The Routledge Handbook of Social Care Work Around the World

Edited by Karen Christensen and Doria Pilling
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Challenges and opportunities

Sema Oglak

Introduction

Although Turkey’s population is younger than that of European countries, the ageing population is growing rapidly and elderly people have an increasing need for long-term care services. The ageing of Turkey’s population reflects a combination of declining birth rates, leading to fewer young people, and increasing life expectancy. The ageing of the population will have major implications for the long-term care sector, and in Turkey there is no long-term care insurance system. Elderly people are usually taken care of within their own family.

The aim of this chapter is to explain the current situation regarding the inadequate long-term care infrastructure, particularly of home care services, and to indicate the challenges posed. The next section briefly describes the background situation in Turkey and the present state of public social spending compared with other OECD countries. This is followed by a section indicating the sources on which the chapter is based. Next, the demographic outlook is set out: the rapidly rising ageing of the population, the expected changes in dependency ratio of older people, and their health. Changes in family structure are briefly described next. Following this, the major reform of health insurance and the social assistance available for older and disabled people are explained. Recent government policies for older people are next described. Then the long-term care situation is set out. The concluding section sums up the current situation of long-term care, and the challenges faced.

Context

Turkey, a country that has undergone rapid urbanization, is a middle-income country, with the 18th largest economy in the world (World Bank, 2017). According to the World Bank, its economic performance has been impressive since 2000, its poverty incidence being halved between 2002 and 2012, and extreme poverty falling even faster. A number of important social reforms have taken place since 2000, including that of the previously occupationally related health insurance system into a national health insurance programme with near universal health coverage. However, growth has slowed since 2012, and the outlook is uncertain (World Bank, 2017).
Table 13.1 Comparing total public social expenditures, 1990–2014 (% of GDP), Turkey and OECD

<table>
<thead>
<tr>
<th>Year</th>
<th>Turkey</th>
<th>OECD</th>
</tr>
</thead>
<tbody>
<tr>
<td>1990</td>
<td>5.5%</td>
<td>16.9%</td>
</tr>
<tr>
<td>2000</td>
<td>7.7%</td>
<td>18.0%</td>
</tr>
<tr>
<td>2005</td>
<td>10.3%</td>
<td>18.8%</td>
</tr>
<tr>
<td>2010</td>
<td>12.8%</td>
<td>21.1%</td>
</tr>
<tr>
<td>2011</td>
<td>12.5%</td>
<td>20.7%</td>
</tr>
<tr>
<td>2012</td>
<td>13.0%</td>
<td>21.0%</td>
</tr>
<tr>
<td>2014</td>
<td>13.5%</td>
<td>21.1%</td>
</tr>
</tbody>
</table>

Source: Adapted by author from OECD Social Expenditure Database (SOEX) (OECD, 2016a).

Turkish public social spending of 13.5 per cent of GDP in 2014 is much below the average of 21.1 per cent (Table 13.1). It has increased from less than 8 per cent in 2000 (Uckardesler, 2015, p. 151). In Turkey, most social spending is related to pension payments and healthcare expenditure (Uckardesler, 2015, p. 152). However, compared to the OECD average for income support, which amounts to 5 per cent of GDP, Turkey spends only 1.1 percent of its GDP to support the disadvantaged population via social assistance and social services. The amount was an even lower 0.30 per cent of GDP in the early 2000s (Uckardesler, 2015, p. 152). Figures are unavailable for expenditure on long-term health and social care.

Methods

This chapter is mainly based on secondary data from various Turkish government sources, including the Turkish Statistical Institute (Turkstat), Ministry of Family and Social Policies (MoFSP) and Ministry of Health (MoH). Data from international sources such as Eurostat and OECD were also used.

An important research source drawn upon in the chapter are analyses of the social implications of changes in the family in Turkey (MoFSP, 2014a, 2014b, 2014c). These analyses are mainly based on data from two surveys using representative samples of families in Turkey, termed Research on Family Structure in Turkey (TAYA) conducted by MoFSP in 2006 and 2011. Data were collected on family structure, lifestyles and values of family life. In TAYA 2006, 12,208 households were included, demographic information of 48,235 individuals belonging to these households was collected, and face-to-face interviews were conducted with 23,279 individuals over the age of 18, 2,213 of these individuals being aged 65+. In TAYA 2011, 12,056 households were included, the demographic information of 44,117 individuals belonging to these households was collected, and face-to-face interviews were conducted with 24,647 individuals over the age of 18, 2,455 individuals being aged 65+. A further Research in Family Structure survey was conducted in 2016 (Turkstat, 2017a). The author’s own research on long-term care in Turkey is also a source for the chapter.

Demographic outlook

Ageing and emerging issues of care are generally more apparent in developed countries. Yet ageing is also becoming more and more important for developing countries, and Turkey is not an exception. Although Turkey is known for its young population, it is now becoming known as one of the fastest-ageing countries in the world (He et al., 2016, p. 11; Apakan, 2012, p. 2).

The percentage of the older population (65+) was around 3.9 per cent in 1935 and remained at under 6 per cent until the 2000s, rising rapidly to 8.3 per cent by 2016 (Turkstat, 2017b,
Table 1). According to population projections by Turkstat, this demographic shift will continue into the future. It is expected that the proportion of the elderly population will rise to 10.2 per cent in 2023, 20.8 per cent in 2050 and 27.7 per cent in 2075 (Turkstat, 2013). In absolute terms, Turkey’s 6.7 million older adults in 2016 (Turkstat, 2017b) already outnumber the total populations of several European countries, such as Denmark (5.7 million) and Norway (5.2 million) (Eurostat, 2015). In the next 20–30 years, both the number of those aged 65+ as well as their share in the total population are expected to increase at an extraordinary rate (He et al., 2016, p. 11).

It is noteworthy that Turkey’s ageing process is different from that of the developed countries. There are two reasons for this. First, Turkey is ageing faster than the developed countries. The demographic changes that took 115 years in developed countries such as France (He et al., 2016, p. 12; National Institute on Aging, 2011, p. 4) will take place in Turkey in only a few decades (velocity of ageing). Second, developed countries first developed and then aged. Therefore, they had the chance to accumulate the capital to finance the burden of ageing. Turkey has to manage its development and ageing processes at the same time (sequence of ageing) (Apakan, 2012, p. 2).

Fertility rates have declined markedly in Turkey since the 1960s from 6.30 children to 2.1 in 2015 (World Bank, 2016). In contrast, as a result of improvements in health and living conditions, life expectancy at birth has gradually increased in Turkey. Table 13.2 indicates the increase in longevity between 1970 and 2015. From this perspective, with the falling fertility rate and the increase in life expectancy, Turkey will not long remain a country with a young population. Turkey currently has a relatively low life expectancy at birth, although it has achieved huge gains in longevity over the past few decades (78.1 in 2014) and is quickly moving towards the OECD average, 80.9 in 2014 (OECD, 2016b, pp. 56–7).

Turning to changes in ratios of dependency, the total ratio of individuals dependent on others (ratio of people aged 0–14 and those aged 65 and over to working-age population, 15–64) has been falling gradually, from 84 in 1940 to 78 in 1980 and 48 in 2012 (Eryurt, 2014, p. 96). However, the elderly dependency ratio of people aged 65+ to the working population (Table 13.3) has increased to 12.2 per cent in 2015, and this measure is expected to reach 33 per cent in 2050.

**Table 13.2 Life expectancy at birth in Turkey (1970–2015)**

<table>
<thead>
<tr>
<th></th>
<th>1970</th>
<th>2002</th>
<th>2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>52.9</td>
<td>70.5</td>
<td>75.4</td>
</tr>
<tr>
<td>Female</td>
<td>57.3</td>
<td>74.7</td>
<td>80.9</td>
</tr>
<tr>
<td>Total</td>
<td>55</td>
<td>72.5</td>
<td>78.1</td>
</tr>
</tbody>
</table>

Source: Adapted by author from: (1) Hamzaoğlu and Özcan (2006, p. 24); (2) MOH (2015a, p. 17, Figure 2.1); and (3) OECD (2016a, p. 57, Tables 3.1 and 3.2).

**Table 13.3 Actual and projected changes in elderly dependency ratio, Turkey, 1940–2075**

<table>
<thead>
<tr>
<th></th>
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<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Elderly dependency ratio (aged 65+)</td>
<td>6.5</td>
<td>5.7</td>
<td>6.4</td>
<td>8.2</td>
<td>8.5</td>
<td>7.1</td>
<td>8.8</td>
<td>10.8</td>
<td>12.2</td>
<td>33</td>
<td>48</td>
</tr>
</tbody>
</table>

Source: Adapted by author from Turkstat (2017b, Table 3); Eryurt (2014, p. 96).
As the ageing population continues to grow, health expenditures are likely to gradually increase, though other factors may have a larger impact than ageing itself (National Institute on Aging, 2011, p. 18).

A crucial question is whether projected gains in longevity will be accompanied by increases in illness, disability and vulnerability. Like other middle-income countries, Turkey is far into the epidemiological transition and has seen major shifts in the main burden of disease away from communicable diseases towards chronic diseases (WHO, 2012, pp. 26–7).

**Health and social inequalities in elderly people**

While the average proportion of people aged 65+ in OECD countries in 2013 reporting good/very good health was 43.4 per cent, less than 20 per cent of over-65s in Turkey reported this (OECD, 2015a, Table 11.6). There were strong differences between men (26.1 per cent) and women (12.6 per cent) reporting good/very good health. Findings from the Turkstat Health Interview Survey 2012 indicate that only 13.6 per cent of women and 24.3 per cent of men aged 75+ reported good/very good health, the percentages being lower in rural than in urban areas (Moh, 2015a, p. 35). Compared with the average for OECD countries (50.1 per cent), a higher proportion of Turkish people (56.9 per cent) aged 65+ also reported that they were limited in their daily activities (OECD, 2015a, Table 11.7). Lower income has also been found to be related to poorer health in people aged 60+ (Ergin and Mandiracioglu, 2015).

**Changing family structure and increase of living alone**

Turkey has become similar to developed countries in family size. Extended families that provided care for elderly family members in the past are being replaced by nuclear families. It was found in the Research on Family Structure survey 2011 that 15.9 per cent of older people lived alone, 22.9 per cent of women and 7.5 per cent of men, while 42.7 per cent lived with their spouse alone (Eryurt, 2014, p. 100). However, according to the 2016 Family Structure survey, it seems that people aged 65+ are still very keen to co-reside with their children if they become unable to care for themselves, 51.3 per cent giving this as their preference, compared with 27.5 per cent wanting home care and only 7.7 per cent wanting to live in a nursing home (Turkstat, 2017b, Table 15).

**Turkish social security system**

In the past, Turkey had a predominantly Bismarckian social security system. This is one in which expenditure is funded through social insurance, employees and employers jointly contributing (SSI, 2016). Social insurance programmes were based on occupational groups, with separate schemes for different groups, and those working in the informal economy were excluded.

**Turkey’s healthcare system**

Before the Health Transformation Programme in Turkey in 2003, the organization and financing of healthcare services were fragmented. There were different health insurance schemes for different occupational groups, and from the 1990s a ‘green card’ non-contributory scheme for people with very low incomes. There were varying benefit packages and premiums for the different schemes (Atun, 2015; Yilmaz, 2013; Agartan, 2012; Baris et al., 2011). The first
major change was the transfer of public hospitals, formerly owned by the insurance funds, to the Ministry of Health, there also being incentives for private health services to play a larger part in public healthcare delivery. Second, under legislation implemented in 2008, the different insurance funds were merged under a single body called the Social Security Institution (SSI). The green card scheme became part of this general health insurance in 2012 (Karadeniz, 2012). Following the healthcare transformation, Turkey has achieved almost universal health insurance coverage (SSI, 2016). Every citizen has to contribute, according to their income, though there is a means test below which those with very low incomes have their contribution paid by the state. Health spending has increased considerably, but at 5.1 per cent of GDP in 2013 (OECD, 2015b) is well below the OECD average of 8.9 per cent of GDP. The share of government spending on healthcare has increased, though, to 78 per cent, above the OECD average of 73 per cent (OECD, 2015b). Since the reforms, reasonably successful and improved health outcomes and high and rising levels of consumer satisfaction have been achieved (WHO, 2012, p. 8). Out of pocket spending by households decreased by half between 2010 and 2013 to 22 per cent. However, there is some evidence that co-payments for hospital visits and medication, and additional co-payments for private providers, may be resulting in income inequalities (Yilmaz, 2013; Agarton, 2012). There are still inequalities in health status, satisfaction levels and access to health services due to differences in healthcare infrastructure, personnel and insurance coverage among different regions and urban-rural settings (Okem and Cakar, 2015, p. 116). The reforms, though, have improved access to healthcare for older people.

Pensions and social assistance for older people

Using data from the TUIK 2009 Household Budget Survey (Karadeniz and Durusoy, 2011, cited by Karadeniz, 2012, p. 11) it was found that nearly 50 per cent of people of pensionable age were receiving a contributory old-age pension or means-tested pension (tax-funded), while 15.4 per cent were receiving a survivor’s pension. There were large differences between men and women, with 68.6 per cent of men receiving an old-age pension but only 8 per cent of women doing so. More women (26.3 per cent) than men (13.2 per cent), though, received a survivor’s pension. Low labour market participation, low-paid or unregistered work (i.e. not paying pension contributions) and unpaid family work result in many women not receiving a contributory old-age pension.

A means-tested pension scheme was introduced in 1976 (Law Number 2022). People aged 65 and over who have no income or other means of assistance have been entitled to a monthly pension since 1977 (Karadeniz, 2012, p. 9). However, while contributory pension rates have increased above the level of inflation over the last 10 years, this is not the case for the tax-funded pension, and it is still extremely low compared with other minimum pension amounts (Karadeniz, 2012, p. 14).

Policies for older people

As well as the improved healthcare coverage, there have been other recent government policies aiming to improve the position of disabled and older people. The Ministry of Family and Social Policies (MoFSP) was established in 2011. The General Directorate of Services for Persons with Disabilities and Elderly People (GDSPE) within the structure of the MoFSP was established at the same time. The MoFSP became the sole government body responsible for both carrying out services and coordinating public and private institutions that provide services for
elderly people (Karadeniz, 2012; Republic of Turkey, 2012). GDSPDE carries out the following activities with the purpose of fulfilling its responsibilities on social policy implementations towards elderly persons: (a) to plan, monitor, coordinate or audit services that aim at determining socially or economically disadvantaged elderly people or providing them care or protection; (b) to plan, implement, monitor or coordinate for the audit of related activities on establishing and systematically enhancing quality of institutional care settings and widespread community and home care facilities; (c) to plan or ensure implementation of activities aiming at protecting elderly people in social life; and (d) to determine the procedure and rules of establishment, operation or audit of institutions for elderly people to be operated by public institutions, natural or legal entities, and to provide guidance, coordination or monitoring for these institutions. The establishment of the GDSPDE brought a new insight to services for elderly people. A National Plan for Action was to focus on social integration of elderly people, improvement of long-term services and solving healthcare problems of elderly people. The plan was not only to improve the quality of the existing services, but also to introduce new service and care models based on societal realities (Republic of Turkey, 2012, p. 3).

**Availability of long-term care for elderly people**

**Lack of data**

There is a lack of information on long-term care in Turkey. Indicators used in *Health at a Glance: Europe* (OECD, 2015c) for the number of care recipients, informal carers, long-term care beds in hospitals or institutions, or long-term care expenditure do not include Turkey, indicating that there is no clear and consistent data collection on long-term care in Turkey. Scheil-Adlung (2015) has pointed out that in the absence of such data, informed decision-making is hardly possible, and issues regarding LTC remain unclear and confusing.

**Informal care**

Traditional family relationships and ties are still very strong for older persons in Turkey; family and friends are the most important source of care for people with long-term care (LTC) needs. Women, in most cases, are responsible for care within the family (Ozbay, 2014, p. 87; Republic of Turkey, 2012, p. 13, SPO, 2007, p. 110). According to the data from the *Research on Family Structure* study (MoFSP, 2014b), care for elderly people in households is conducted primarily by daughters-in-law (32 per cent). The rate of households where care is given by the spouse is 27 per cent, by the son 22 per cent, and by the daughter 20 per cent. The rate of households with a paid caregiver is only 2 per cent (MoFSP, 2014b, pp. 278–9). Six per cent of households in Turkey were found to have an elderly person in need of care. The Turkish Civil Code and the Turkish Penal Code include certain obligations for the family to look after dependents (Karadeniz, 2012, p. 23). Results from the *Turkish Population and Health* study (2008) show that even when children do not live with their parent, they prefer to either live in the same building or nearby (Koc et al., 2010, cited by Eryurt, 2014, p. 103).

There are no clear and sustainable support services or policies for informal caregivers in Turkey, apart from monetary help to poor families (Ozbay, 2014, p. 87). Often the type of care provided by informal family caregivers is very demanding, particularly if care is needed beyond the activities of daily living such as dressing and eating. As indicated above, it is not easy to obtain data on the number of people caring for family and friends in Turkey.
Migrant care workers

Declining family size, increased geographical mobility and rising participation rates of women in the labour market mean that there is a risk that fewer people will be willing and able to provide informal care in the future in Turkey. The lack of adequate public care services and formal care worker shortages are the main drivers of demand for migrant care workers (Tuğan and Seedsman, 2015; Gökşayrak, 2009, pp. 60-1). It is particularly upper- and middle-class Turkish families who counter the lack of formal care provision and high female labour market participation by employing migrant women as domestic care workers.

Migrant care workers in Turkey are mainly women who have migrated from ex-communist countries such as the former Soviet Union, particularly Moldova, Uzbekistan, Turkmenistan, Azerbaijan, Bulgaria and Georgia. Since the mid-1990s, Moldova has become one of the main sending countries, especially for migrants of Gagauz ethnic origin who speak the Turkish language (Tuğan and Seedsman, 2015, p. 43; Akalan, 2007, pp. 121-2). Since 2003, new Turkish legislation (Work Permits for Foreigners, Law No. 4817) allows working foreigners to be employed as domestic workers (Official Gazette, 2003).

Formal care workers

One of the challenges in the LTC sector is the lack of skilled formal care workers (Karadeniz, 2012, pp. 4-5). Formal LTC workers per 100 people aged 65 and over in Turkey in 2013 have been reported as 0.1, compared with the average of 6.1 (OECD, 2015c, Table 11.17). Care workers in nursing homes have expressed the need for higher wages, better physical conditions, and psychological support (Öntanc and Tunç, 2011, cited by Karadeniz, 2012, p. 26).

Since 1998, care workers’ vocational training in Turkey has been provided by different institutions such as universities (vocational schools), the Ministry of Education (MoE) and the Ministry of Labour (Karadeniz, 2012, p. 26; Oglak, 2008, p. 243). Although the number of relevant faculties at universities, vocational training colleges and the number of courses have increased in recent years, formal care worker shortages have continued. Unfortunately, there is also no law that regulates the work of formal care workers in terms of defining their function and licensing.

Long-term care funding

Turkey does not have a long-term care insurance (LTCI), although this is planned for the future (Karadeniz, 2012, p. 4). A national long-term care insurance system benefits not only elderly people, but also protects the family members and the entire population against much of the financial risk of chronic illness and disability (Geraedts et al., 2000, p. 375). LTCI would provide relief from much of the financial burden of long-term disability and illness, thereby complementing the comprehensive medical services financed by a health insurance fund.

In the absence of an LTC insurance system, however, there are regulations in Turkey establishing a right to financial help with long-term care for low-income families. In order to support families with low incomes that care for disabled people, a tax-financed programme was introduced in 2006 (Karadeniz, 2012, pp. 23-4; Oglak, 2008). Only persons falling under certain income and wealth thresholds enjoy legal coverage for LTC. Thus, older people with income or assets above the thresholds have to first use up their savings and assets (sometimes even support of their relatives is taken into account) before being entitled to services. If a family’s income is below the poverty threshold, the MoFSP provides social assistance to family
caregivers (domiciliary care allowance) or payments to care homes or day centres. LTC coverage therefore exists but is limited. This system does not provide help to middle- or high-income groups (Karadeniz, 2012, p. 4).

Some older people who have no one legally responsible for looking after them, no pension, no property that would enable them to survive, or where the person legally responsible for them has an income too low to care for them, are entitled to free residential care (Karadeniz, 2012, p. 24). Five per cent of the capacity of private homes is also dedicated to poor older people who cannot afford the fees. The MoFSP local management determines the eligibility of elderly people for free care (Karadeniz, 2012, p. 24).

Provision of LTC

Provision of LTC is carried out by the MoFSP, municipalities, public institutions, NGOs, and minority ethnic groups – Greek, Armenian, Italian (mostly in Istanbul) – and private sector organizations, generally in residential care settings. Municipalities have duties and responsibilities to provide relevant services for ‘disabled, elderly, dependent and needy persons’ (SPO, 2007, p. 13). The Turkish Red Crescent (Kızılay) is an example of an NGO providing LTC. They provide residential or home-based care to people who have donated real estate to them (SPO, 2007, p. 36).

The changes in social structure have also changed people’s needs/demands and expectations of receiving care services from outside of the family. These expectations constitute not only residential care, but also patterns of social care services that do not separate elderly people from their social life, daily routines, friends, neighbours and relatives, allowing them to spend their leisure time effectively and productively. Karadeniz (2012) suggests that there has been a shift in political priority away from institutional care and towards home care.

Due to the lack of care facilities and insurance, many older people have difficulty accessing services, especially in rural areas (Republic of Turkey, 2012; Oglak, 2007, pp. 104–8).

Residential care

As seen in Table 13.4, approximately 38 per cent of residential care homes in Turkey are funded by the government, 6 per cent by the municipalities, and almost half by for-profit organizations. Altogether, there were 29,186 beds based in 353 facilities in 2016. The number of residential facilities has been growing but is still very limited; GDSPD facilities have increased from 106 in 2012 to 133 in 2016, and for-profit facilities from 123 to 164 (Eryurt, 2014, p. 103; cf. GDSPD, 2017 p. 15). Given that the population of those 65 years of age and older in Turkey is nearly 6.5 million and the number of elders residing in care institutions is 23,532, the rate of older adults residing in residential care or nursing homes is 0.004 per cent. These very limited capacities are concentrated in certain communities in large cities (GDSPD, 2017).

Residential care is the least preferred option for older people needing care services, both by family members and older people. Although the number of beds is limited, they are not totally occupied. While the results of several studies show that elderly people are satisfied with the social services and the support in residential care homes, at the same time they describe residential care homes as such places that force them to stay away from the people they love and the environment they lived in; study respondents state that they would never prefer residential care if they had any other choice (MoH, 2015a; MoFSP, 2014b; Oztop et al., 2008).
Applicants to MoFSP residential care homes have to be people over 60 years old who do not have any chronic illnesses or any physical or mental disabilities, but need social, physical or psychological support. They have to be able to perform daily necessities (eating, drinking, using the rest room) independently and not have any contagious disease (Özmete et al., 2016, p. 13). However, these homes also serve elderly people whose physical or mental condition declines after they begin their stay at residential care homes in special care services in a different section of the home (Özmete et al., 2016, p. 14). In addition, those who are in such situations in their homes and whose care has become difficult for their families may occasionally be admitted to special care services in care homes, or they can be admitted to private homes (MoFSP, 2014d). Private nursing homes admit people from the age of 55 (Özmete et al., 2016, p. 6). Their prices are also higher than those of public residential care.

There are also some innovatory forms of residential care for elderly people, such as small homes built in the grounds of residential care homes. Life homes are for more capable people, aiming to allow people to remain integrated in society. They are situated outside residential homes but are affiliated with them (MoFSP, 2017). Another innovation is elderly houses. These houses are ordinary apartment flats around the city that can accommodate up to four elderly persons (Republic of Turkey, 2012, p. 8).

Finally, hospitals are still highly important institutions for elderly people to obtain LTC. The hospitalization rate of people who are 75 years and older is 2.5 times higher than those between 25 and 44 years old (MoH, 2015b). The number of geriatric clinics and hospitals that are prepared for LTC has recently increased, but has still not reached a desirable level.

**Home-based care**

The provision of home care began quite late in Turkey. Home care services were first provided by private institutions, and since 2001 these services have been followed by some municipalities (MoH, 2015b, pp. 47–8). The first legal regulation in this field was the ‘Regulation on Home Care Service Providing by Private Organisations’, which was issued by the MoH and came into force in 2005, many years after the onset of care provision. The provision of home healthcare by public hospitals started in 2004, and regulation of this by MoH in 2010 was an important step for the dissemination of these services throughout the country (MoH, 2015b, pp. 47–8; Oglak, 2008; Oglak, 2007, p. 101). In response to most people’s preference to receive LTC services

<table>
<thead>
<tr>
<th>Table 13.4 Number of residential care facilities in Turkey (2016)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Number</strong></td>
</tr>
<tr>
<td>Operated by the General Directorate of Disabled and Elderly Services, Ministry of Family and Social Policies</td>
</tr>
<tr>
<td>Life Homes for Elderly Persons</td>
</tr>
<tr>
<td>Operated by other ministries</td>
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<td>Operated by municipalities</td>
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<td>Operated by associations and foundations (non-profit)</td>
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<td>Operated by Minorities</td>
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<td>Operated by for-profit private institutions</td>
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<td><strong>Total</strong></td>
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Source: Compiled by author from GDSPDE (2017).
at home, home healthcare services aim to ensure that dependent people in need of healthcare services are treated in their homes in a familiar environment. Delivering the necessary medical care and rehabilitation services outside of a hospital environment whenever possible reduces the number and duration of hospital stays (Karadeniz, 2012, p. 5).

With regard to home-based care, some public services (municipalities, NGOs) exist that are directed to helping people in need of social care with their daily activities. Generally, the availability of home-based care services is fragmented, very limited, and seldom available or affordable for older persons in need of care. Municipalities generally only provide social home care to poor and frail people, although there are plans to transfer government resources to them to develop their services (Özmete et al., 2016, p. 11). Furthermore, public and private home social care facilities tend to be located in the main cities, concentrated in provinces such as Istanbul, Ankara, Kocaeli, Trabzon, Aydin and Izmir (Oglak, 2008).

The MoFSP carried out a number of regulations in this field in 2006. Yet the MoFSP does not directly provide services at home. As indicated above, a means-tested monthly payment of the net minimum wage is paid by MoFSP to the family member caring for the elderly and/or disabled person in need of care living at home (Karadeniz, 2012, pp. 23–4). Means-tested limited public-funded LTC to the poor parts of the population creates extreme inequities in access to LTC. Rather than providing for the right to financial support to access LTC, policymakers have decided to enact legislation that shifts the burden of LTC from the government to families. In the case of insufficient quality or absence of public services, it also forces those in need to purchase services privately. It has been argued that giving support to family members reinforces women’s caregiving role and conflicts with their struggle to head out into the public sphere (Ozbay, 2014, p. 87).

Adult day-care services are very limited in Turkey (Özmete et al., 2016, p. 10). Bettio and Verashchagina (2012, p. 74) found reported coverage of semi-residential care provision (e.g. respite care, adult day centres) in Turkey to be almost zero (0.02 per cent). There are five public adult day-care centres, affiliated with the MoFSP, and a few organized by NGOs, particularly the Alzheimer’s Society (Özmete et al., 2016, p. 12). Recently, a service has been initiated where a care worker can be requested from the nearest nursing home, but very few people are benefitting from this (Özmete et al, 2016, p. 10).

Finally, it should be mentioned that elderly solidarity centres have been set up in several cities throughout the country, designed similar to an ADC for elderly people. They provide several social activity opportunities such as music groups, art classes, educational activities on healthy living, and picnics that bring the elderly together. Older people are able to play an active part in these centres, and take part in their administration. Other than a symbolic membership fee, benefiting from the facilities is free (Republic of Turkey, 2012; SPO, 2007, p. 32).

**Concluding discussion**

Despite its young population compared with European countries, and relatively low proportion of older people (aged 65+), Turkey is ageing rapidly. This is occurring much faster than it did in the developed countries, and at a stage of lower economic development. The growing proportion of older people has consequences for many aspects of Turkish society, including healthcare and long-term social care. This is especially so because of other changes in Turkish society, similar to those in developed countries, the transition from extended to nuclear families, and a considerable proportion of older people living alone.
Since the 1990s, the reform of the Turkish social security system has been on the agenda. Previously, pensions and healthcare were dependent on social insurance determined by employment status, and many people in the large informal economy were excluded, though some benefitted as dependents of employed people. There is tax-funded social assistance for disabled people and those aged 65 and over for people without a contributory pension, but it is very low. Legislation in 2008 ended occupationally based health insurance and implemented near universal health coverage. However, there is no social insurance for long-term care, although this is under discussion. Long-term care is still predominantly regarded as a role for the family.

The absence of clear and consistent data collection on long-term care at the national level makes planning difficult, mirroring the priority given to this.

The most important step taken by the government in relation to the ageing population was setting up, in 2011, the General Directorate of Services for Persons with Disabilities and Elderly People within the Ministry of Family and Social Policies. Among its responsibilities are the regulation and improvement of quality of residential services for older people, and the introduction of new models of care. However, institutional care at present remains fragmented, provided by a variety of organizations, including various non-profit associations and for-profit entities, and having different eligibility rules. Free care is only available to older people on very low incomes who do not have anyone to care for them. Above all, the availability of residential care is totally inadequate, covering only 0.004 per cent of the population aged 65 and over in 2016.

Home-based care is the least developed, not widely available, and beyond the means of most families. Families mainly provide the care for elderly people needing this, the main support being a means-tested monthly allowance equivalent to the minimum wage to a family member providing care for a disabled or older person. This reinforces family responsibility, and particularly of women as caregivers. Home-based services were first provided by private organizations, then by municipalities. Services provided by the municipalities are limited and only for the poor, though there are plans to develop these.

Additionally, there is an insufficient number of formal care workers. Training is provided by a variety of institutions, but there is no common curriculum, and conditions of work need to be improved.

There are some interesting innovations in care provision for older people in Turkey, but they only cover very small numbers.

Overall, long-term care provision for older people in Turkey is fragmented and uncoordinated, lacking in availability, does not have a high profile, and although there are attempts at improvement, there is a notable lack of a clear policy vision on how to address critical issues.

References


