Long Term Care in the United States and Turkey

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The World Health Organization (WHO) (2009b) defines active ageing as "the process of optimizing opportunities for health participation and security in order to enhance quality of life as people age" and accepts people 60 and over as old (p.1). According to WHO (2009a), a proportion of people aged 60 and over in the world is growing faster than ever due to longer life expectancy and declines in fertility rates. Increases are seen as a success of improved health care and technologies, however, new challenges include adaptation and maximizing and utilizing health resources (WHO, 2009b). A shift in health care systems towards geriatric care, including prevention and management of chronic diseases and more formal long-term care systems is needed (WHO, 2005). The purpose of this paper is to compare long-term health care systems of the U.S. and Turkey in reference to similar population changes. Practice, policy, and research implications are discussed.

Health care in US

Population increase and health issues

In 2007, there were 37 million (12.6% of population) people age 65 and older in the United States, an increase of 635,000 people since 2006 (U.S. Census, 2009). Growth in population and life expectancy has resulted in increased health problems (i.e., heart disease, cancer, diabetes) (CDC, 2007). Mental health issues of concern for older adults include social isolation (Grant, Hamer, & Steptoe, 2009), depression (Hybels & Blazer, 2003), limited physical functioning (Roberts, Kaplan, Shema, & Strawbridge, 1997), and suicide deaths (people age 65 and older 16 percent in 2004) (NIMH, 2009).

As health and mental health issues increase as does the level of care required. Functional assistance with activities of daily living (ADLs) such as bathing, personal hygiene, and dressing along with incontinence care and medication management are reported most frequently (Golant, 2004; Quinn, Johnson, Andress, McGinnis, & Ramesh, 1999). Falls and mobility problems are two of the most common and serious concerns facing older adults' ability to function independently (Rubenstein, Powers, & MacLean, 2001). A higher level of care for a growing population requires a long-term care system.

American Culture

The ideal choice for long-term care is to age in place (at home), however a shortage of informal caregivers (friends, families, etc.) indicates a need for alternative provisions of care (Quinn et al., 1999). This shortage of caregivers is partly due to their full-time employment statuses (Scharlach, Gustavson & Dal Santo, 2007). When caregivers are not available, care alternatives including facility placements are considered.

Long-term care

Long-term care is a variety of services and supports provided to meet health or personal care needs over an extended period of time; mostly consisting of non-skilled personal care assistance with ADLs (U.S. Department of Health and Human Services (DHHS), 2008). The goal in the U.S. is to maximize independence and functioning when being fully independent is not possible. Factors increasing risk of needing long-term care include being older, single, and female; as well as lifestyle factors (i.e., poor diet and exercise habits, health and family history). As older adults age in America, long-term care needs are expected to change from short rehabilitation treatment to daily contact with personal care staff (DHHS, 2008).

Most common care alternatives include nursing homes with 24-hour presence of licensed nursing personnel (Quinn, et al., 1999) and assisted living facilities with 24-hour supervision, not required to be medically licensed personnel (Aud & Rantz, 2004; Maas & Buckwalter, 2006). Nursing homes are preferred, when it is no longer possible to care for a person at home safely or when care in the home becomes too expensive, because they are federally regulated and must be licensed by state governments (DHHS, 2008). In 2004, about 1.5 million people lived in nursing homes in the U.S. (AARP, 2007). Alternatively, there are roughly 800,000 residents living in 33,000 assisted living facilities nation-wide; however, unlike nursing homes standard policy regulations are nonexistent (Aud et al., 2007).

Community-based health care is increasingly providing the least restrictive environments for elders who no longer function independently (Quinn et al., 1999). Personal care homes are community-based facilities that provide living arrangements, assistance with basic needs and protective oversight (Quinn et al., 1999). Board and care settings offer a combination of

affordability, homelike environment, and personalized care; however, limited studies report the effect of regulations on quality of care (Carder et al., 2006).

Financing long-term care further confounds older adults' struggle with extended care needs. Medicare solely pays for long-term care if skilled services or a short period of recuperative care is needed. It does not cover non-skilled assistance with ADLs; the most common need for long-term care (DHHS, 2008). Medicaid is available for the largest share of long-term care services; however recipients must meet financial and functional criteria (DHHS, 2008). The Older Americans Act and Veterans Affairs pay for long-term care, but are restricted to special populations (DHHS, 2008). Similar to Medicare, HMOs long-term care plans usually cover only skilled, short-term medically necessary care (DHHS, 2008). Another option for finding is Supplemental Security Income (SSI), a Federal income supplement program payable to people 65 and older without disabilities who meet the financial limits (Social Security Administration, 2009).

Federal Regulations

In the U. S., long-term care environments have not been regulated outside of nursing homes. Nursing homes providing skilled nursing services have federal regulations that define the rights of residents and standards of care. In contrast, individual states are responsible for developing regulations and licensure mechanisms for assisted living, personal care and board and care level settings (Aud & Rantz, 2004; Maas & Buckwalter, 2006).

Health care in Turkey

Population increase and health issues

Turkey's population is considered relatively young; however, an increase in the elderly population is present. In 2003, life expectancy was on average 70 years, and since 1990, Turks have gained about four years in life expectancy (WHO, 2005). In 2005, 5.9% of the population in Turkey was 65 and older, and it is estimated to reach 8% by 2012 (Cankurtaran & Eker, 2007).

Three main socioeconomic factors effecting health in Turkey include income, education and employment. The poor generally suffer worse health and die younger than people with higher income because goods and services that contribute to better health (i.e., nutritious food, good living conditions) are more affordable (WHO, 2005). The government pays a quarterly salary to adults 65 and older; however, it is not enough to meet an older adult's needs (Celik & Celik, 2001). Education contributes to an individual's job opportunities, in turn, improving income which affects health outcomes (WHO, 2005). Living longer magnifies the areas of income, education, and employment. Older adults pose a more serious challenge for many public pension schemes and there is greater financial need for those adults living beyond the expected retirement years (Celik & Celik, 2001; Dogan & Deger, 2004).

Physical and mental health issues are on the rise as the population ages. Ninety percent of people aged 65 and over have chronic health problems such as hypertension, cardiovascular and respiratory system problems, thyroid and malignant disease (Altun I, 1998). Mental health concerns (i.e., depression and dementia) require services for strengthening and maintaining relationships with others (Celik & Celik, 2001; Cankurtarian & Eker, 2007). Increased physical and mental health changes lead to lower functioning and higher need for assistance; however, access to and availability of health care services are limited (Celik & Celik, 2001; Dogan & Deger, 2004).

Turkish Culture

Irregular income and loneliness are big problems in Turkey and more serious considering Turkish culture. Elderly may not express accurate and consistent needs to strangers, even when in great need (Celik & Celik, 2001). Therefore, studies might underestimate needs of older adults. Historically and currently in rural areas, Turkish people die at home under family care where religious rituals are performed in the last moments of life. However, urban migration has increased the number of deaths in hospitals. Turkish elders prefer to be cared for at home, or in a familiar environment by family members (Dogan & Deger, 2004; Evci, Ergin, & Beser, 2006). Elders desire caregivers with good communication, continuity of care, and maintaining their respect and dignity (Dogan & Deger, 2004). Increased need for women to work, former caregivers of dying elderly, leaves many elders spending their last days traveling to distant hospitals or on waiting lists (Oguz, Miles, Buken, & Civaner, 2003).

Long term care

Long term care in Turkey, provides older adults with home care including assistance with daily activities no longer performed alone or by the family (Celik & Celik, 2001). The majority of older adults do not want to be hospitalized and preferred hospitalization to be brief with a goal of returning home (Dogan & Deger, 2004). Older adults are particularly tied to their homes both emotionally and physically; and there is a strong need to remain at home until death (Celik & Celik, 2001).

Home safety is a concern for the elderly population due to hazards and accidents occurring with decreased functioning; however, most accidents are preventable (Evci et al., 2006). Home accidents increase with chronic illnesses, use of eye glasses and assistive devices, hearing problems, physical disability, losing a spouse and medication side effects (Evci et al., 2006). Unfortunately, designing homes specifically for older people is not a routine practice in Turkey.

There are no hospices in Turkey for palliative or end of life care. Policies for end of life care, pain management, DNR orders, or a framework for advance directives do not exist (Oguz et al., 2003). Private home care services are not covered by state insurance and families lack support and resources to properly care for their loved ones.

Government Regulations

Currently, Turkey belongs to the World Health Organization (WHO) and the Organization of Economic Cooperation and Development (OECD). Turkey provides three levels of health care: primary health care system which focuses on preventing infectious disease and on treating acute and chronic disease; secondary healthcare which is structured around state hospitals, with a national insurance system for workers and their dependents managing its own state hospitals; and tertiary healthcare which include the University hospitals (Oguz et al., 2003).

Older adults do not hold special status in the health insurance system in Turkey. The system lacks a professional standard for informing and educating patients and families about the severity of health situations (Oguz et al., 2003). When an elder has social insurance, she/he can go to primary health care centers or state hospitals or to other state hospitals (i.e., University hospitals) with a social security hospital referral. In 2003, legislation changes allowed some private hospitals to accept some state insurance schemes; otherwise only elders with private insurance are eligible for private hospital treatment. Private physician examinations or any kind of home care or home visits are not covered by any state insurances, only by special categories of private insurance (Dogan & Deger, 2004).

Implications

Socioeconomic concerns for elders in the U.S. were studied mostly in the 1990s with similar outcomes as Turkey reports currently including education and income (Ciesla, 1997; House et al., 1994). Current U.S. research is focused on the critique of the existing long-term care system. In contrast, Turkish literature focuses more on key variables of the aging population and suggestions for creating a long-term care system.

The most common suggestion in the literature for creating and sustaining long-term care system is a new treatment philosophy that describes the types and levels of care and quality of care and services provided, and includes public discussion about needs of older adults (Oguz et al., 2003), creating legislative agendas including long term care policies (Celik & Celik, 2001), and establishing quality control and training in accessible and available services (Aud et al., 2007; Celik & Celik, 2001; Dogan & Deger, 2004; Maas, & Buckwalter, 2006). Additionally, improving quality of housing and preservation of independence for elders living at home (Evci et al., 2006) and empowering older adults to be actively involved in their care for improved self-efficacy and more efficient use of services (Celik & Celik, 2001; Cankurtaran & Eker, 2007).

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