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Intervention Models in the Long-Term Care (LTC) of Elderly in Europe: Lessons for Turkey

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Abstract

The Long-Term Care of the elderly has become a contested issue for present day welfare states, owing to challenges brought about by demographic ageing and shifts in family relationships. Seeing these challenges as priorities, welfare states have developed alternative ways to support their elderly. Since the speed of ageing is relatively faster in Europe than other world regions, European welfare states have been swift to take numerous measures to tackle the issue. Further, as a transitional economy Turkey is prone to the challenges that are caused by ageing in the upcoming decades. The long-term care of the elderly is one of such challenges. Owing to the demographic challenges and shifts in family relationships, present resources for elderly care will not be sufficient for Turkey. As an EU candidate, Turkey has to develop appropriate long-term care policies. In this respect, in order to introduce a suitable programme, the need to look at alternative practices in Europe is vital for Turkey. For this reason, the paper compares Turkey with Sweden, Germany and the UK, which each represent a different model for long-term care of the elderly. These countries are compared to Turkey in terms of typologies, type of care services and financing. The findings show that the German long-term care model for the elderly has the highest transferability to Turkish system considering the similarities in the welfare typologies and social, structural and institutional similarities.

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LIST OF ABBREVIATIONS

ABGS	:	GENERAL SECRETARIAT FOR THE EUROPEAN UNION IN TURKEY
EC	:	EUROPEAN COMMISSION
ECSC	:	EUROPEAN COAL AND STEEL COMMUNITY
EPC	:	EUROPEAN POLITICAL COOPERATION
EU	:	EUROPEAN UNION
GDP	:	GROSS DOMESTIC PRODUCT
LTC	:	LONG-TERM CARE
NHS	:	NATIONAL HEALTH SERVICE
OECD:		ORGANISATION FOR ECONOMIC COOPERATION AND DEVELOPMENT
OZIDA:		ADMINISTRATION FOR DISABLED PEOPLE, PRIME MINISTRY OF TURKISH REPUBLIC
PTT	:	POST-TELEPHONE-TELEGRAPH INSTITUTE
SHCEK:		SOCIAL SERVICES AND CHILD PROTECTION INSTITUTION
SDI	:	SOCIAL DEPENDENCY INSURANCE
SEK	:	SWEDISH KRONAS (SWEDISH CURRENCY)
TUIK	:	TURKISH STATISTICAL INSTITUTE
SMHSA:		SWEDISH MINISTRY OF HEALTH AND SOCIAL AFFAIRS
UN	:	UNITED NATIONS
UNPF:		UNITED NATIONS POPULATION FUND
UK	:	UNITED KINGDOM
WWII	:	WORLD WAR TWO

CHAPTER 1: Introduction

1.1 Research Background

World population is ageing. Increased longevity, declining fertility rates, lower replacement rates and baby boom generation moving into old age all contribute to the process of ageing (Mc Donald & Kippen, 2001). During 1950s, people were expected to live for 47 years on average whereas this number has increased to 65 years in 2005. Today, the average lifespan of a human being is 65.1 for males and 69.6 for females (UNFP, 2008).

Especially this process of ageing is very intensive in European countries since it is both faster and broader in Europe compared to Australia, Canada, and the United States, where birth rates are relatively higher (Coleman, 2001). According to OECD statistics, old people (65+) constitute approximately 20 percent of the population in most of the European countries (OECD, 2008). Today, the average life expectancy for males in Europe is 70.6 whereas this number is 78.9 for the females. On the other hand, as a transitional Eurasian economy, life expectancy for men is 69.5 whereas it is 74.4 for women in Turkey (UNPF, 2008). However, these numbers are prone to increase in the upcoming decades.

Ageing will bring about and is already bringing challenges to the European Welfare States. Health care and long-term care of the elderly, rehabilitation and

prevention of illnesses, provision of sufficient living conditions, decline in the labour force, social benefits and pensions are the main challenges that the European Welfare States are facing (European Commission, 2008).

Long-term care (LTC) of the elderly is one of the main challenges that European Welfare States face as a consequence of ageing. With increased longevity, change in the family structures and women entering to labour market, care of the elderly has become problematic. Inadequacy of kin sources available for care and the increase in the labour force participation is putting children and parents under escalating pressure (Ovseiko, 2007). Inability to combine care and work duties has confronted families in terms of social and economic aspects.

This decrease in the availability of the informal resources for elderly care has resulted in the increased expectancy of governments' involvement (European Commission, 2008). According to the projections of European Political Cooperation (EPC), it is predicted that in every European country there will be an increase in public long-term care expenditure of 0.7 percentage of the GDP on average. And yet, since these projections are based on current institutional and political arrangements, it is more likely that the expenditures that are predicted will be higher (European Commission, 2008).

Speaking of Turkey, owing to its younger population, ageing is not as intense in Turkey as it is in European Union countries. Having a relatively higher fertility rate and younger population, the percentage of elderly (+65) constitutes 6% of the population in Turkey (OECD, 2008). However, considering its relatively larger

population, in the long-term, Turkey is more prone to come across severe challenges in terms of ageing. Even though fertility rates are currently above the replacement rate, the change in the number of elderly people will be very dramatic and will increase more than threefold (18%) by 2050 (Ovseiko, 2008). In this respect, LTC of the elderly will also be a requirement for Turkey to employ.

Turkey, on the other hand, is a transitional economy and a candidate for European Union. In order to access to European Union, Turkey is on the process of transferring EU practices to its own policies and internalizing EU Acquis. Even if health care in general and specifically long-term care of the elderly is not a chapter of negotiation, it is closely linked with other negotiation topics such as "Social Policy and Employment", "Taxation", and "Regional Policy and Coordination of Structural Instruments" (ABGS, 2009). In this respect, developing an appropriate LTC policy for the elderly is a substantial requirement for Turkey.

Seeing the global challenge of ageing, Turkey has only started to handle ageing as an issue recently. In 2002, Turkey signed up to Madrid International Plan of Action on Ageing. This international agreement sought to respond to the opportunities and challenges of population ageing in the 21st century and to promote the development of a society for all ages. As a direct consequence, the State Planning Institution in Turkey produced an action plan, which was released in 2007. However, since then, not very much action has been taken. State involvement in LTC is currently very limited and highly means-tested. Still,

strong family relations and informal care prevail in the long-term care of the elderly in the Turkish society.

1.2 Research Question

The central focus of this research project is the assumption is that Turkey is going to experience significant ageing problems in the upcoming decades and long-term care of the elderly will be an important issue that needs to be handled. In that respect, it is appropriate to develop a long-term care strategy for Turkey. Since Turkey is on the process of joining EU, this research paper aims to look at the best practices and intervention models in European Union in order to compare and draw lessons for a proper LTC strategy for the elderly in Turkey. For this comparison, Sweden, Germany and UK are selected since they represent different intervention and social care models. The ultimate goal is to find the most transferable LTC services for the elderly in Turkey. However, it is important to note that the ultimate goal is not to compare LTC systems in the mentioned EU countries. Such literature is already existent and extensive in this field of research.

Majority of research relevant to the sphere of ageing in Turkey has largely been dominated by work focusing on health-care and bio-medical aspects of old age. Sociological and socio-economic dimensions of ageing are very much neglected. As far as the research undertaken on the subject of LTC of the elderly in Turkey is concerned, all the comparative studies that are done do not go beyond

being descriptive literature reviews. They only describe and prescribe best practices in Europe and suggest policies without analysing their structural, institutional and economic context and applicability. However, this paper seeks to base the arguments on a systematic comparative approach through which different aspects of the subject matter will be analysed. In this respect, this research study aims to be discrete owing to its academic nature.

1.3 Methodology

> '*An age-old idea of philosophers is that knowledge of the self is gained through knowledge of others'* (Dogan & Pelassy, 1990, p. 5.)

Since the purpose of this paper is to draw lessons for Turkey, it is important to look at other practices of LTC for the elderly. In order to assess the applicability and transferability of the LTC systems, it is important to point out the similarities between the countries. Those similarities can only be assesses through comparison. For that reason, as a methodology, comparative literature review will be employed. For comparison, government and international organizations' documents and existent literature will be used. This systematic review of three countries with Turkey will help drawing lessons for Turkey to develop appropriate LTC services for the elderly.

For comparison, three European Union countries are selected, which represent a different kind of welfare state typology according to Esping-Anderson's welfare state typologies (1990). These countries have different arrangements and financing systems in terms of long-term elderly care. Sweden as

a Scandinavian country provides universal long-term care for its elderly citizens and finances it through taxation. Germany, as a corporatist country, provides LTC for elderly through an insurance system. On the other hand, UK as a liberal welfare state has a means-tested system and provision is generally maintained by private suppliers. Moreover, these countries represent a different intervention model of LTC for elderly on a continuum line where there is high provision of service led model (Sweden) at one end and informal care model at the other end (Germany).

As a matter of fact, all of the three systems have their advantages and disadvantages within themselves and all the three countries are in search for improving their own systems in response to the criticisms. However, favourable or not, they all have a system of LTC for the elderly that is designed according to their own type of welfare system. On the other hand, Turkey is far behind in having extensive and systematic LTC services for the elderly. In that respect, it is important for Turkey to take a further step to adopt an LTC system that fits into its own understanding and structure of a welfare state. In order to find the most appropriate one, all the options should be considered.

Moreover, as Francis Castles argues, "Policy change, tends to develop in a predetermined way, not infrequently on a growth path, but usually in such a way as not to disturb the established policy implementation modes and the balance of incorporated interests" (1985, p. 75). In that respect, it is important for Turkey to find its path to develop for the LTC of elderly.

1.4 Limitations

Multidimensionality of the issue constitutes the first challenge to the methodology employed. In the design of the LTC services for the elderly, demographic challenges unique to that country, social and cultural values, political environment, institutional capacity and aspects, financial sustainability and efficiency, quality and accessibility of the services and consumer choice, recruitment of the LTC workforce play a crucial role (EU Commission, 2008). In order to assess the best practices and transfer policies, all these different aspects of the subject matter must be analysed. However, owing to the word limitations, this paper will only have a general look on the transferability of different types of services and financial aspect of the LTC for the elderly.

One of the main challenges for conducting a comparative research is the discrepancy in the definition of compared concepts, policies, services, institutions and jurisdictions. Concepts are necessary as common points of reference for grouping phenomena that are differentiated geographically and often linguistically (Rose, 1991). In that respect, it is crucial to identify clearly the elements of comparison to draw more accurate findings. For that reason, a section for definitions will be devoted to clarify the terminology of the subject matter to ensure that the comparison is meaningful.

Another limitation to the dissertation is a recent development in UK about a debate on long-term care. As described above, the UK has a means-tested system for the elderly. However, a recent green paper that is published on the 14th of July

in 2009 by the Department of Health has come up with three different long-term care models to be introduced in the UK. The first one suggests Partnership where the cost of long-term care is shared by the state and the recipient. The second option is an insurance system where people contribute to their personal funds, which is very similar to the German system. And the third one proposes a comprehensive system where people who are able to afford pay in to the system for free long-term care. This third system on the other hand, is very similar to the Swedish system of long-term care (Department of Health, 2009). In consequence, the British system of long-term care getting ready for fundamental changes in the long-term care of the elderly, which will either shift towards Swedish or German system. In that respect, selection of the UK and comparing it with Turkey as a different representative of a LTC model is challenging in terms of the methodology employed. However, since such changes have not taken place, this paper will consider UK as a different agent of LTC policies.

1.5 Definitions

First and foremost, since the policies towards elderly are being analysed, it is important to look at the definition of "old age" or "elderly" in order to make sure that care policies and services are being made and provided for the same target population. According to EU Commission's definition (2009), old people are considered as people aged 65 and over. In Turkey, all the legal arrangements that refer to elderly cover people aged 65 and over. As a matter of fact, this specific demarcation is very much related with the average life expectancy. In the future,

this age limit is likely to increase but for the time being, in all countries, “elderly” refers to people who are 65 and over.

As long as LTC policies for the elderly are concerned, the definitions that member states use do not always concur (European Commission, 2008). Determination of length of the care, identification of the care recipient and the taxonomies defining long-term care facilities vary according to country. Moreover, health-care and long-term care facilities are very likely to overlap. This ambiguity between the demarcation of acute health (temporary medical) care and long-term care results in different policy implementations and LTC models. Since the objective of this paper is not to compare European LTC policies for the elderly, these nuances in definition of the concepts can be underestimated. However, it is essential to define certain terms in order to be precise about what is being compared.

Long-term care (LTC) is defined as "a cross-cutting policy issue that brings together a range of services for persons who are dependent on help with basic activities of daily living over an extended period of time. Elements of long-term care include rehabilitation, basic medical services, home nursing, social care, housing and services such as transport, meals, occupational and empowerment activities, thus also including help with instrumental activities of daily living” (EU Commission, 2008, p.3). It is important to note that LTC policies might also apply to disabled and sick people who are not able to continue their lives without a help of another person. However, in this paper, LTC of the elderly will be the subject of focus.

Informal care is described as “the extra help given to ill, disabled and older people by friends and relatives, as distinct from that given as part of a formal paid job such as nursing, care assistant, home help or support worker” (Alcock, 2008, p. 219) The countries, who support care giving by relatives are denominated as “informal-care led” countries such as Germany (Pavolini &Ranci 2008). Most of the time, this is maintained by cash benefits to the relatives.

On the other hand, formal care can be described as professional care services provided by third parties apart from relatives. (EU Commission, 2008) Formal care can refer to both residential and home-based care. Residential formal care generally refers to care given in a residential setting apart from home. Countries, which have extensive formal care facilities like Sweden, fall under the “services-led model” of welfare state (Pavolini & Ranci 2008).

CHAPTER 2: DEVELOPMENT OF THE NEED FOR LTC IN EUROPE

2.1 Demographic Changes in Europe

The purpose of this paper is to compare Turkey with other three European countries in order to draw lessons for a suitable long-term care policy for the elderly. Before moving directly to the comparison, it is appropriate to explain the rising need for LTC for the elderly. This chapter will be devoted to explain those reasons, which are demographic ageing and changing family contexts.

The very first reason why LTC for the elderly is going to be a challenge and need for the welfare states is the demographic ageing. "Population, or demographic, ageing can be defined as the combined impact of declining fertility rates and falling mortality rates on the age structure of a population" (Hantrais, 2004, p. 12). This combined impact of declining birth rates and falling death rates result in the increase in the proportion of old aged people within a given population. By 2050, the number of people over 65 is expected to increase by 77 % on average in European countries (European Commission, 2008).

Another reason of demographic ageing is the increase in longevity, in other words, increase in the life expectancy. Combined with better nutrition facilities and better working and living conditions, technological and medical developments in healthcare have increased the average number of years that a person can enjoy throughout his/her life. In the EU, life expectancy at birth for men is estimated to

increase by 8.4 years from 76 in 2008 to 84.5 in 2060. For women, life expectancy at birth would increase by 6.9 years for women, from 82 in 2008 to 89 in 2060 (European Commission, 2009). However, these numbers do not represent the world average. In some of the developing countries, the average life expectancy is as low as 41.4 (Angola) and 41.9 (Mozambique) (UNFP, 2008).

Today's population ageing is also triggered by post war era baby boom population moving into old age. In the past 100 years, the population of the world has increased from 2 billion to 6 billion (Coleman, 2001). Especially after the World War II, there has been a rapid increase in the birth rates all over the world. Considering the average human life span, these babies of post war age have started turning old . Combined with longevity and low birth rates, the percentage of elderly has increased dramatically and prone to increase in the future. "The rate of aging will step up a gear in the next 30 years as the exceptionally large post – World War II birth cohorts (the `baby boom` generations in Western countries) enter the older ages" (McDonald, 2001). In this respect, specifically for the next few decades, this generation of baby boom will specifically be a burden on the forthcoming generation.

Turkey on the other hand is a country with a transitional economy, has relatively higher birth rates compared to other European countries. The fertility rate is 2.13 for Turkey whereas it is 1.6 on average for European countries (UNFP, 2008). However, according to future demographic projections for the next few decades, every country is subject to face population decline at one point or another (Coleman, 2005). According to OECD estimates, currently 6 percent of

the Turkish population is considered as ‘old’ with the anticipated figure in 2050 almost reaching 20 percent. Compared to other OECD and EU countries, this projection can be considered relatively low. However, given the rapid speed of ageing, Turkey is due to face economic and social challenges.

2.2 Changing Family Dynamics

After the World War II, women started to participate in the paid labour force since a lot of man had become either martyrs or veterans. In that respect, women had to take the role of a “breadwinner” in the household (Hantrais 2004). This increase of women in the labour market has continued with the feminist and modernist movements. The necessity of earning money has turned into ideological trends. The stereotype of male “breadwinner” form of households has started to turn into “dual earner” or “adult earner” models in which both couples work. As a consequence of this increase in the number women entering labour market, the number of women that are available for care has decreased. Since the women are the main care-givers in the households (both for the children and elderly), intervention by the state has emerged as a necessity for welfare states (Harper, 2006).

Moreover, there has been a change of attitude in the provision of care support to the elderly and as a consequence a shift from extended family to nuclear or “beanpole” family appeared (Harper, 2006). Family sizes are getting smaller and married couples have started to live separately from their parents. They became

more independent and their mobility has increased with technology and changing family values. Individualism over communalism has started to prevail among young couples. Goode's and Hareven's study revealed that the extended family had encouraged respect and responsibility for elderly care whereas today's nuclear families lack the resources to provide care which is very much inflicted by a shift from "familism to individualism" (Harper, 2006).

Furthermore, patterns of adult union are changing. The old notion of mother, father and children as members of a family is shifting. Dissolution of marriage, single parenthood, heterosexual and homosexual partnership, step parents and siblings are all the new constituents of a family (Harper, 2006). For that reason, what constitutes a family is not solely marriage and blood link anymore. Mutual agreements, consensual partnerships have replaced the moral milestone of the families. Because of these changing family patterns within the household, long-term care of the elderly might not be guaranteed. For that reason, state intervention by the countries is becoming a priority for the elderly.

And yet, ageing and increased longevity is changing the role of family members in the family (Hantrais, 2004). The duties of spouses and the children as carers are more likely to increase within the household. As a result of decline in the replacement rates, the rate at which deaths are replaced by births, horizontal ties among generations have weakened (Harper, 2006). There had been a necessity of increase in the vertical ties between the generations as they have become more dependent on each other. Moreover, the elderly of the elderly (80+) have children who are above 60 and 65, who may as well require long-term care.

Assuming that children are the assets for care does not work among the very elderly any more. For that reason, a third part intervention by the state is necessary for the LTC of the elderly.

CHAPTER 3: Typologies

In this section, Sweden, Germany and the UK will be classified according to Esping-Anderson's welfare state typologies and their structure will be briefly introduced. And then, Turkey will be compared with the three other countries to classify Turkish Welfare State. There will be no specific reference to the LTC of the elderly in this section. However, pointing out the differences and similarities between Turkey and other three countries will be helpful to assess the transferability LTC policies according to their social model dynamics.

3.1 Sweden

According to Esping Anderson's welfare state typologies, Sweden is classified as a Scandinavian country or as a Nordic country. These types of countries are also referred as "Social Democratic" countries since social democracy is the key element for the social welfare in these countries (Esping-Anderson, 1990). Historically, "the welfare state has been developed by strongly organised and highly centralised trade unions" (Pierson, 2006). Granting of the social rights is a natural consequence of social citizenship (Handler, 2004).

In Swedish model, state is regarded as the main welfare provider before the market and the family. Also, the level of de-commodification in social services is high and those services are universal. For instance, health and medical care, elderly care and education are the universal services that are provided by the public sector. Moreover, child benefit and insurance systems including sickness insurance, unemployment insurance and pensions are the other services that are provided by the welfare state (SMHSA, 2009)

3.2 Germany

According to Esping-Anderson's welfare state typologies, Germany is considered under the category of "Corporatist" or "Conservative" Welfare States (1990). The German welfare state has its origin with Bismarckian rule. During Bismark's era, certain social rights were granted to the workers in order to prevent working class mobilisation. With the expansion of these social rights, today's German welfare system has emerged (Pierson, 2006).

In this type of regimes, commodification and market principles are not prevailing and social rights are essential for the welfare states; however, these social rights are highly attached to class and status (Esping-Anderson, 1990). Moreover, corporatist regimes are generally attached to the Church and the state plays a "subsidiary" role, in which the state intervenes when the family and the

Church is not able to provide welfare (Pierson, 1991, pp. 175). However, this is now shifting due to the decline of the influence of the Church and rise of individualism and this situation is increasing the pressure on the German Welfare State.

3.3 United Kingdom

Emergence of welfare state in the UK is linked with the poverty studies carried out at the beginning of 20th century by Charles Booth and Seebohm Rowntree. The Fabian society, which played a crucial role in the formation and growth of the Labour Party, was very much influenced by the findings of Booth and Rowntree, which revealed that the extent and depth of poverty is very severe (Alcock, 2008). In his report, "Poverty: The Study of Town Life", 27.8 % of the population, which represent 43.4% of the working population was living in poverty. These findings have set the foundations of today's British welfare model in the UK (Havighurst, 198, p. 47)

According to Esping Anderson' classification, the United Kingdom is classified as a Liberal Welfare Regime (1990). According to this typology, liberal economy principles prevail over state regulation or interventions. State plays a regulatory role to make sure that market is functioning properly. Welfare of the citizens is believed to be in full employment, in other words, working and a stable income is regarded the best way to reach welfare. If people fail to be a part of the

market system owing to other reasons such as long term-disability and sickness and poverty, state plays a residual role in the provision of social services and that is why these types of regimes are known as “Residual Welfare Models” (Pierson, 2006) However, getting benefits from the social services is highly means-tested. In order to be eligible for the benefits, claimants must prove that they really need the benefit, which requires tedious and rigorous procedure (Walker, 2005). On the other hand, it is important to bear in mind that even though social services are highly commodified in the UK, healthcare is free and universal under the National Health Service.

3.4 Turkey

In the second provision of the Turkish Constitution, it is stated that Turkey is a social state governed by the rule of law (Turkish Constitution, 2009).The State is declared as the main welfare provider for the protection of the family. Especially children and mothers are stated as the vulnerable group, which needs special care by the state. However, as the scope of social rights, only protection of family and education rights is covered in the Constitution. In this respect, even though there is a great emphasis on Turkey being a social welfare state, it does not go beyond being a “welfare state of promises” (Koray, 1996). For that reason, the extent and depth of social rights in Turkey is very limited compared to other three European countries. As a transitional economy, Turkey is going through rapid social and economic changes. For that reason, it is hardly possible to identify

Turkey as a welfare state and exactly fit into Esping-Anderson's welfare state typologies.

When we compare Turkey with Sweden, we see that it stands further away from Swedish or Scandinavian model. In Turkey, there is no universal and free provision of social services as it is the case in Sweden. Moreover, no extensive taxation and variety of social services is existent in the Turkish welfare state model. In that respect, it is not possible to come up with similarities between Turkish and Swedish models and put them in the same category or typology.

However, regarding the similarities between the German system and Turkish system, Turkey might be considered as a Corporatist Welfare State. Regarding the social rights that are granted to citizens, it can be observed that only working class can enjoy the benefits of the welfare state. Like in Germany, pensions and healthcare services are only granted to working people, who are part of the social security system. In Turkey, each working person, according to their occupations, is supposed to be a part of the three public insurance systems, which are under the process of unification as one institution by a law passed in 2006 (Social Security Institution, 2009a). This insurance system covers health care and old age pensions. For that reason, Turkey might be considered as a Corporatist Welfare State.

On the other hand, Turkey might be considered as a liberal regime, where the state plays a residual role. People, who have no social security at all, are granted a certain degree of social assistance. For healthcare, people are with no social security and no other means are given "green cards", which provide free healthcare for the needy. According to 2009 statistics, over 9 million people are entitled to have this card (Social Security Institution, 2009b). However, these benefits are highly means tested and infinitesimal. In that respect, Turkey is similar to UK liberal system in terms of its residual welfare state characteristics, however, since rights attached to the working class prevail in the Turkish society, it can be concluded that Turkish system has closer links with the German system.

CHAPTER 4: Current LTC Services in Europe and Turkey

In this section, different state intervention models for LTC of the elderly in three different European countries (Sweden, Germany, and the UK) will be presented. And also, current structure of services for the elderly care in Turkey will be introduced. However, it is important to bear in mind that state intervention to provide welfare support to the elderly is a new and growing concept for Turkey. Even if there are some attempts to support long term elderly care (which will be discussed in this section), it is very primal compared to other European countries. For that reason, the purpose of this study is to look at the similarities and differences between Turkey and three European countries to assess transferability and applicability of the LTC practices, rather than the LTC practices itself. However, before moving on to countries, it is convenient to have a look at the application of social policies in the EU level.

The establishment of European Union dates back to Treaty of Paris in 1951, which set up the European Coal and Steel Community (ECSC) (Hantrais, 2007). This economic cooperation has been expanded to social and political spheres. However, only economic sphere has legal sanctions for the member states. Even though European Union strictly requires its members to follow certain fiscal and monetary policies both in public and private sector, in terms of social services, there is no legal sanction for member states to implement certain policies. Instead of having policy prescriptions, European Union has common objectives to achieve

in terms of social goals. In other words, every country is free to pursue its own social policies as long as they are progressing to reach the common goals (Hantrais, 2007).

As long as care policies are concerned, member states are expected to be committed to provide "accessible, high quality and sustainable health-care and long-term care" (European Commission, 2008). However, they all have different policies in terms of LTC for the elderly. In some European countries, the need for long-term care is handled through health or social services whereas some regard LTC as a different type of social risk. The degree of ageing and increase in the additional years that people enjoy is very crucial in determining the appropriate LTC policies employed. (European Commission, 2008). This variety of different welfare systems also highlights the strengths of each system within a wider framework, and allows for easier policy learning and transfer, which the EU naturally facilitates.

4.1 SWEDEN

4.1.1 Historical Development

With the Social Services Act in 1982, which was revised in 2001, the provision of social services is granted as a social right equally to all citizens. However, long-term care of the elderly has been a focus of policy area since 1992

with the Elderly Reform. Before the reform, healthcare was being provided by county councils and social care was the responsibility of municipalities. However, with the expansion of social care services, the distinction between health-care and social care has blurred and management of those services have become very complicated. For instance, for the same patient, county councils and municipalities were providing similar care services. Moreover, the elderly receiving social care were crowding out the hospitals, which is specifically referred as bed-blocking (Karlsson et. al 2004).

The scope of this reform was to change the responsible authority for providing services. With the 1993 Elderly Reform, funding and management of the elderly care has been transferred to municipalities. Municipalities were already providing housing and social services for elderly. With this reform, municipalities also became responsible for the financial management of the elderly care services. The ultimate goal of the reform was to integrate elderly care services at the local level for enhancing services and reaching maximum number of needy. Subsequently, delegating care of elderly from counties to the municipalities has reduced the number of elderly people that are waiting to be discharged at the hospitals (Royal Commission, 2009).

4.1.2 Residential Care

With the introduction of the Elderly Reform, a new concept of "special accommodation" has emerged. This term covers nursing homes, old people's homes, service flats and sheltered housing, each of which serves to different purposes of care. As of 30 June 2008, about 94.200 elderly (65+) people have received long-term care in one of the mentioned residences. This number only constitutes the 6 % of the total formal LTC recipients (Official Statistics, 2009).

4.1.3 Home-based Care

Even though residential care is very developed in Sweden, home care services are preferred to residential care, both by the government and the service users (Fact Sheet, 2007). Since, there is a variety of home care services; it is more popular in Swedish society. Home care services vary from grants for tailoring the house according to the needs of the elderly to day care services and provision of personal safety alarms. All the arrangements are provided according to the needs of the care recipient. These needs are assessed according to each individual by a case manager employed by the municipality. However, client choice is also important in deciding for the suitable care facility for the elderly (Fact Sheet, 2007).

On the other hand, the municipalities are also supporting the family carers through family grants. Between the years 2006–2007, the Swedish government have granted 125 million SEK to facilitate municipalities to extend support for family carers (Fact Sheet 2007). Even though informal care is supported by the system, formal care still prevails over informal care services and Sweden remains as a strong representative of a services-led model of welfare states.

4.1.4 Financing

In Sweden, the financing of the public sector expenditure is provided through taxes, central government grants, and in some part through patient fees (Fact Sheet, 2007). However, local income taxes are the main way of funding long-term care. These taxes are general income taxes that are collected by the municipalities at an average flat rate of 20% of the income (Karlsson et. al, 2004).

Even though its share is small (approximately 5%), the patient fees are another way of funding the expenditures. Service users are charged for both institutional and home-based care depending on the policy of the particular municipality. There are no legal restrictions for the extent of this charging of "out of pocket money". However, they are supposed to be "fair", not exceed their "full economic cost" and must leave enough for a "personal expenses allowance" (Karlsson et. al, 2004, p. 32).

Moreover, central government grants, which are paid in three different ways, also contribute to the funding of long-term care services. The first type of central government grants is the general payments to each municipality, which is the same amount for every municipality. The second one is an age-related grant and the third one regards" cost adjustment" to make sure that different demographic structures do not render the municipalities inadequate in LTC provision (Karlsson et. al, 2004).

4.2 GERMANY

4.2.1 Historical Development

Starting from mid 1980s and onwards, need for long-term care of the elderly has increased with the increase in the aged population in Germany. Since the health insurance system only covered the acute illnesses, long-term care need of the elderly people had to be covered privately or by local social assistance which was already stigmatised as a "poor benefit". In that respect, a public debate has come into the scene and a need to introduce a special service for long-term elderly care has emerged. Moreover, current regulations on long-term elderly care were intensifying dependency on institutional care and promoting unpaid work by women at home. At that time, other European countries had more facilities than Germany for providing home care led services (Royal Commission, 1999).

As a corporatist welfare state, social assistance and welfare in Germany is based on bread-winner family model. Traditionally, women and spouses are expected to take care of the children and elderly who are in need. However, in practice, family relations were not operating as it was perceived or desired by the government. “While the law stipulated that offspring as well as spouses could be responsible for these costs before social assistance was payable, this was increasingly seen as anachronistic and patchily applied in practice” (Royal Commission, 1999, pp. 184).

With the reforms in 1995, Germany introduced a universal model of long-term care called Social Dependency Insurance (SDI). This insurance provides citizens in need for at least six months of care (Pavolini & Ranci 2008). This long-term care service is being provided through either cash benefits or a set of services. The type of benefit to be received is left to consumer choice. They may either choose to receive care at home or a residential place or they can receive cash benefits. Mix of two different benefits is also possible (Karlsson et. al, 2004).

4.2.2 Residential Care

Before the LTC insurance reform in Germany, the care of the elderly was being operated social stations (Sozialstation) since 1970s. These stations have been providing non-institutional care, helping elderly with consulting, transport, shopping, household care and day care. They have also been providing nursing

services through insurance companies. Currently, there are approximately 4000 social stations in the country and 15.000 to 25.000 people in the rural areas can benefit from these stations whereas this number is 20.000 to 50.000 in the urban areas or towns (Lezovic & Kovac 2008).

With the introduction of SDI system, the role of these stations has also changed. Since SDI started to fund private care, the demand for social stations has decreased. In a consumer-choice oriented care market, non-profit or public institutions have lost their popularity and had to engage in a competition with private providers (Lezovic &Kovac 2008).

4.2.3 Home-based care

Home care services in Germany are provided in two different ways, which are cash and non-cash benefits. Non-cash benefits are provided as care services supplied by home care agencies or home care services whereas cash benefits are granted as long as the person in need is receiving sufficient care by the help of a family member, neighbour or some acquaintance. A mixture and combination of two is also possible. There are three different (the need for considerable care, severe care, and highly intensive care) levels of care needs defined by the LTC law. The need for different levels of care is assessed by health professionals (Karlsson et. al, 2004).

LTC insurance programme in Germany also provides social security insurance coverage for the carers who are not working at all or not working for more than 30 hours a week. All the social security insurance premiums are paid by LTC insurance fund. In that sense, LTC insurance scheme not only helps to provide care services to the elderly people, but also compensates for the unpaid work by the family relatives (Karlsson et. al, 2004).

4.2.4 Financing

In 1995, a special insurance system for LTC is introduced in Germany as a 5^{th} pillar insurance system after health, accident, pension and unemployment insurance schemes. These insurance schemes are run by self-administered institutions and they do not constitute a part of public body (Karlsson et. al, 2004).

The new insurance scheme is compulsory and developed under the health insurance programmes in Germany. Every person has to register for both acute and long-term health care insurance. The premiums to be paid are determined by the income of the citizens. There are both public and private insurance schemes. In the public insurance scheme, there are 70 million contributors whereas this number is 8.5 million for private insurance scheme. (Lezovic & Kovac, 2008)

4.3 UNITED KINGDOM

4.3.1 Historical Development

Care provision for the elderly has a long history in the UK and even dates back to 1601 when the first Poor Law was enacted. The main principles of LTC for elderly started to evolve during post war era when municipalities started to provide residential support for the frail people. At the time, NHS was also providing care services without means testing and this has started to become financially problematic. A need for reform has escalated and today's LTC model in the UK is introduced by the Community Care Reforms which is incorporated in 1990 but started to be implemented in 1993 (Howse, 2007).

With the Community Care Reforms, the role of the local authorities has changed. Before the reform, Local Authorities were providing care serviced to the needy. With the reform, centralised power was devolved and local authorities gained more power. Their role shifted from a service provider to service purchaser for the elderly. By this way, a quasi-market was aimed to be created in the care sector (Karlsson et. al, 2004).

However, provision of these services is highly means-tested. The elderly, who wish to receive financial support from the local authorities have to prove that they both need it and unable to afford the necessary care. However, this is a very

controversial issue in the UK. After the community care reforms, the government has set up a Royal Commission in 1997 and the report presented proposed a free care for the people. However, this proposition has never been put into action and the debates still continue. In July 14th 2009, Department of Health has issued a green paper that proposed three different financing systems for LTC.

4.3.2 Residential Care

In the UK, there are different types of residential care facilities which include nursing homes, residential care homes, retirement homes, assisted living and close-care in tailored housing. However, the main ones are nursing homes and residential homes. The first one generally provides nursing facilities which require more intensive care for the more frail and disabled elderly. On the other hand, the latter provides board and daily care. There are both public and private residential facilities but as stated before, since the Local Authorities purchase the services, competition is high and private provision is dominant in the market (Karlsson et al, 2004).

4.3.3 Home-based Care

In the UK, home-based care is the dominant type of service provision since the majority of care recipients prefer to stay in their own houses. These services are

very flexible and there are different types of home-based care available for the elderly. The needy have an option to choose from care workers or registered nurses as an assistant depending on their need levels. The length and time of the care provided also varies from a couple of hours to 24 hours of assistance. The assessment of need is determined by a care manager employed by the Local Authority (Howse, 2007).

4.3.4 Financing

In the UK, public expenditure on social care comes from a mixture of central government grants, council tax revenues, and user charges. However, the majority of the financing (2/3) is provided by the government grants (Lessons from international experience p 196). It is up to individual councils to decide how to use that funding and how much of it to spend on social care. The overall gross expenditure on adult social care in 2005-06 was approximately £13.7 billion (NHS, 2009).

4.4 TURKEY

4.4.1 Historical Background

As a traditional Islamic country, intergenerational solidarity has operated through extended family relations in Turkey. The responsibility of taking care for the elderly has always been the duty of their children (Canatan, 2008). Children were regarded as a future investment for parents in old age. Turkish society had the roots of intergenerational solidarity deeply embedded within the culture for centuries. Until recently, the cohesion between the generations has been effectual, consensual, functional and practically structural. The body of evidence continues to stress that intergenerational solidarity and altruism has remained strong until quite recently (Kohli, 2006). As it can be seen from the other European countries, the need for LTC for the elderly is stipulated by the demographic challenges and public debates. However, Turkey's initiative for the LTC of elderly has emerged with the debates on ageing and as a necessity to follow EU practices. Now it is appropriate to have a look at what type of care services are existent in Turkey.

4.4.2 Institutional Care

Institutional care of the elderly in Turkey is generally operated through a particular institution called "Social Services and Child Protection Institution (SHCEK)". There are 81 nursing homes operating under SHCEK. There are also

22 nursing homes belonging to local authorities, 34 belonging to associations and foundations, 7 belonging to ethnic minorities and 6 belonging to other public institutions (Ministry of Education, Ministry of Internal Affairs, Public Pension Fund, General Directorate of Turkish Post-PTT and Darulaceze Institution). When we look at the capacity of all the nursing homes described above, they are only able to serve 20.879 people (SHCEK, 2009). Turkey has a population of over 71 and a half million (TUIK, 2008) and more than 4 million of them are aged over 65 assuming that 6 percent of the population is constituted by elderly (Antolin, 2008). Currently, 3639 (OZIDA, 2009) people are waiting to benefit from the nursing homes. Regarding the gap between the capacity of the nursing homes and population aged over 65, the insufficiency of these institutions is evident. Regarding future projections in aged population, this shortage of institutional care services is more likely to increase.

4.4.3 Home-based care

As stated previously, care of the elderly was being operated by family relations and state intervention in home-based care is a very recent development for Turkey. However, these benefits are extremely means-tested. In order to be eligible for the benefit, the patient or the person in need should have a disability ratio of 70% and not to be able to continue his/her life without the help of a third party. Moreover, eligibility requires no fixed income or covered by any type of social security (OZIDA, 2009).

The application process itself is also very rigorous. People who want to receive the elderly care benefit have to apply to the Provincial Social Services Administrations who operate under the Prime Ministry of Turkish Republic. The documents for application include a disability report that includes the level and category of disability, which is going to be issued by the relevant Health Council. Other documents include papers such as consulting covenant and photos (OZIDA, 2009).

CHAPTER 5: Findings

5.1 Different Service Types

In the previous chapter, all the four countries are classified according to welfare state typologies and their LTC for the elderly arrangements are introduced under the light of their own typology. Now in this section, it is appropriate to assess the transferability of the services by comparing different aspects of the states. The comparison will be made in terms of institutional capacity, affordability (financial aspect) and the impact of consumer choice.

5.1.1 Institutional Capacity

When we look at the arrangement and management of LTC services, we see that local governments are the main suppliers of such services in all the three EU countries. They all have their own autonomy on the determination of need of the care facility, and except for Germany; they are partially responsible for financing of the LTC services. In short, municipalities or local governments play a major role in the provision of the care services in these countries. Similarly, taking care of the frail elderly is delegated to the municipalities in Turkey.

However, looking at the institutional capacity for residential service provision in Turkey and other EU countries, it can be easily seen that Turkey's existing resources are not sufficient to meet the demands for institutional care. As stated above, in Turkey there are only 150 nursing homes that provide care for the elderly and 3639 people are already waiting to be served in these institutions. However, in Germany there are 4000 social stations that serve the elderly. Similarly, there is a variety of formal care facilities in the UK and Sweden, which provide both residential and home-based services. In that respect, Turkey's institutional capacity is not sufficient for a services-led intervention

5.1.2 Financial Constraints

Even though there are different types of service systems in each of the three EU countries, all of them has a pressure of cutting down on their expenditures on LTC as a result of globalisation process and increasing service costs. Since home-based care is less costly, there is a shift towards promoting and providing home-based care compared to residential care (Wilson, 2006).

According to EU statistics, the unit (per patient) cost of formal care in an institution is relatively higher than the cost of a unit of care provided in the home of the care recipient (EU Commission, 2009). According to a sensitivity test that is applied to future expenditure projections on long-term care, a 1 % yearly shift of informal care recipients to formal care would result in an additional expenditure of 0.6 of GDP (European Commission, 2008). In that respect, home-based care is a better option for Turkey regarding the budget constraints.

5.1.3 Consumer choice

Assuredly, personal choice of the care recipient is important in shaping LTC policies. In order to meet the demands in LTC sector, welfare states also has to modify or adopt appropriate policies. According to a Eurobarometer survey in 2007, 45 % of the participants prefer or expect to be receive long-term care at home by a relative. 25 % is again in favour of care at home but by a professional

care service provision. On the other hand, only 10 % prefers or expects to receive an institutional care. In that respect, we can easily conclude that majority of the European people are in favour of home-based long-term care being either formal or informal (European Commission, 2008).

The research also shows that service users in Germany are more content with the cash benefits rather than services (Pavolini & Rancini, 2008) Even though German system offers a wide range of professional home-care services, care recipients prefer to be taken care of by their relatives. According to the statistics, the main caregivers are spouses and daughters. Among those who are between 65 and 79, the percentage of spouses giving care is 40 percent, whereas this number is 25 % for the daughters. And for the care recipients who are 89 and above, the percentage of spouses taking care is 12% and 44 % refers to the number of daughters who are in charge of the care activities (Harper, 2006). From this data, it can be inferred that in German society, family relations prevail in the LTC of the elderly.

As far as Turkey is concerned, tendency toward staying at home is the similar. According to this research, 55 % of the participants stated that they would prefer to stay with their children in old age. 17.8 % stated that they would prefer to receive home care service. Only 9.3 % indicated that they would go to nursing homes or receive institutional care. 1.2 % mentioned other forms of care whereas 16.8 stated that they have no idea about the issue. These statistics show that majority of the people prefer to stay with their children to receive care from their

own relatives. And a considerable number (17.8) prefers home-based formal care, which again shows that there is a tendency towards home-based care.

5.2 Financing Options for the Proposed Services

After having looked at the different types of services, it is convenient to propose a suitable financing system. In this section, we will have a look at the different financing models of LTC in Sweden, Germany and the UK. Since there is no systematic provision of LTC care services in Turkey, comparison will focus on the transferability of the financing mechanisms. Since all the three European countries have diverse forms of financing, different indicators (taxation and healthcare model) will be assessed in each country for transferability.

When we compare Sweden with Turkey, our parameter is the extent of taxation. In Sweden, LTC facilities are funded through local social services. In 2008, Swedish government has spent 49.1 billion Swedish Kronas (SEK) on healthcare, medical care and social services, which constitutes 7 % of the total public expenditure. Moreover, the government spends 115.9 billion SEK for the financial security of the sick and disabled, which constitutes 15 % of the total government expenditure (Facts & Figures, 2008). Looking at the statistics, it can be inferred that social care constitutes a significant amount of the total public expenditure. However, this is not politically and financially feasible for Turkey.

Regarding the financial capacity of the municipalities in Turkey, it is not financially feasible to pass the responsibility to the local authorities. Since the economic and urban infrastructure of Turkey is still in progress, municipalities have other priorities and responsibilities to actualise other than care services. In Turkey, according to 2004 statistics (the most up-to-date data available), internal expenditures such as personnel wages and fixture purchases constitute approximately 60% of the total expenditure of the local authorities. Around 20% of the expenditures are invested on physical and urban infrastructure of the local division. And the rest 20% belongs to the transfer expenditures such as debts, financial, economic and social transfers. However, the share of social transfers is only2.1 % of the total expenditure of municipalities (TUIK, 2004).

As long as Germany is concerned, since financing of the healthcare systems are similar in Turkey, it is more suitable for Turkey to introduce an insurance scheme for the LTC of the elderly. In Turkey, only working people and their 1st degree relatives (spouses and children) are eligible to receive as long as they are contributing to the public insurance scheme. All the health expenditures are financed by the government through general budget. For that reason, LTC of the elderly in Turkey might be financed through insurance that is linked to healthcare in Turkey.

Moreover, since the LTC insurance funds are operated by the same health insurance company that the person is already registered. There are no additional personnel employed for the administration of LTC insurance system. For that

reason, the insurance scheme brings no extra cost in terms of recruitment and it is financially more feasible. In this respect, it is more financially viable for Turkey to link LTC insurance to health care insurance.

For the UK, looking at healthcare system financing does not work for comparison since the provision of healthcare services and long-term care services are completely different. Healthcare services are universal and free at the point of delivery whereas LTC services are means-tested. In that respect, our parameter for the UK is going to be the local authority expenditures. However, as it is the case in Sweden, it is not financially feasible for municipalities to raise funding for LTC services.

CONCLUSION

After depicting and analysing the LTC services for the elderly, the findings show that the transferability of the German system of LTC for the elderly is higher compared to Sweden and the UK, owing to the similarities in the welfare state models and social and cultural structures.

First of all, regarding the typologies, Turkey is more similar to Germany and can be categorised as a corporatist welfare state. Since all the social rights are attached to the class and status, namely to the working class, the structure of the welfare institutions are similar. In this respect, the transferability of German LTC services is higher.

Secondly, home-based services and informal led-care intervention model is more suitable for Turkey owing to social and cultural similarities with Germany. Social relations in Turkish society are highly embedded around family ties. Family is the key care provider to the elderly. Similarly German society is a very traditional and conservative culture, where family relations prevail. In that respect, as a conservative society Turkey is very much alike with Germany. Since Germany is favouring an informal led-model of social services, it is more suitable for Turkey to adopt a similar attitude. Moreover, the evidence on institutional and financial capacity of Turkey, recent trends on cost containment and the impact of

consumer choice support that informal-care led services in a home setting is a more feasible for Turkish Welfare State.

As far as the financing of LTC systems are concerned, financing of the proposed services is more feasible through an insurance system attached to healthcare system since the social security provision is similar in Germany and Turkey. Taxation and government grants to local authorities and charging the users, as it is the case in the UK and Germany, are not politically and financially feasible for Turkey regarding the economic and institutional structure.

In conclusion, both theoretical and empirical evidence show that applicability and transferability of an informal-led, home-based care model of social services is higher. It might be argued that the new system that is introduced in 2007 is very similar what is proposed in this paper. However, regarding the absence of a financing system and lack of expansion and coverage of the services, it is not possible to talk about adequacy of the current arrangements. Moreover, institutional and financial incapability for a formal services-led model does not mean that Turkey has to abandon improving formal LTC services. For future welfare of the elderly, development and improvement of the formal LTC services is essential. Also, regarding that there is a considerable number of people who are not covered by insurance schemes, introduction of an insurance system is not sufficient. Means-tested LTC systems should also be expanded.

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