Care is very similar in the three Countries, even thought these services are different in each one of the Country analysed. These services can be provided by:

- authorized health care providers who meet needs of medical care;
- professional caregivers who daily support elder people in their daily activities;
- other people (who are not nurses, doctors or other professionals with license)

who support elder people in their daily activities (ex. bathroom activities, meal, cleaning the house and so on). In all three countries the concept of elder homecare services includes social services and health services. In Italy there is a specific service that integrates this two dimensions: the social-health home care. The service can be provided also by money for the family as benefit. Basically elder HomeCare service can be defined as a service that replaces institution in taking care and decreases the timing that elder people spend in health-care institutions (hospitals, nursing homes etc.).

2 History of Home Care in Turkey, Italy and Poland

2.1 Policies and legislation

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In the three Countries legislative policies addressed to elder people have been influenced by socio-demographic changes, (as the consequent aging of the population), and by the perception of their effects on the living conditions. However, awareness of these needs came in different historical periods: while in Italy first legislative actions addressed specifically to elder people were introduced to the 50s, in Turkey and Poland are much more recent. In Turkey legislative actions for home care services were introduced to 1964. Then in 2007 for the first time it was introduced the concept of Elder Home Care services providing home care assistance with the aim to increase quality of life of elder people. In Poland traditionally has always provided care for its elder members, disabled or sick.

Current status analysis in Turkey, Italy and Poland

In 2004 a law on social assistance has introduced the right for elder people to be supported and to meet their basic needs in their home. In Italy the National Health Service was introduced in 1978. It deals with elder people by providing specific rights related to health, including "in-home" services.

2.2 Nature and typologies ofservices

The provision of home care services for elder people is ensured primarily by local authorities (municipalities) in Italy and in Turkey, by the Ministry in Poland. In all three countries the aim of the system of care services provided is to support elder people in their natural environment, reducing transfer to external structures. It is believed that this helps elder people to keep a good level of life, despite the aging process. In Italy Regions and Municipalites provide two types of service: Home health-care services (SAD)

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Integrated home health-care services (ADI).
These services lie within social and social-health interventions provided by Social Plans made by municipality or groups of Municipalities . These services are addressed to not autonomous people including elder people.

Home health-care services (SAD) is addressed to people:
• Sick or people who need help from other people
• Not having enough support from their own family
• Not living in suitable environment
Integrated home health-care services (ADI) is addressed to:
• Partially or totally not autonomous people (even temporary) coming from critical conditions in terms of social needs (example: not supported by family) or in terms of health and pathological issues.
• Elder people and disable people in needs with chronic disease – degenerative disease that restrict their autonomy.

In Turkey, municipalities provide services to elder people such as transport, probing at home, bloodletting, blood pressure monitoring, serum installation, injection, pressure ulcer nursing as well as social services. The Central State provides a professional care support for elder people who are entitled to home care. They are provided by health professionals.

In Poland, Central State provide support services, hygiene of care recommended by doctor, guarantee to control environment. Care services include nursing care and assistance in addressing daily needs (food, personal hygiene, hygiene of the house, shopping, buying and and providing of medicines, medical prescriptions, doctor visits, leisure, etc.). Services are addressed to people who live alone and that, due to their age, illness or other reasons, need help of other people (and family can't provide such assistance). These people are alone, sick, disabled, isolated, without any support from the family.

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Current status analysis in Turkey, Italy and Poland

Both in Italy and Turkey services provided by private organisations are available. Private organisation must be accredited in order to ensure social and health compliance. In Italy there are also intermediary organizations as trade unions (ACLI) or private organizations in the third sector (non-profit) who provide services to the families of elder people by helping them to find and manage a caregiver. In Turkey in recent years, especially in big cities, home care services supplied provided by private organisations are increasing. Private services are not supported by Central State both in Turkey and in England. In Poland these services are provided by private organizations such as NGOs, but it is not so common.

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Beside direct care services provided by public organisations and other organisations, in all three Countries benefits in money are provided to family who takes care to its own elder people. In Italy elder people receive also other kind of services provided by I.N.P.S. (National Institute for Social Services). They are money subsistence for specific handicap or personal disability. Services for elder people are:

a) Subsistence money for assistance: for disabled or wounded people who need a continuous help from other people and who can't do normal actions in their daliy life. Over 65 can receive this service if they show they have difficulties in doing ordinary activities.
b) Recognition of serious disability: it is considered serious disability when the person needs a permanent, continuous and comprehensive care assistance
In Turkey, Ministry of Family and Social Policy provides subsistence money for disabled people living in the family, on the basis of family income. In Poland there are benefits that may have a temporary or permanent nature, related to long-term disease. They are provided on the basis of income criteria. This benefit covers the purchase of food, medicines and treatments. In some justified cases, a person or a family may receive benefit for special uses. These benefits are not mandatory responsibilities of municipalities; their implementation depends on the Municipality financial capacity and must respond to local needs. Money subsistence are provided by Municipality in order to partially cover costs to pay another person in supporting an elder person. It is granted to over 75. This allowance is not granted to people who already receive allowance for assistance all day long / 7 days a week (24/7). These benefits are currently inadequate to meet the needs of older people.

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2.3 Demographic changes; changes of needs and demand of care

In the three Countries, population is getting older, with a consequent increase in demand for care for elder people. Number of people who need care (elderl people) is increasing while number of people in working age is decreasing.

Looking to number and quality of the data analyzed in the three reports there is a situation of strong differentiation, which makes difficult to do a proper comparison. While in the Italian report there is high variety of data concerning both demographic changes and evolution of the needs for elder people, in Turkish and Polish reports data are not enough. In Poland only in 2015 was introduced a law with the need to monitoring the condition of elder people. The comparison can be done on some common data:

- over 65 population is almost double in Italy (22%) compared to Turkey (12.04%);
- The old age dependency indicator is much higher in Italy (34.2%) than in Turkey (12.2%);
- life expectancy of Italian elder people is slightly higher (80.1 M and 84.7 F) compared to Turkey (78); In recent years care services provided both in the form of services or money have increased significantly in all three Countries (above all in Turkey).

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3 Purpose of the Home Care Services

3.1 Objectives of home care services

Looking to objectives of the services, in Italy there is a distinction between Home Care and Home Health Care.
SAD aims to tackle exclusion and isolation of elder people, supporting their stay within their family and social environment. Through appropriate tools for needs assessment, the service aims to ensuring that elder person can keep his family and social relationships, necessary to live independently.
ADI aims to protect elder people in a global health condiition (mental and physicalsocial), particularly week elder people. It aims to ensure continuity of care in the home through a home-supply network, to create better institutional, managerial and professional conditions for all in the way of integration.
In Poland and Turkey there is not such a distinction.

In Poland home care services aim to:
- keep or improve physical condition of elder people, their good mental condition and the level of integration with the community on the base of individual abilities and needs,
- keep a stable health condition,
- avoid problems connected with hospitalization or prolonged immobilization;
- improving well-being of the person
- reducing social isolation

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In Turkey the main objective of Elder Home Care Services is to ensure that needed people can be supported in their own family and social environment, and he family can receive support in line with principles of welfare state.

Current status analysis in Turkey, Italy and Poland

3.2 Models, approaches and methodologies adopted by home care services

As anticipated, with regard to approaches, models and methodologies, in Italy there is a distinction between social care services to elder people and social-health care services to elder people. SAD services are provided by local municipality and delivered directly at home through home care workers. They aim to remove and overcome situations of need and difficulty that people can face during their life. Home care workers of municipality aretrained and qualified. SAD are provided on the basis of an individualized care plan. In ADI service, there are not only home-care workers, but also health professionals: nurses, doctors. Services aim to facilitate the stay of the person in its own area, helping the family to deal with the assistance. A Multidimensional Assessment Unit takes care to elder person in an integrated way.

In Turkey needed people receive help through home care services at least 6 months for the implementation of activities such as personal hygiene, nutrition, mobility, house works. Home Care Services are designed to meet both the needs of elder people and their families, in order to ensure that elder people can live in their home as long as possible in conditions of peace and comfort.
In Poland the aim of the care services provided for older people in their place of residence is to enable them to continue functioning in their current environment (for as long as possible), despite the constraints they experience in catering for their basic and essential needs on their own and in spite of the barriers to integration with the environment. Through appropriate support offered to an elderly person in the form of such care, the above-mentioned limitations and barriers should be mitigated, helping to maintain or raise the level of their life (in spite of the continuing process of ageing). Providing services in an organized manner, adequate to the identified needs, should always assume the participation of the elderly person in performing specific activities within the scope of the services (the services being of asupportive and activating nature, not doing things for the elderly) and close cooperation in performing the services with the immediate environment of the elderly person (in accordance with the principle of subsidiarity).

4 Types of Home Care Services

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4.1Typologies of home care and their characteristics

SAD services are provided on the base of specific and personalised project of assistance in order to promote the person and his own network. Services can be:

a. Domestic type: consisting in take care of hygienical conditions of main rooms (bedroom, kitchen, bathroom), main household services (laundry and ironing, meal preparation, assistance in managing domestic activities;

b. Personal-help type: personal cleanliness of person immobilised to the bed, little mobility, wearing, checking temperature, pharmaceutical support, support in eating, support in basic psychophysical abilities

c. Psycho-social support: consisting in activities such social secretariat, promoting familiar and social network in cooperation with other local services in order to promote the socialisation
d. Mobility type: moving from home to hospital, to administrative offices and so on.

ADI services mean not only social-assistance services above mentioned, but also health services (medical, nursing, rehabilitation and psychological) provided but local point of Public Health Service. ADI services are multi-disciplinary and multi-professional; they are divided into 4 different profiles assistance:

1. Home-care Performance, characterized by occasional health services - even once, only one or two hours, occasionally, for an emergency - or programmed cycle;

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2. Integrated home-care performance I, II and III level, characterized by the formulation of an individualized plan (PAI) prepared according to the global multi-dimensional evaluation and delivered through multi-disciplinary and multi-professional services;
3. Palliative home-care performance for terminally ill, characterized by an intensive response to highly complex needs defined by PAI and delivered by a team with specific skills;
Home-care social performance consisting in social welfare assistance to be provided to citizens in order to help the permanence in their living environment, avoiding the institutionalization and allowing them a satisfactory social life through a set of social benefits
In Turkey, services are distinct between Health Home Care Service and Care Services for Elderly and Disabled. Health Home Care Service is presented in their home or family environment to the individuals who have different health problems. It involves social and psychological councenling as well as examination, monitoring, analysis, treatment, medical care, and rehabilitation immplementation efectively and efficiently.
Necessary monitoring, education about regular drug use, renewal of committee reports and necessary equipments, dressing of bedsore, and education of caregiver abot bedsore dressing, education of caregiver about exercise with physiotherapist support if needed is organized by Health Home Care Service Units. Benefits from the ServicePatients who are unable to self care because of being bedridden and old age,with COPD or other respiratory diseases,who are not able to g oto the hospital because of diability, at terminal period (Palliatif Care patients),with severe Myopathy, Bursa Health Home Care Service was established on 14.09.2010. As of the beginning of 2016, 10 Community Health Center, 16 State Hospital, 3 Integrated District Hospital, 3 Oral and Dental Health Center, 1 Oral and Dental Health Hospital has been serving with 159 staff. Care Services for Elderly and Disabledis presented for elderly and isabled by Ministry of Family and Social Politics, and by municipalities. The private sector also provides care service very new. To get home care payment of the Ministry of Family and Social Politics, the total income divided into number of family members must be lower than 24 2/3 of minimum wage. Charge of care service given to the disabled in need of care that would be paid is determined as follows;

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a) For the disabled getting care service from inpatient care centers for 24 hours, at a value of two net minimum wages is paid;
b) For the disabled getting care service from day-care centers for eight hours a day (full day), at a value of a net minimum wage is paid.
c) For the disabled getting care service from day-care centers for four hours a day (half day), at a value of half minimum wage is paid.
d) For the disabled getting care service at their own house by the care workers employed by private care centers for three hours a day, at a value of a net minimum wage is paid to the care center.
e) For the disabled who are cared for by their relatives for 24 hours a day, the relatives are paid at a value of a net minimum wage.

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4.2 Integration in management of home care systems among players in charge of.

In Italy the role of Municipality has is getting more and more important on this issue: municipality realises, organises and manages social services, according to indication coming from regional level. Actions, objectives and priorities of Municipality are defined in Social Local-Plan. Moreover municipality has to realise and adopt the Chart of Social Services showing social opportunities available and how to use them. Indeed Municipalities, Regions and Central State must involve no-profit sectors. These organizations can provide and manage services as alternative ones to those of public bodies for citizens who need them. Regions define the necessary requirements of the services and control the quality of work, even including regional registers of authorized organizations. Within the Presidency of the Council of Ministers, it was established a Commission of inquiry on social exclusion. It has the task to work in research and surveys about poverty and exclusion in Italy, to promote knowledge in the institutions and in public opinion, to make proposals, to promote feedback on the effect of social exclusion.

In Tukey integration and management of care services has something similar and something different compared to Italy. Like Italy, even in Turkey services are provided by public or private entitiels, according rules of Ministry of Family and Social Politics.Provincial Directorate of Family and Social Politics has the task to receive and assess Home Care applications. The care services are provided by public or private centers. In case that the relatives provide the care service, Care Service Evaluation Committee guides the caregiver about the implementation of the Care Plan. Upon the request of the disabled in need of care or the legal representative, care service can be given by relatives or care workers under the control and supervision of General Directorate at the individual's place of residence. Under these conditions the charge of care services provided to the disabled is paid monthly by the Provincial Directorate to the relatives or to the private care centers that care workers are employed.

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With regard to Poland, it is not so clear the integration between public and private organisations. In all three Countries, Elder Home Care Services are provided by National law and then provided by local institutions (Municipality / Province / Region). However, in Turkey and Italy resources come from Central State, in Poland resources come from local level. That changes the impact of these services on the elder population.

4.3 Home Health Service Delivery

4.3.1 Types and network of services, integration among different services and organisations

From the point of view of integration among services and players, Italy, Turkey and Poland have different situations.

In Italy local authorities, Regions and Central State (each one within its own competence) shall ensure the planning of actions and resources. Even the third sector (private parties) is involved in planning; however private organisations need to be authorised in advance. Today a stressed point in Italy is the need to integrate community care and hospital care. It entails a new territorial organization of primary care and home care, able to guarantee high technical quality, continuity of care, operational integration, customization of care pathways, appropriate technology to support the offering of intermediate and home care services.
Reform of the sector is based on a logic to change National Health Service gradually, taking into the account the following principles:

- Promotion of health
- Guarantee essential and uniform levels of assistance
- Reinforce the role of municipalities in health planning
- Reinforce local districts
- Promote social-care intergration
- Promote doctors from general medicine and paediatrician on their own accord

The Health District is considered the center of the services where the health issues are faced in a unique and globally way. In Turkey Home Care Services are implemented by mobile teams organised within Health Directorates and by home care service units organised within hospitals in 81 provinces of Turkey with the 'Procedures and Principles of the Home Health Services Directive offered by the Ministry of Health'(01.02.2010). With the 'Direction about Procedures and the Principles of Home Care Service' presented by the Ministry of Health, the aim is to define the home care units within health institutions, determine the medical and social standards of the patients utilizing this service, standardize the health team providing home care service and the required equipments, authorize the related staff, set up the systems of appointment, registration and following up, provide home care services as regulating the procedure and the principles of the performing system and regulate the legislations and back up related with the supervision by the public enterprises under the approach of the social state and making applicable in an effective and accessible way on countrywide.

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Home
Health Care
Units work with
appointment system
within work hours and the
service area is limited to the adjacent
of the provincial or district municipalities
where the health institution is.
There are not information about Poland.

4.3.2 Roles and types of private Home Health Service Delivery (relatives, private care-givers)

With regard to Elder Home Health Services provided by family members and informal carers, the situation is very different between Italy and Poland. Italy report shows that caregiving is a widespread phenomenon: informal caregivers (above all foreign caregivers) not belonging to the family support elder people.

In Poland the involvement of family members (often the partner) is still the most common way of supporting elder people, despite it is decreasing. The massive growth in the number of caregivers, as many national surveys show, confirms on one hand as families become available to invest financial resources to get care services; and on the other hand the presence of workers available to carry out this particular care activities, often in a not "official way". Families renounce to quality of care in exchange of freedom from contract obligations. Caregivers renounce to a system of guarantees in order to receive an higher salary. That impacts on the quality of care and assistance services and the most delicate players (not autonomous people) pay consequences. Moreover, in Italy assistance to elder people is provided even by volunteers. They are a valuable resource, since they run for free and they have staff with specific qualification. An important point is the issue of responsibility: from a legal viewpoint it must be clear the limits within volunteers can act. In Polond, the basic forms of care provided by informal family caregivers and include: emotional support, instrumental activities performed in and outside the home (such as transportation, meal preparation, shopping), grooming and personal hygiene (for example, bathing, feeding, dressing, changing nappies) and making contact with agencies specializing in services for seniors, coordinating and supervising them. If possible, the first caregiver of an elderly person requiring care is usually the spouse. The majority of carer of this profile are older people who experience the same health problems themselves and, most importantly, often hide from the environment the fact that their health deteriorates for fear of losing the possibility of caring for their spouse and of doing it at home. The needs of care may evolve, putting an increasing burden on the partner who, as research shows, attempts to hide the fact from other family members, afraid to lose their and their spouse's independence. This leads to the deliberate exclusion of possible supply of support for the primary caregiver, and, in consequence, to an actual decrease in the period of care provided by the partner due to an overload of responsibilities. Here the activities of the third sector may be appreciated. When the scope of assistance for an elderly person is wider and includes assistance and help with personal hygiene, washing, bathing, dressing and dispensing medicines, such people, even if they are not professionals, (also from the immediate environment), should be properly trained and instructed on how to perform the tasks most effectively, not only for the elderly but also for themselves as carers.

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The great majority of dependent people in Poland receives care primarily from their family and relatives, although according to a study of European trends its share is decreasing. However, in very many cases, providing such care is not a voluntary decision, but a necessity. 75% of carers feel that there is no choice when it comes to taking responsibility over patient care. Caring for a sick person changes many aspects of life for the caregiver, especially his or her work and financial situation, their relations with the environment, their health and well-being. Empirical studies show that "a small number of municipalities has implemented support for families or individual family members caring for dependants. Only 18% of respondents indicated that their municipality offers care also for the carers of older people. At the same time, more than 64% of the respondents indicated the need for such measures".

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Leaving caregivers without support or assistance could lead to a situation where, because of their financial problems (or even poverty, in extreme cases) or a deterioration of their mental and physical health, the carers will stop providing care and will need support from social assistance themselves. As a result, the cost of the help that will have to be covered by the family and the entities of local social policy, as a consequence of the lack of action at the early stages of care, will be much higher than if adequate measures had been taken earlier. Unfortunately, informal carers feel unappreciated and claim that their needs are overlooked or ignored. They do not receive the necessary information or training on how they should take care of a sick person. They need to "fight" for help, and if they receive it, it is insufficient or of poor quality. The development of respite care would significantly relieve the caregiver and make it possible to avoid the negative consequences of excessive care burden and thus improve the quality of life of the patient and the caregiver. The units making decisions to grant social assistance due to a long-term illness should recognize and appreciate the economic/financial value of care provided by informal carers, and thus be aware of the losses they will incur, if the carers stop providing care. From Turkish report, there are not information about informal caregivers.

BÖLÜM 2 – HOME CARE POLICIES BY COUNTRY

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5 Home care policies

5.1 Current legislation and strategic priorities of programming

Home care current legislation is the result of overtaking the "centralist framework" (so from welfare state to welfare community).

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Now following principles are at the base: subsidiarity (in vertical way among institutions and in horizontal way among institutions and citizens); negotiated planning among various players; concept of healthcare integration as compulsory response to the huge change due to the increasing of fragility conditions in the population (with the consequent reorientation of the supply system from hospital health care to home care). One of the main law is the law n. 328 del 2000. It is the law for assistance, aimed to promote social actions, welfare, social-health actions that ensure practical help to individuals and families in need. Main goal of the law is, in addition to the assistance of the individual, even the support of the person within his own family. Objectives of the law are: quality of life; prevention; reduction and elimination of disability; reduction and elimination of personal and family discomfort; access to welfare services. It is a framework legislation: so the implementation depends on administrative orders from Government, Ministries, Regions.

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Another important law is the Law no. 104 / 1992 modified by law March 8, 2000, n. 53 and the legislative decree 26 March 2001 n. 151. The law is addressed to "disabled" people: people with physical, mental or sensory handicap. This laws deals with assistance, social integration and rights for handicapped people. The aim is to overcome obstacles among handicapped people and their better integration in the society. Some benefits are accessible to all people with disabilities while other specific benefits are recognized in relation to the severity of the disability. Types of benefits: employment benefits, benefits for relatives, fiscal facilitation.

Moreover, over the years many strategic programmes have been implemented:
- National Health Plan 2006-2008: the institutional framework in which it has been written is the "health-care federalism". The main objective of the Plan is to guarantee that not autonomous elder people can stay at their own home (as much as possible). Consequently institutions and formal and informal groups must cooperate in order to optimise actions in their own fields of competences. The way is to work on implementation among various health-care components (at hospital and on territory).

• National Health Plan 2010-12 stressed on process on de-hospitalization processes and organization of home care services for elder people and not autonomous people; moreover it was focused on Activation of information flows related home care services and residential care services.

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• National Health Plan 2014-16 keep the importance to have a sustainable health system, able to face new challenges as the aging of population. In Turkey, the Regulations, the Ministry of Family and Social Politics makes a payment of a net minimum wage for the disabled person who are taken care of by their families. The Disabled Law (no.5378), proposes systematic and qualitative care service regulations for the disabled individuals in need of care, and give prior importance to provide care services in home environment rather than institution care.

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According to the Regulations, the Ministry of Family and Social Politics makes a payment of a net minimum wage for the disabled person who are taken care of by their families.

Regarding strategic programmes, although sustainability of home care services was the target of First Five-year Progress Plan prepared in 1963, studies in this field has started as of late in Turkey. The Ministry of Health brought legislations about the institutions Providing home care services with the Regulation About Provision of Home Care Services, published on official journal in 10th March 2005, no. 25751, fort he first time. In Polond current legislation lies on a set of recent laws.

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The Law on Cash Benefits from Social Insurance in Case of Illness and Motherhood of 25 June 1999 introduced akind of benefit that a person taking care of a sick member of the family could receive is the care allowance. It belongs to cash benefits from social insurance in case of sickness and maternity, known also as the provision of sickness insurance benefit. According to Article 32 the allowance may be granted to people who have a sickness insurance, both compulsory and voluntary, exempted from work because of the need to personally care for another sick family member. The monthly care allowance is paid in the amount of 80% of the salary of the insured. The acquisition of the right to the care allowance requires a medical certificate stating the necessity of the insured person to care for a sick family member.

The Law on Family Benefits of 28th November 2003introduced carer's allowance is a kind of care allowance which belongs to family benefits which are governed by the provisions of the Law on Family Benefits. According to Article 17 of the Law, these benefits are for people who do not start or who give up employment or other paid work to be able to care for a person holding a disability certificate. Obtaining the patient's certificate of moderate or slight disability is not a sufficient reason to grant an attendance allowance for his or her guardian, as additional circumstances should occur: the need for permanent or long-term care or assistance of another person in connection with a much reduced possibility of independent existence and the need for constant interaction of the child's guardian on a daily basis in the process of the child's treatment, rehabilitation and education.

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The Law on Social Assistance (The Law of 12th March of 2004) regulates the functioning of extremely important forms of assistance to the elderly. A person living alone who due to age, illness or other reasons requires the help of other people and is devoid of it is entitled to assistance in the form of care or specialist care services. Care services include assistance in meeting everyday needs, hygienic care, nursing prescribed by a doctor and, if possible, ensuring contact with the environment. Specialized care services are the services tailored to the specific needs arising from the type of illness or disability, provided by people with special professional skills.

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The system of social assistance provides benefits for people who do not start employment or stop working due to the need to provide care. These include the provision of an inkind benefit in the form of paying social security contributions for the carer. The Law on the Elderly of 11th September 2015,the purpose of the Law is to implement a system of monitoring the situation of the elderly. This task is to be carried out by public administration bodies, state agencies and other organizations involved in shaping the situation of the elderly. The scope of monitoring includes: the demographic situation, income situation, housing conditions, economic activity, family situation and the structure of households, the situation of people with disabilities, social activity and active citizenship, educational and cultural activity, sports and recreational activity, health, the availability and performance of social services, equal treatment and preventing discrimination based on age and the senior policy implementation.

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Regarding strategic programmes there are some important documents:
- The Assumptions of Long-Term Senior Citizen Policy in Poland for 2014-2020, fulfil the obligations laid down in the Government Programme for Social Active Ageing for 2012-2013 (ASOS). The ASOS programme is the first nationwide programme developed on such a scale, designed for the elderly and intergenerational cooperation. The implementation of the ASOS Programme helped to lay the foundations for the senior citizen policy in Poland (a policy pertaining to elderly people and for the elderly). The Assumptions of LongTerm Senior Citizen Policy in Poland for 2014-2020 constitute a framework but offer a concrete set of necessary measures for the area of the senior citizen policy in Poland, which is directed at a wider audience. The document indicates the necessary actions in various areas of public policy aimed at creating a synergy effect, such as:

o Health and independence (including the conditions of Medical Solutions — Protection, Security, Space and Residence);
o Activity of people 50+;
o Educational, Social and Cultural Activity of the Elderly;
o Silver Economy;
o Intergenerational Relationships

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A comprehensive approach taking into account the problems of the senior caregivers can be found in Priority 3 in the area of Health and Independence of ZDPS — "The development of social and care services tailored to the needs of older people" and its Aim 4 "The creation of systems supporting informal carers, particularly at the local level." The recommended directions of intervention include: o supporting the family and informal carers, o developing systemic solutions to support those caring for the elderly (enabling to combine work and care), o creating access to information on support options for carers and on how to improve the quality of care by informal carers, o enabling long- and short-term care over the older person, for example in the case of the caregiver's hospitalization or respite care, o the development of voluntary care (including in the neighbourhood, in the local environment).

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Other recommendations important for family caregivers and the quality of home care are also present in other sections of the document. It is worth turning one's attention to the postulate of creating a comprehensive system of geriatric care, including in particular the geriatric home care. A novelty in Poland is recommended, i.e. the development of a system of benefits in cash or in-kind or in the form of cheques to cover expenses for services and care-related products (in combination with the eradication of the shadow economy in the care sector). It is also important to create conditions for increasing the diversity of care for the elderly: daily nursing homes, daycare caregivers, organized neighbourhood support, support for the development of self-help, volunteering and other forms, elimination of legislative and administrative barriers to the regulation of employment of informal carers.
The possibility of improving the quality of care services for older people is to be seen also in:

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- establishing a system of informing and educating caregivers about the problems associated with the care over an older person and the ways of dealing with them, together with the transfer of knowledge and experience from others, o enabling education, training, practices and exchange of practices and experiences for informal caregivers who need to care for older people (the family, neighbourhood support, volunteers),
- introducing a register, qualification, confirmation of skills and competence and issuing certificates for formal and informal caregivers.
- The Government Programme for Social Active Ageing (ASOS) for 2014-2020, the design of this programme has been based on the experience of a programme under the same name conducted in 2012-2013, which consisted of two components: the long-term (system) and the short-term (tender) component. The component of the current tender programme was based around these assumptions, calling for action in four priority fields:
o Education for the elderly;
o Social activity;
o Social participation of the elderly;
o Social services for the elderly (external services).
- The Programme "Solidarity across generations. Measures aiming at increasing the economic activity of people over, introduced Measures aiming at increasing the economic activity of people over 50" adopted on 24th December 2013 with ASOS and ZDPS. the objective of the current programme "Solidarity across generations" is to achieve an employment rate of 50% for people aged 55-64 by 2020, which in 2013, according to data from the Central Statistical Office, amounted to 40.6% (annual average data). The programme "Solidarity across generations 50+" emphasizes the provision of care, including care of the elderly,by working people.One of the challenges formulated in the programme is to support those who, on the one hand, will be excessively involved in the care of their older family members because of the almost non-existent solutions that would support them in this care, but on the other hand — especially in light of the changes in regulations to increase the retirement age — will have to combine care with work (the growing importance of the problem of "double burden").Under Priority 3.3 "The implementation of system solutions to encourage people aged over 50 to remain in employment and start work", among others, the following directions of intervention are defined:

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- the development and, first and foremost, popularization of the existing solutions supporting the reconciliation of professional and family life;
- introduce solutions reducing the burden of caring for dependants (elderly family members);
- the development of qualifications of a guardian of the elderly, accepted by all stakeholders, their inclusion in the integrated register of qualifications;
- increasing the employment rate of people aged 50+.

5.2 Expenditure for home care

With regard to expenditure for Home Care, good quality and quantity of data is available only in the Italian report. In the Turkish report there is the total expenditure
amount while thre are not data in the Polish report. So it's mpossible to do a joint analysis.

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BÖLÜM 3 – HOME CARE SERVICES APPLICATIONS WITH DATA

6 Home Care by Numbers

6.1 Number of people receiving home care

With regard to elder people who receives home care services at territorial level (local or regional), ECAH partners provided the following data.
In the Municipality of L'Aquila, in 2015, 83 elder people, especially female, have received home care service. Specifically: 40 people social and assistential care (SAD); 43 home care of health type (with the involvement of healthcare assistants, physiotherapists, doctors). Public home-care services provided monthly by the Municipality of L'Aquila is:

- 122 hours for SAD services (around 3h/month for user)
- 175 for ADI services (around 4h/month for user)

Moreover, Municipality of L'Aquila provides on-demand service to 29 elder people.

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Fig. 1 *Elder people receiving home-care (SAD and ADI)-Municipality of L'Aquila 2015*

Service provided	Elder people	Gender		Family unit		
		Male	Female	alone	Two members	Three or more members
SAD	40	*7*	*33*	23	8	9
ADI	43	*13*	*40*	3	22	18
Total	**83**	***20***	***73***	**26**	**30**	**27**

Source: Municipality of L'Aquila

The Local Plan for Not Self-Sufficiency provides for further benefit of various kind:

Fig.2 *Elder people receiving benefit by Plan for Not Self-sufficiency -Municipality of L'Aquila 2015*

Type of benefit	Elder people
Help-line	13
Mobility	9
Care allowance	16
Care allowance for serious disability	3
Care allowance for serious SLA (ALS-Amyotrophic Lateral Sclerosis)	3
Climatic Sojourn	25

Source: Municipality of L'Aquila, 2015

According 2015 Turkish Statistical Institute, in **Bursa** there are 238.698 over 65 people in total benefiting home care services.

Fig.3 *Elder people receiving home-care- Bursa 2015*

AGE	MALE	FEMALE	TOTAL
65-69	41.998	47.318	89.316
70-74	27.379	33.544	60.923
75-79	18.242	25.194	43.436
80-84	11.435	16.897	28.332
85-89	4.259	8.392	12.651
90+	1.310	2.730	4.040
	104.623	**134.075**	**238.698**

Source: Governorship of Bursa, 2015

Regarding at informal caregivers who take care to their relatives with disability, in Bursa, (data June 2016) there are 13.747 people getting home care payment, above all male gender (7.179). This numbers concern all people with disability, but if it takes in account only carers who assistant elder people (3.457) they are especially female (66,9%).

Fig.4 *Number of people benefiting from Home care payment- Bursa 2015*

AGE	MALE	FEMALE	TOTAL
0-4	260	185	465
5-9	641	442	1083
10-14	674	478	1152
15-19	800	504	1304
20-24	595	391	986
25-29	452	306	758
30-34	456	315	771
35-39	397	333	730
40-44	380	300	680
45-49	378	230	608
50-54	369	260	629
55-59	319	209	528
60-64	315	285	600
65-69	243	294	537
70-74	252	374	626
75-79	211	472	683
80-84	239	546	785
85-89	126	424	550
90-94	63	156	219
95-99	9	35	44
100-104	0	12	12
105	0	1	1
TOTAL	**7.179**	**6.568**	**13.747**

Source: The Ministry of Family and Social Politics-Bursa, June 2016

In Western Pomeriana (Poland) there aren't data about both elder people who receive home care services and informal caregivers . The Polish project partner has made an attempt to estimate the recipients of informal care in Western Pomerania on the basis of the benefits provided. The results are shown in the following table. In 2010, in Western Pomerania nearly 4,000 people were covered by the care services. While almost 2,000 people received benefits due to an extended illness. Unfortunately, this is only a small portion of people who are under the care of informal carers, and one als needs to be aware that these numbers are growing year to year.

Fig.5: Home care services and benefits- Western Pomeriana

Type of benefit	The number of people with a benefit granting decision	Total number of benefits
Specialist care services in the place of residence for people with mental disorders	448	84 007
Granted because of a prolonged illness	1 897	5 516
Granted due to disability	2 865	10 046
Care services - total	3 684	605 327
Specialist care services	186	17 141
The fee for the municipality for a stay in a nursing home	1 577	8 793

Source: Collegium Balticum study based on "Sprawozdanie półroczne z udzielonych świadczeń pomocy społecznej -pieniężnych, w naturze i usługach za styczeń - czerwiec 2010", Ministerstwo Pracy i Polityki Społecznej.

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6.2 Number of Home Care Providers Institutions /Which Organizations?

In the area of Municipality of L'Aquila there are many providers (both public and private) of care services for elder people:

- Elderly Health Care service Centre of Municipality of L'Aquila ("Istituzione Centro Servizi per anziani")
- Professional Social Service Municipality of L'Aquila ("Servizio sociale professionale" made up of social workers)
- "Multiprofessional Evaluation Unit" (Unità di Valutazione Muldisciplinare), of Local Health Unit of L'Aquila-Avezzano-Sulmona, is local work group in charge of evaluation of social-care needs of patient and his family. That unit consists in health professionals and one social-workers. Those three bodies are of planning and monitoring of home care services, with the collaboration of doctors from general medicine.

Practical management and implementation of home-care services is provided by a social cooperative, voluntary associations, working with public body. Network of services works thanks to the integration among those public and private bodies and family. The main local private bodies involved are:

- A.U.S.E.R. (Associazione per l'invecchiamento attivo- Active Ageing Association);
- 180 Amici (Associazione per la tutela della salute mentale- Mental Health Association);
- V.A.D.O. (Volontariato per l'assistenza domiciliare- Voluntary Home Care Association);
- Red Cross – Local district of Aquila;
- White Cross of Aquila (it doesn't provide home-care services. It provides only emergency services);
- Caritas Abruzzo.

Also in Turkey, home care service is served by central government, local governments, private organizations and NGO's. The Ministry of Family and Social Politics, and the Ministry of Health are the main provider on the central governmental basis. On the other hand, at local basis municipalities are the main providers of home care. Besides protective and preventive services, the Ministry of Family and Social Politics for children, youngesters, women, families, disabled people and elder people wo are in need of protection, rehabilitation, care or help in the both day and night institutions.

7. Home Care Services Applications Implemented Locally

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In Turkey, the local management system of home care services is mainly in charge of Municipalities. Municipalities are the local operators which filling deficiencies of the centralized management in the social services by taking the advantage of the physical and the psychological closeness. It is increasingly diversified services within the municipalities involved in and services become more socially dimensional. Law number 5393 points the municipalities to be the primary service providers so as to provide the basis for the municipalities to meet the social and cultural needs besides their traditional responsabilities. Municipalities proposes services for the elderly; such as home and institutional care services, psychological services, health services, counseling, guidance and accompaniment services, social and cultural activities, cleaning and care services, in-house maintenance and repair services, food, clothing and fuel help, economic support services, priority service card, emergency, the elderly free card.

The Disabled Law (no.5378), proposes systematic and qualitative care serviceregulations for the disabled individuals in need of care, and give prior importance to provide care services in home environment rather than institution care. Metropolitan Municipality Law with number 5216 obligates the metropolitan municipalities to establish the unit of disabled people services. Under this law, Regulation of Disabled People Service Units within Metropolitan Municipalities has been legislated in 16th August 2016.

There is not such a standard approach to the implementations of home care services in Turkey. Services that are provided differs from one municipality to the other. The needs and the necessities of the citizens are the determinant factors of the service range In the unit founded within the Department of Health Affairs of Bursa Metropolitan Municipality, home care service is provided since 2010.

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In Italy, care-service system is managed by a set of public and private players working together. Municipality of L'Aquila works mainly through Istituzione Centro Servizi per Anziani of Municipality who manages social services for elder people over 65. Indeed it's ADI and SAD services. Moreover, Municipality provides even "Rete di prossimità"
(Proximity Network) services:
o On-demand support service for elder people living alone
o Practical coordination center of social mobility services
o Help and orientation phone-centers for citizens with problems

Through Local Plan for not self-sufficiency, Municipality provides:
o Help-line service addressed to elder people and not autonomous people facing emergency situation
o Support-line service: set of services provided by phone, very important for elder people. For many patients they are the only opportunities to stimulate socialisation
o Mobility service addressed mainly to over 65 and serious disabled
o Daily Care Centres: services supporting families and other people who take care elder people all day long.
o Care allowance: for families taking care of elder people in their own homes (avoiding hospital).
o Allowance for serious disability: just for families taking care people with serious disability, who need social-health assistance and monitoring h24.
o Allowance for serious disability addressed to people with SLA (ALSAmyotrophic Lateral Sclerosis)
o Thermal baths for elder people not autonomous As an alternative and/or in integration of familiar assistance and assistance provided by Municipality, Centro Servizi Progetto Famiglia Network dell'Aquila (Family Project Network L'Aquila) provides home-care services for elder people who need help for ordinary activities. This player provides social-health services, social-care services and services to person 7 days per week. Types of services provided:

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- Home-care assistance (day and night)
- Supporting services for elder people
- Domestic actions for personal cleanliness
- Helping at bath
- Supporting in meal: preparation and provision
- Helping in moving from bed
- Domestic cleaning
- Nursing services
- Physioteraphy services
- Caregiving services

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The Health District of L'Aquila Area is the headquarter of the Local Health Authority. It provides 37 Municipalities with a population of about 100,000 inhabitants, mostly elderly, widespread mainly in mountainous area. Among practical units there is "Cure Intermedie" (Intermediate Care) including: residential care and semi-residential care - Home Care that deals with the following home care activities:

a) home care performance (basic performance, random or planned in cycles. They are medical, nursing and/or physiotherapy ones) provided to 692 users in 2015, 538 users in the first-half of 2016.

b) complex and/or integrated home care performance (complex services with coordinated intervention of several professionals, including medical specialists and/or care workers) provided to 1432 users in 2015, to 845 users in the first quarter of 2016;

Patronage ACLI (charitable institution), provides services addressed to elder and disabled people. Some services: Sportello Salute (Health Office); Servizio Incontra Lavoro (Job Service); Servizio Mondo Colf ("World Caregiver" Service). Users in L'Aquila are around 500.

Mobile Desk-service of INPS provides services to retired people by telephone or at home. Users based in the Municipality are 2.525 (over 80).

People receiving disability allowance in L'Aquila Municipality are 1.727.

Serious disabled recognised in the Municipality are 2.390.

The recognition of the holders of severe disabilities within the territory are municipal
in 2390.

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PART 4 - SWOT ANALYSIS

In the last part of the analysis a research on field was carried out through the involvement of main local stakeholders. 3 meetings (held in Italy, Turkey and Poland) was focused on the informal caregiving addressed to elder people. A SWOT Analysis has been realized in which the main elements came up.

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Strengths		
ITALY	**POLAND**	**TURKEY**
1. Compactness of all family members 2. Sharing of assistance tasks 3. Reinforcement of sentimental relationship in the family 4. Competences needed are acquired quickly 5. Attention and availability in learning needed competences and using them 6.Valorisation and recognition of the role of caregiver 7. Elder person feels better in staying at home (great feeling of indentity) 8.Good timing balance among family members 9. Frequency and continuity of the relationship 10. Increased "Network of help" 11. Great relationship of informal caregivers with services and formal caregivers (usually they	1.An emotional bond between the elderly person and his or her caregiver. 2.The elderly person stays in a familiar environment – a sense of security. 3.Attachment between the caregiver and the person he or she cares for. 4.The involvement of carers. 6.Self-help by older people in senior clubs and from volunteering seniors. 7.The existence of institutions and organizations providing services to the elderly.	1.Strong corporate infrastructure 2.Legislation existence of institutions 3.Support of local authorities 4.It's preferred by people in need of care 5.Care at home is common and preferred 6.Free of charge service 7.To prevent over bed capacity in health institutions 8. Care at home is cheaper than services given by institutions 9. Becoming widespread of information Technologies in public services presentation 10.Being open to innovation and change 11.Presence of educated expert technical staff 12.Demographic and cultural

Strengths		
ITALY	**POLAND**	**TURKEY**
are friendly and available to hear problems) 12.Good level of information (thanks to informal network – ex. Neighbours) 13.Accessory support (ex. Law 104) 14.Incomes from elder person help in economy of the family		diversity, social capital 13.Strengthens in traditional and cultural structure 14.The activity field is open to improve project and services 15.Support of government in social services and policies

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WEAKNESSES		
ITALY	**POLAND**	**TURKEY**
1. Excessive attachment to elder person (too much involvement and emotion) 2. Roles within the family are not well-specified 3.Female members of family have too much responsabilities 4. The lack of emotional detachment in some cases (ex. Emergency) 5.Ethnicization of care (in case of foreign caregivers) 6.Not all houses fit needs in terms of space	1.The lack of support to the caregiver from other family members. 2.Financial problems of family caregivers due to lack of work or part-time work. 3.The high cost of home care services based on the market services. 4. Health problems of caregivers resulting from stress and neglecting their own health. 5.The lack of information on solutions that can facilitate care. 6.The lack of trust in institutions on the part of caregivers. 7.The age of caregivers, who are often elderly themselves. 8.The lack of preparation of informal carers to provide care. 9.The lack of time and willingness on the part of	1.The lack of coordination and communication between institutions 2.Having insufficiencies in application of home care services policies by some institutions 3.Absence of common language in applications 4.Lost of morale and motivation of long term care-givers 5.Lack of units which supports care-givers socially and psychologically 6.Increasing of women employment 7.Assuming home care pension as salary 8.Insufficiency in trainings of care-givers

WEAKNESSES		
ITALY	**POLAND**	**TURKEY**
	caregivers to receive training on care and nursing.	9.A few departments about home care services in undergraduate studies of universities 10.Couldn't make house conditions suitable to care environment 11. Limited number of home care staff to cover service demand 12. Insurance Premium not paid by the Government 13. Insufficiency actions in advertisement and public relations 14.Problem in technical staff 15. Not enough NGOs in the field 16. Inadequate legislation about home care activities 17. Focused demand working approach

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Opportunities		
ITALY	POLAND	TURKEY
1. Identification of new tools to promote a comprehensive response to the needs of people (eg. Cohousing - cooperatives where to buy cheap products - banks of the time) 2. Developing and implementing new technologies, above all communication skills related to elder people and home care, access to services, communication among services, volunteers and local bodies. 3. New training opportunities and Exchange among social workers, social-health workers and volunteers. 4. Net Age as opportunity to learn and do networking 5.Developing a public-private partnership by involving all sectors of society in ensuring the best possible quality of life on territory, allowing a better balance of timing and work (often female gender is more stressed). 6. Providing the possibility that (where it is possible), relative in the family officially gets the role of "caregiver" by earning money from the pension received by the	1.The change of state policy in relation to the service system – from institutional to home services. 2.Training for informal carers. 3.Financial support for carers who give up paid employment completely or partially. 4.Establishing a greater number of daycare homes for the elderly with transportation, rehabilitation and warm meals for the elderly. 5.Temporary forms of support for the carer who doesn't work (a few hours a week). 6.Adapting daycare homes to the needs of seniors with varying degrees of efficiency, including people with dementia. 7.Temporary residence for the elderly person (at least once a year) – a break for the caregiver. 8.Free transport services. 9.Co-ordinator / assistant of home care as a form of support for carers. 10.New forms of obtaining information,	1. Presence of database 2.Using technology in service presentation actively 3. Giving home care pension to care-givers 4.Awareness of healthy elderliness 5.Strong family bonds 6.Stimulate quality improvement in care services during EU accession process 7.Willingness of institutions in services presentation 8.Accessory Materia medical paid by Social Security Institution 9.Willingness of local authorities 10.Raising employment quality and capacity in care and health field 11.Increasing demand in qualified service

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OPPORTUNITIES		
ITALY	POLAND	TURKEY
elder people. 7. Providing the possibility to organize network of proximity and social volunteer networks that can help informal caregivers in their work 8. Hypothesizeing the possibility of a specific training to family members who work as informal caregivers in order to give them a specific "competence" they can spend in the labour market. 9. New generation of elder people will be more aware and ready to face emergency 10. To increase training courses about elder people care 11. To improve health conditions of elder people by getting them aware on topics about health 12. Developing interngenerational partnerships and collaboration among schools and universities; 13. Greater cooperation in the name of a common commitment, involving all aspects of society so that local communities and voluntary organizations become more aware of their	e.g. E-consultancy. 11.Psychological support for carers. 12.The creation of support groups associating caregivers. 13.Non-governmental organizations supporting informal carers, e.g. through free training. 14.Good cooperation between NGOs, local governments, schools, hospitals and social assistance in terms of services for the elderly. 15.Educating volunteers on supporting older people. 16.Social workers visiting people over 70 years old. 17.Issuing a guide for seniors and caregivers. 18.The possibility of obtaining financial support from assistance funds for activities for the elderly. 19.The increase in wealth of the society, including the elderly. 20.Implementation of programmes and social projects for the elderly.	

OPPORTUNITIES		
ITALY	POLAND	TURKEY
responsibilities for the quality life of citizens. 14. Inclusion of EU and non-EU citizens into the local society. 15. Support services and home support, even with economic benefits, particularly for families who have reception tasks, care of disabled people and elder people. 16. Comfort services to caregivers, also providing for the possibility of replacing them in nursing responsibilities during working hours. 17. Approval of the national programme of social health assistance 18. Preparation of law about long-term care 19.Adopting fiscal measures addressed to elder people within health and social welfare services, even taking into the account the issue of poverty reduction. 20. Planning a proper welfare system, even at local level 21. Institutional welfare system needs to be better protected by developing a network of public-private management services 22. Increasing competences, skills and		

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Opportunities		
ITALY	POLAND	TURKEY
self-esteem of caregivers; it becomes a strength of the social protection system and prevention against social exclusion. 23.Learning experiences both individual that in group also for specific diseases (see dementias, chronic disabling diseases, oncological diseases etc.). 24. Psycological and personal counseling for situations entailing greatest emotional commitment and / or particular fragility of people.		

Threats		
ITALY	POLAND	TURKEY
1. Inaccessability to data about services for elder people 2. New Italian pension system increases the duration of working life, by reducing timing that family members can spend for the care of the elder people. 3. Shortage of professional training courses for caregivers and/or relatives. Few training courses available are very expensive. 4. For informal caregivers all day long assistance is a limit to perform their own jobs and to have opportunities outside the work. 5. Number of elder people is growing. Also number of elder people abandoned is growing. 6. Not close relationship among family members, shortage of social relations. So family of elder person often is alone in caregiving tasks. 7.Cult of individualism and poor social relationships 8. Negative perception of	1. Ageing population. 2. Increasing average life expectancy. 3. Decreasing fertility rate. 4. Changes in the family model (economic migration, the weakening of family ties). 5. Difficult access to information which is located in many sectors – health, social insurance, social assistance. 6. No reports on the number of informal carers in Poland or the region. 7. Exclusion and discrimination of older people. 8. Low income of elderly people in relation to the basic needs and the reality of the market. 9. Too low income criterion in the Law on Social Assistance to provide free assistance. 10.Reduced level of care for the elderly by family members.	1.Increasing rate employment join of relatives who give care 2.Possibility of insufficiency in financial resources for providing service 3.Changing family structure to elementary family 4. Increasing elder population gradually 5. Increasing of chronic illnesses 6. Negative change in cultural structure 7.Giving up home care policies by institutions 8.Not prefer home care by family members 9.Insufficiency in quantity and quality of care giver experts

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AB PROJE ve DIŞ İLİŞKİLER
KOORDİNASYON MERKEZİ

T.C.
Aile ve
Sosyal Politikalar
Bakanlığı

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