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Long-term care for older people

Turkey

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European Social Policy Network (ESPN)

ESPN Thematic Report on long-term care for older people

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Highlights

- Turkey has a rapidly ageing population; 9.1% of the population was aged 65 or older in 2019, with projected increases to 12.9% and 22.6% in 2030 and 2060. The old-age ratio was 13.4% in 2019, and the disability rate was 23% for people aged 65-69, 31.9% for those aged 70-74, and 46.5% for those older than 75.
- Institutional capacity has been growing in recent years but remains rather limited. Care at home, mostly informal, is the dominant means of providing long-term care (LTC) services. The Ministry of Family, Labour and Social Services (MOFLSS) pays the relatives of low-income disabled people for home-care.
- Carers are often women and usually work informally. A number of adverse conditions are reported for carers. The payment made to carers under the public home-care programme for low-income households is considered a social benefit, and thus a social security contribution for carers is not paid by the government. Carers also lacking proper training, and are likely to experience difficulties in joining the labour force later on.
- The quality of care is rather low in home-care, as training is largely lacking. Quality standards in institutional care were introduced in 2020.
- While official documents emphasise the importance of multi- and interdisciplinary services and a comprehensive approach, a systematic plan has yet to be implemented. The number and quality of institutional providers should be increased. Support systems and adequate training should be introduced in home-care.

1 Description of main features of the long-term care system

1.1 Demographic trends

In Turkey, 9.1% of the population was 65 or older in 2019, a sharp increase from 6.8% in 2008.[1] According to TURKSTAT projections, 12.9% and 22.6% of the population will be in this age range in 2030 and 2060 respectively, indicating a rapidly ageing population. Of the elderly population, 63% were aged 65-74 and 9.1% were older than 85 in 2019. As to regional differences, it should be noted that the share of those aged 65 or over in the population is strikingly low, below 5%, in the south-eastern region.

The old-age ratio[2] was 13.4% in 2019, and is expected to rise to 19.6%, 25.3%, 37.5% and 43.6% by 2030, 2040, 2060 and 2080, respectively. While 23.5% of households had at least one household member who was 65 or older, 24.4% of these households were composed of a single person of that age; 75.7% of such households were composed of women. The Turkish family structure survey by TURKSTAT and MoFLSS (previously the Ministry of Family and Social Policies, MoFSP) found that, in 2016, 6% of all households had an elderly member in need of care.

According to the Turkey population and housing survey of 2011, the most recent study to contain disability statistics, the disability rate was 23% in the 65-69 age group, 31.9% in the 70-74 age group, and 46.5% for those older than 75.[3] The number of disabled elderly people registered with the MoFLSS for disability benefits is 543,735, 7% of all those aged 65 or more (MoFLSS, 2020). The female/male ratio among those who are 65 or older increases with age, as mortality is higher among men than women. There is a need for nationwide updated prevalence data on disability and related issues.

1.2 Governance and financial arrangements

The General Directorate of Disabled and Elderly Services attached to the MoFLSS is responsible for providing services to both the elderly and the disabled of all ages. The Ministry of Health is also indirectly involved in providing at-home healthcare services for the elderly. As is the case with various social services, some municipalities are active in providing care services to their communities, but in 2014 Law No 6518 made it mandatory for care services provided by municipalities and other public institutions to take place under supervision of the MoFLSS.

The Law on Disabled People (Law No 5378) came into effect in 2005 with the aim 'to prevent disability, to enable people with disabilities to participate in society by taking measures which will provide solutions to their problems regarding health, education, rehabilitation, employment, care and social security to remove the obstacles these people face, and to make the necessary arrangements for the coordination of these services.' The law asserted the importance of care services, and described how and by whom these services would be provided.

Although plans for LTC insurance have been in the works for some time and were once again mentioned in the 11th development plan (2019-2023), it has not yet materialised. Currently all LTC services provided by the government to those in need are tax-financed. Because these services cover only poor households, it is likely that a large group of individuals receive LTC fully paid for by out-of-pocket (OOP) expenditure or by family members.

[1] Statistics on the demographics of the elderly population were obtained from TURKSTAT: http://tuik.gov.tr/PreHaberBultenleri.do?id=33712.

[2] The ratio between the number of people aged 65+ and the number of working age (15-64).

[3] In the survey, disability was defined as experiencing difficulty in performing at least one the following: seeing; hearing; speaking; walking and climbing stairs; carrying and holding objects; and learning and remembering.

Since formal care constitutes a small fraction of LTC services provided and there exists no estimate of OOP expenditure and the size of the informal care sector, it is not possible to assess the funds allocated to LTC expenditure, or their share of GDP. As to the expenditure on specific programmes, MoFLSS (2020) states that expenditure on home-care for disabled of all ages in poor households had a budget of 8.2 billion TRY (€1.3 billion) in 2019. Expenditure on institutional care for disabled people (of all ages) financed by the government was 1.6 billion TRY (€0.25 billion) in 2019, of which half was paid for services in private facilities.

1.3 Social protection provisions

Home-care, in which family member carers are paid for services provided to people with disabilities at home, is the main approach in LTC provision by the government. Disabled people with low income can benefit from this programme. The conditions for the programme are as follows.

(a) A medical report has been provided by a hospital medical council stating that the individual is severely disabled (*ağır özürlü*), as defined by a disability level of 40% or above or needing care in order to sustain his/her life.

(b) The per capita income of the family is less than two-thirds of the minimum wage.

(c) The carer is a relative of the dependent individual.

Applications are made to provincial offices of the MoFLSS. The payment was 1,457 TRY (€229[4]) per month as of January 2020. The amount of this monthly payment used to be adjusted in line with the pay of government employees every six months, but has been determined at the discretion of the MoFLSS since 2018. The increase still paralleled the raise in government employees' pay over the last two years. The payment is considered a social benefit, and no social security contribution is provided for the carer. However, carers may pay their own social security premiums and have the work count towards retirement conditions. In 2019, 514,000 households with disabled members received payments, and the annual cost was around 8.1 billion TRY (€1.3 billion) (MoFLSS, 2020).

Individuals in need of LTC, as certified by a hospital report, who cannot receive care at home may receive care at a public institution or be funded for care at a private institution. For private facilities, the payment is 2,767 TRY (€435) per month and is paid to the institution. Establishing eligibility requires means-testing, with the incomes of all household members living together being taken into account. MoFLSS documents emphasise a preference for home-care by family members, but there is no legal requirement for family members to care for their relatives at home.

There are also regular social assistance payments to disabled and elderly people who have no social security coverage.

Finally, there are discounts on certain goods, such as water and electricity, provided to households with disabled members. There is no legislation in this area, and the discounts are at the discretion of the relevant municipalities and private companies.

1.4 Supply of services

Oglak *et al*. (2017) states that the LTC infrastructure is rather limited, and the elderly are usually taken care of within the family. The major institutional mechanism for the elderly and people with disabilities in terms of LTC is residential homes/institutions. Operated by the MoFLSS, their numbers have increased sharply over the last two decades, but there are still few of them. As of January 2019, institutional capacity was 15,527, and the number of beneficiaries was 13,925 in 153 institutions – 91% higher than a capacity of 8,126 in 2009 (MoFLSS, 2020). Compared with the more than 500,000 individuals receiving home-

[4] At the average exchange rate for 2019 of 6.36 TRY/Euro.

care assistance from the government, the number of those receiving institutional care is rather low and displays the reliance on relatives for LTC.

Although institutional care capacity has been increasing rapidly, it is not sufficient in the face of the growing elderly population. In the final declaration of the 1st National Council on Ageing, organised by the MoFLSS in February 2019, the need to increase capacity for LTC was mentioned.

For the disabled, institutional services include public care and rehabilitation centres, and 8,118 individuals made use of these services in 2019 (a 78% increase relative to 4,569 in 2009). According to MoFLSS records, there have been no unmet requests to stay at these care providers since 2010 (MoFLSS, 2020).

Limitations in coverage by the public sector for people with disabilities and the elderly in terms of LTC have caused the private sector to enter this area. For the disabled, private provision of services is common, but it is expensive and primarily located in metropolitan cities in very limited amounts. In 2019, 19,658 disabled individuals, 70% of those supported by the government under the care for the disabled programme, received care at private institutions paid for by the government, at a cost of 770 million TRY (€121 million, MoFLSS, 2020).

It should be noted that some municipalities provide day-care services at no cost. These complement those operated by the MoFLSS. NGOs have also been actively involved in this area, some dealing with people with disabilities and others with the elderly.

As noted above, care at home is more prevalent. For care supported by the MOFLSS, the carer has to be a relative of the service receiver. As to those receiving care services at home without financial support from the government, there exist no available data regarding the qualifications and employment status of the carers.

2 Assessment of the long-term care challenges in the country

2.1 Access and affordability

Turkey has a rapidly ageing population and faces difficulties in addressing the surging demand for care services. Lack of capacity for nursing homes is an ongoing problem, which was noted by Subaşı and Öztek (2006) and Oglak *et al*. (2017). Although care needs for the disabled appear to be met, with no waiting list for institutional care, this is largely because of the home-care programme for low-income households where a relative is available to provide care. While the home-care programme covers a large population, support systems are lacking and the quality of care is questionable.

Those who do not qualify for government assistance for either home or institutional care have to bear all costs by themselves. There are no available data on the burden created by these costs on the elderly and their relatives who support them.

Non-take-up of services may also be a problem. In Turkey, informality is high and that makes it difficult to implement means-testing mechanisms. As a result, the discretion of the administration is likely to result in non-take-up. The free public health insurance programme uses the same means-testing mechanism, and in that programme, Erus *et al*. (2015) finds non-take-up among low-income households with elderly or ill household members to be 30%. As also noted in a report by Parliament (TBMM, 2013), there are discrepancies in medical reports on the level of disability. The lack of standard procedures mean two comparable individuals can receive different reports. It is also noted that payments for care should not be fixed, but should vary with the severity of disability and income of the household.

2.2 Quality

Starting from 2020, the MoFLSS will conduct inspections at all institutional care facilities. Inspections will be based on newly developed quality standards. Standards set by the MoFLSS include a range of rules, such as: the minimum requirements for physical conditions of the facility; the provision of certain services including psycho-social support to patients and their relatives; the operation of necessary devices without interruption; and the preparation of documents regarding care procedures.

As to home-care, there exist no requirements regarding the qualifications of the carer in MoFLSS programmes, and quality of care is a major issue. To support home-care, the Ministry of Health provides home healthcare services. The legislation describes healthcare services as diagnosis, treatment, follow-up and rehabilitation, including social and psychological consultancy at home; health professionals (basically physicians and nurses) working at family health centres are expected to provide home healthcare services mainly in terms of rehabilitation, physiotherapy, post-operational care and social services.

Trained personnel (healthcare, social workers, etc.) are largely lacking in terms of both quantity and quality (Tatar *et al*., 2011). A training system does not exist in home-care assistance funded by the government; hence, it is difficult to argue that appropriate care is provided. We are not aware of monitoring procedures regarding care provided by family members enrolled in the programme. This is also a problem with regards to OOP expenditure on home-care. In a study looking at informal carers of neutropenic patients, Bağçivan *et al*. (2015) found that while carers were informed about the general rules regarding cleanliness, other important rules, such as giving a bath, were poorly known. Sabancıoğulları and Tel (2015) mention in their study that the majority of carers had difficulty in communicating with their patients. Evidence suggests that unskilled women dominate the labour force in the LTC of aged people (Tatar *et al*., 2011).

Burnout is common in elderly care services provided by family members. Boyacıoğlu and Kutlu (2017) showed the increased burden on people caring for their elderly family members. Yıldızhan *et al*. (2019) found that professional caregivers of Alzheimer's disease patients in geriatric care centres suffered from burnout in all dimensions (emotional exhaustion, depersonalisation and personal accomplishment).

Violence, maltreatment, neglect and abuse are other issues encountered within the LTC system. Old people are found to be subject to various types of violence – physical, economic, sexual, etc. – some less some more (Gürsoy and Kara, 2020).

There is a recent global threat, since late December 2019,[5] which has had a disproportionate impact on the elderly. The first case of COVID-19 in Turkey was reported on 10 March 2020. By 28 March 2020, there were 7,402 cases, 108 deaths and 70 people who had recovered.[6] Groups at risk include the elderly, people with chronic diseases, and smokers. In Turkey, on 22 March 2020, a circular by the Ministry of Internal Affairs imposed a curfew on people aged 65 and above.[7] Although additional precautions have been taken to alleviate the impact of the curfew, it presently remains unknown whether this had an adverse impact on those receiving home-care.

Nursing homes and other institutional bodies in care services are at higher risk for COVID-19. The MoFLSS announced that precautionary measures have been taken to prevent the spread of the virus in institutional care.

[5] https://www.who.int/emergencies/diseases/novel-coronavirus-2019.

[6] https://covid19.saglik.gov.tr/, https://www.worldometers.info/coronavirus/#countries.

[7] https://www.icisleri.gov.tr/65-yas-ve-ustu-ile-kronik-rahatsizligi-olanlara-sokaga-cikma-yasagi-ek-genelgesi.

2.3 Employment (workforce and informal carers)

The current system, largely based on home-care, relies heavily on relatives of those being cared for, and these carers are usually unqualified. Regarding the policies addressing the work-life balance of carers, benefits and social assistance are rather limited in Turkey. There is no leave for the care of elderly dependants, with the exception of government employees. There are few in-kind benefits and these are not available on a regular basis. The MoFLSS conducts some training programmes, but with a rather limited capacity.

While statistics are lacking regarding the composition of the workforce in formal LTC, various findings point to the role of women. The Turkish family structure survey by TURKSTAT and the (former) MoFSP found that, in 2011, 32% of the elderly received care from their daughter-in-law, 27% from their wife or husband, 22% from their son and 20% from their daughter. Görgün Baran (2005) states that, in elderly care, 83.2% of the caregivers were women. In Tekin Önür's (2015) study conducted among 177 carers of elderly people in Afyonkarahisar, a province in the Aegean region, female family members took on more responsibility than males in looking after family members in need. Taşdelen and Ateş (2012) found that the majority of family members who took on care-giving responsibilities were women, and almost half of the carers had at least one chronic health condition. Combined with deficiencies in the LTC system, this hinders female labour force participation.

Adequate training programmes designed for carers are lacking. This decreases the chance of long-term careers in this field. It also has an adverse effect on the physical and mental states of caregivers. A number of adverse medical conditions resulting from care services have been reported in earlier studies of caregivers (Yikilkan *et al*., 2014; Kokurcan *et al*., 2015; Bozkurt Zincir *et al*., 2014; Aslan *et al*., 2009). As such, the system is far from providing a long-term career for caregivers. Furthermore, social security provisions are lacking, since these payments are considered transfers and do not count towards social security; carers have to pay premiums out of their own pocket in order to make adequate provision for retirement.

As mentioned repeatedly, informality is an important issue with regards to caregivers. A recent report by the medical/health and occupational organisations in Turkey (Beyazıt *et al*., 2015) declares that providers of home-care largely lack economic, occupational and social rights, and should be protected by public authorities. In the case of the home-care programme financed by the government for poor households (see Section 1.3 for details), caregiving is not considered official employment and is naturally limited to the lifetime of the dependant.

The fact that carers are usually relatives aggravates the problem of low female labour force participation in Turkey. According to the authors' calculations, based on the 2014 TURKSTAT labour force survey, 7.95% of female part-time workers stated that caring for a family member was the reason for part-time employment. This was stated as a reason for being out of the labour force by 0.69% of women.

Lack of access to leave, except for government officials, makes it difficult for women carers to join the workforce, even though care needs are rather limited or temporary. It should be noted that even if legislative measures to address these issues were introduced in the future, it would not cover a large proportion of the workforce due to significant informality.

It is likely that, in some cases, young female members of households drop out of school to provide care for the elderly and to receive home-care payments, if eligible. Lack of education, in turn, would reduce their chances of joining the labour market in the future.

2.4 Financial sustainability

With the ageing population and growing demand for care services, sustainability is likely to become an important challenge. Capacity is already lacking, and the social assistance system is already financially constrained in providing support to those in need. With weakening family ties, a larger proportion of the elderly are likely to need institutional care in the future. Nonetheless, we are not aware of any study that quantifies current expenditure or makes projections regarding future financing needs.

2.5 Country-specific challenges regarding LTC for other age groups in need of care

The LTC needs of disabled individuals of all ages is an important challenge for Turkey. The MoFLSS relies mostly on home-care by relatives, who do not have adequate training, and furthermore the reliance on relatives (mostly young women) is likely to bring about distortions in the labour market – as these people will find very difficult to further their education and get employment in a formal sector. Issues that were raised above in terms of the elderly arise for disabled individuals of all ages. Institutional care turns out therefore to be provided with limited capacity. Career opportunities for carers are limited. All in all, one may conclude that the overall quality of care is rather low, lowering the welfare of those who depend on LTC.

3 Reform objective and trends

It is acknowledged in official documents, such as the 2007 and 2015 national action plan for elderly people, that a rational, systematic and sustainable system should be established to respond to all people in need in society. Yet there have been no significant reforms that would affect the provision and funding of such services in recent years. A number of plans and documents, on the other hand, point to the need for policies to address issues arising from an ageing population.

The 2007 national action plan for elderly people, updated in 2015, recognises the need for a comprehensive policy to address most issues. Multidisciplinary and interdisciplinary services are recommended to be provided in LTC facilities. A second goal is the intention to bring all these services under a comprehensive approach, including preventive, treatment and rehabilitation services (MoH, 2015). Although goals were set for 2015 and 2020, these have not been achieved to a large extent.

National development plans in the past had touched on issues related to ageing and care services, emphasising the importance of institutional care capacity and active ageing. The 11th development plan includes policies related to LTC and states that 'the services for the elderly in need of long-term care will be diversified and expanded'. It mentions policies to increase the involvement of local government but does not provide any details. Finally, it proposes establishing a comprehensive and sustainable care insurance system.

In February 2019, the 1st Council on Ageing was organised by the MoFLSS under the auspices of the Presidency of the Turkish Republic. Six themes were discussed and working groups were formed on: active ageing/healthy living; active ageing/participation in community life; the care economy, elderly care services and quality of life; age-friendly cities and local government; the rights of older people; and the economics of ageing.

The only change in recent years regarding LTC has been the implementation of quality standards for all institutional care facilities. Inspections based on these standards are expected to begin in 2020.

4 Main opportunities for addressing LTC challenges

All the issues raised above should be addressed to improve the quality of relevant services. In a systematic and comprehensive approach, caring responsibilities should be based on state-municipality collaboration as recommended in international documents. Family members, other relatives and friends should only play a supportive role.

Residential institutions as well as care and rehabilitation centres should be increased to respond to the needs of those who may be unable to provide temporary or permanent care to their relatives. The quality of the services provided should be improved as well, and a certification procedure that ensures sustainable quality should be introduced.

Coordination should be established among different institutions providing support to the elderly and people with disabilities.

While care provision by relatives at home may provide a solution to the increasing need for services, it is clear that such a system requires a number of support systems to work efficiently. An efficient training system is necessary to ensure that required care is provided but also to provide carers with a long-term career in the care sector. Social security provisions should be set to enable carers to fulfil their obligations towards retirement and hence support themselves when they are old. Additionally, a set of assistance and support services may be devised such as (i) assistance with self-care, (ii) residential support services, (iii) support in education for children with disabilities, (iv) communication support (through sign language interpreters) and (v) assistance animals.

Lack of paid leave and temporary institutional support, such as care during the daytime, is also likely to have a negative effect on carers and other household members who usually replace them in case of their absence.

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Statistical annex

Table A.1 Demographics

		2008	Most recent	2030	2060
Population (in millions), 2019		71.5	83.2	93.3	107.1
Old age ratio, 2019		10.2	13.4	19.6	37.5
Population 65+ (in millions), 2019	*Total*	4.9	7.6	12.0	24.2
	Women	2.8	4.2	6.6	13.2
	Men	2.1	3.3	5.5	11.0
Share of 65+ in population (%), 2019		6.8	9.1	12.9	22.6
Share of 75+ in population (%), 2019		2.7	3.4	5.0	11.8
Life expectancy at the age of 65 (in years), 2018	*Total*	n.a.	18	n.a.	n.a.
	Women	n.a.	19.6	n.a.	n.a.
	Men	n.a.	16.2	n.a.	n.a.

Source: Turkstat
N.a.: not available.

Table A.2 People in need of LTC

	2014	Most recent	2030	2050
Share of population 65+ in need of LTC, defined as having at least one severe difficulty in personal care and/or household activities (%), 2019	51.8	n.a.	n.a.	n.a.

Source: Eurostat

Access to LTC

		2008	Most recent	2030	2050
Share of population 65+ who used home care services for personal needs in the past 12 months (%), 2014 [a]	*Total*	n.a.	0.5	n.a.	n.a.
	Women	n.a.	0.6	n.a.	n.a.
	Men	n.a.	0.4	n.a.	n.a.
Long-term care beds per 100,000 inhabitants, 2018[b]		n.a.	78.0	n.a.	n.a.

Source: a) Eurostat, b) OECD
Old age ratio: the ratio between the number of persons aged 65+ and the number of working-age persons (15-64)
LTC workforce and expenditure statistics are not available.

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