

Old Age And Its Related Problems Considered From An Elderly Perspective In A Group Of Turkish Elderly

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Abstract

Aim: The aim was to evaluate the elderly health status, existing health problems, and feelings about old age and death in a Turkish community

Methods: The study group consisted of 261 elderly living either in their own homes with family members, or in residential homes between February 2002 and April 2002. Data obtained were recorded on a datum collection, which were evaluated using chi-square (χ^2) test and percent ratios.

Results: The majority of elderly indicated that their health status was "bad" or "not bad" and that they were satisfied with their place of residence (72.8% and 72.8%, respectively). Of those remaining with family members, 64.4% reported satisfaction with the place in which they were living, whereas the rate was only 42.3% in residential care homes ($p < 0.001$). The most frequently reported health problem was hypertension (26.1%).

Conclusions: The aging of the population all over the country has not only brought with it new and serious issues, but has also become a national and international health matter to be dealt with as in our country.

INTRODUCTION

Old age has been divided into different groups: biological, physiological, emotional and functional.

Biological aging is concerned with changes occurring in the structure and functions of the human body; physiological aging is concerned with individual and behavioral changes; emotional aging describes changes in one's attitude and lifestyle dependent on one's self-perception of being old; and finally functional aging is the comparison of individuals of the same age group in terms of those within the group being unable to maintain their functions in society (1).

The most obvious manifestations of old age are changes in physical appearance, such as wrinkles appearing on the face; the graying of hair, slowing down of reactions, followed by restriction of movement and sense organs, and proneness to chronic illnesses (2).

Advances in science and technology, as well as improvements in health services available, have played an important role in the increasing number of elderly in the

world. The 20th century saw an increase in both anticipated and actual life expectancy figures, a phenomenon described as the 'aging population' (1,3).

In the industrialized countries of the west, the elderly population in the 1990s was 7-15% of the total population, and is expected to reach 25% by the year 2020 (4). According to the 1985 census, the group of elderly aged 65 and over constituted 4.2% of the population in Turkey. This ratio had risen to 4.3% in 1990, 4.7% in 1995, and is expected to reach 6.3% in 2005 and 7.1% by the year 2010 (5).

There are currently 580 million elderly aged 60 and over in the world, and of these 355 million live in the developing countries. Within the last fifty years, the rate of accelerated death in developing countries has visibly decreased, and life expectancy at birth has increased from 41 years in the early 1950s to 62 years in 1990. In the year 2020, life expectancy at birth is predicted to reach 70 (6). Similarly, it has been estimated that the anticipated life expectancy averages at birth in Turkey of 72.7 years for women and 68 years for

men in the year 2005 will have risen to 73.8 for women and 69 for men by the year 2010 (5). This increase in the average life expectancy has become a social problem due to the resulting effects made on social life by the industrial revolution.

The requirements of individuals change the older they become. By the year 2020, it is anticipated that one in three deaths in developing countries will be through causes related to old age, and that the majority of these deaths will be from non-contagious diseases such as circulation system disorders, cancers and diabetes. As life expectancy increases, so does the risk of some chronic diseases. The elderly become ill more frequently, have to live with more chronic diseases or problems, and are generally trying to fight against several health problems at once, resulting in an increase in the number of medications taken (7,8,9). Consequently, the elderly apply to health institutions more and stay for longer periods in hospitals, rendering the elderly passive, dependent consumers. (10,11,12,13,14).

The aging of the community brings with it new and serious problems both nationally and internationally, with WHO describing it as an important developmental element requiring emergency action. The term 'old age' defines not only an individual's appearance, but also refers to a loss of power, role and position. Loss of full possession of the faculties and a proneness to physical diseases causes an individual to become more dependent on others, a fact that requires consideration when deciding on the manner in which the elderly are approached (6,11,12,15). Beyond the traditional approach of caring for the elderly in the accommodation of their own homes or in residential care homes, the state or private enterprise must seek alternative services in order to ensure the well-being of the elderly.

The aim of this survey is to determine the health status of elderly individuals, the way in which they perceive old age, existing health problems, habits related to health, old age and the problems old age causes, and their thoughts concerning death. In this way we hope to extend the advice offered and develop appropriate service policies.

METHODS

General knowledge concerning Eskisehir, the health insurance system of Turkey and residential care homes in Eskisehir

Eskisehir is a semi rural province situated in the western part of Turkey, with a population of 460,000; approximately

12,000 of which are aged over 65 years. There are no recreation facilities for the aged in the city. The socio-economical level of the city is average compared to other Turkish cities.

There are several health insurance foundations operating in Turkey, covering 90% of Turkey's total population (68.000.000). Membership of these organizations is dependent on an individual's job. Manual workers, constituting 32%, are covered under SSK, the Social Security Organization. Farmers, tradesmen and housewives, 12% of the population, are covered by BAGKUR, the Private Entrepreneurs Organization. Government officials/clerks are covered under EMEKLI SANDIGI, the Retirement Organization, which covers 28 percent of the population. Those under EMEKLI SANDIGI can attend private health centres and university hospitals, thus, membership of this association is seen as elite. It is estimated that between 3-6% is covered by private insurance (16). The Green Card Scheme, also called the Poverty Card, which is valid for only examination and analysis expenses, covers about 5% of the population.

There are only two elderly homes, Maide Bolel and Suleyman Cakir, in Eskisehir. The former is a home with a capacity of 44, and accepts those who are fit, healthy and capable of doing their daily activities on their own, whereas, the latter with a capacity of 59, serves those in need of care. Both were built by philanthropists and handed over to the administration of the Ministry of Social Welfare, controlled by Eskisehir Municipality. Each home has only one nurse responsible from all primary care tasks.

Subjects: The elderly interviewed were aged 65 and older, residing in either of the two residential care homes, or their own houses.

Selection of those living in houses: Two health centers (numbered 5 and 14) were selected from a total of 20, by applying a cluster sampling method. From the health records of 2000 elderly patients attending these centres, 356 were randomly selected. However, due to a variety of factors, the sample consisted of 209 individuals. Reasons for non-participation were as follows: 41 were not at home; 49 were unwilling to participate; 23 had communication difficulties; 22 were no longer living at the addresses provided by the health centers; and 12 dropped out in the middle of interview saying that they found the study to be "unnecessary and nonsense".

Selection of those living in residential care homes Our objective at the outset was to interview all the residents of the 2 care homes; however this proved to be impossible. Eighteen of the residents were away on notified holidays, thirteen had communication difficulties, and twenty were not willing to participate. The number of participants in this group was 52.

The study was conducted between the dates of February 1st, 2004 and April 31st, 2004.

Both groups were advised that participation was strictly voluntary and refusal would not affect residency status. The approval of local authorities, such as the State Health Authority and Osmangazi University, and the Central Administration of Municipality in the city concerned was sought and obtained, as was consent from each member.

Procedures: A quiet atmosphere was provided to ensure maintenance of the quality of the research protocol and to enable interviewees to reveal their feelings freely.

Voluntarism was essential, and they were assured that this study was conducted purely to better understand their needs and provide better help.

Questionnaire: The questionnaire was designed by the researchers to learn demographic characteristics. These were namely age, occupation, economic status, place of residence, existence of health insurance, health status, medication used, usage of cigarettes and alcohol, restrictions in daily activities due to health problems, health controls, personal feelings about old age, satisfaction with the place in which they lived, and the place where the wished to pass away.

Statistical Analysis: Data were evaluated by a SPSS program. Statistical differences were analyzed using the Pearson’s chi-square statistical test (χ^2) and percent ratios where appropriate. The level of significance was set at 5% ($p < 0.05$).

RESULTS

Although the original objective was to interview a total of 459 elderly, 356 living in their own houses and 103 at residential care homes, we were only able to record the information of 261, 209 from the first group (58.7%) and 52 from the second (50.5%). The average age of correspondents was 71.2±6.9 (min:60-max:87 years). Although the average age of the group living with family 71.2±6.9 (min:60-max:87) was slightly higher than that of other group 69.6±5.9 (min:60-max:79) it revealed no significant

differences ($p > 0.05$).

The distribution of respondents according to socio-demographic characteristics and gender is presented in Table 1. Approximately two thirds (66.2%) of the study group were women and just over one-third (33.8%) men. More than half of the respondents (56.4%) were aged 60-69 years, whereas only 5.7% were 80 years and over. More women belonged to the 60-69 and 70-79 age groups than the 80 and older age group.

Figure 1

Table 1: The distribution of respondents according to socio-demographic characteristics and gender

Socio-demographic characteristics of the elderly	Female n(%)	Male n(%)	Total n(%)
	173(66.2)	88(33.8)	261(100)
Ages	$\chi^2=19.6$; $df=2$; $p=0.000$		
60-69	94(63.9)	53(36.1)	147(56.4)
70-79	76(76.7)	23(23.3)	99(37.9)
80 and over	3(20.0)	12(80.0)	15 (5.7)
Living children	ns*		
Yes	157(66.7)	75(33.3)	232(88.9)
No	16(55.2)	13(44.8)	29(11.1)
Last occupation	$\chi^2=204.36$; $df=3$; $p=0.000$		
Housewife	148(100)	- (-)	148(56.7)
Civil servant (blue collar)	17(65.4)	9(34.6)	26(10.0)
Worker	4(25.0)	12(75.0)	16 (6.1)
Farmer/ free entrepreneur	4 (5.6)	67(94.4)	71(27.3)
Financial status	$\chi^2=7.21$; $df=2$; $p=0.027$		
No income	32(64.0)	21(36.0)	53(20.3)
Elderly aid (Social welfare)	8(42.1)	11(57.9)	19 (7.3)
Retirement pay	133(70.4)	56(29.6)	189(72.4)
Type of social security	$\chi^2=63.07$; $df=4$; $p=0.000$		
None	3(33.3)	6(66.7)	9 (3.4)
EMEKLİ SANDIĞI (Retirement Organization)	46(80.7)	11(19.3)	57(21.9)
SSK (Social Security Organization)	85(74.6)	39(25.4)	114(43.7)
BAG-KUR (Private Entrepreneurs Organization)	45(90.0)	5(10.0)	50(19.1)
Green card (Poverty card)	4(12.9)	27(87.1)	31(11.9)

*statistically nonsense

More than half of the elderly (56.7%) were housewives (148/173=85.5%), followed by civil servants (17/173=9.8%). Most of the men had been farmers (67/88=76.1%), followed by workers (12/88=13.6%) ($p < 0.001$). 76.9% of the women (133 out of total 173) were in receipt of retirement pay, most likely received via a husband or dead father. 20.3% of the elderly had no income (64% women and 36% men). 57.9% of those receiving support were men, whereas 70.4% of those in receipt of retirement pay were women ($p < 0.05$). SSK was the most common provider, with 43.7%. 96.6% of the elderly had some type of social security.

When questioned about levels of care satisfaction provided by the social security organizations, most participants indicated that they were happy. The degree of satisfaction was much higher in those who were under the coverage of

EMEKLİ SANDIĞI (79.2%), followed by BAG-KUR (61.1%), SSK (50.4%) and Green Card (46.7%) (Unshown data).

The relationship between the age groups and their definition of health is presented in Table 2. Of the elderly, just 27.2% said that they were in ‘good health’ and 63.6% ‘not bad’. The majority (66.7%) of those reporting their health status as ‘bad’ were in the age group of 70-79, whereas the majority (60.5%) of those reporting their health status as ‘good’ were in the age groups of 60-69 and 80 years of age (100%) ($p < 0.001$).

Figure 2

Table 2: Personal definitions of health according to the age groups of the respondents

Definition of health	Age groups			Total n=261(100.0)
	60-69 n=147(56.4%)	70-79 n=99(37.9%)	80 and over n=15(5.7%)	
	$\chi^2=20.9; df=4; p=0.000$			
Bad	8(33.3)	16(66.7)	-	24 (9.2)
Not bad	96(57.8)	70(42.2)	-	166(63.6)
Good	43(60.5)	13(32.3)	15(100)	71(27.2)

Satisfaction status according to respondents’ residence place is presented in Table 3. 72.8% of the elderly reported that they were pleased with their place of residence, with 64.4% of those living at home expressing content. However, this figure was just 42.3% for those living in residential care

homes ($p < 0.001$).

Figure 3

Table 3: Level of satisfaction with the place of residence

	Satisfaction Status		Total n=261(100%)
	Yes n=190(72.8%)	No n=71(27.2%)	
Residence place	$\chi^2=30.5; sd=2; p=0.000$		
Home	168(64.4)	41(15.7)	209(80.1)
Residential care	22(42.3)	30(57.7)	52(19.9)

Information concerning the distribution of existing health problems, restriction of daily activities due to disease, status/method of taking medicine (drug), and health institutions supplying health checks to the elderly is presented at Table 4. The most frequently reported health problem was hypertension (26.1%), followed by rheumatism (18.8%) and osteoporosis (12.3%). 30% of the elderly expressed that their health problem did not affect their daily activities, while 8.9% were affected quite a lot by their health problems. Health centers were the most frequented health institutions for health checks (37.5%). Private hospital/clinics were used only by a small percentage (8.5%). Most of the elderly reported that they were still taking medicine (72.8%), whereas only 7.7% were not taking any medicine.

Figure 4

Table 4: The distribution of existing health problems, restriction of daily activities due to disease, status/method of taking medicine (drug), and health institutions attended for health checks

Existing health problems	Total n(%) 261(100)
High blood pressure (Hypertension)	68(26.1)
Rheumatismal disease	49(18.8)
Osteoporosis	32(12.3)
Heart disease	28(10.7)
Diabetes	23 (8.8)
Neurological disease	18 (6.9)
Gastrointestinal disease	17 (6.5)
More than one health problem	13 (5.0)
Asthma	9 (3.4)
No health problems	4 (1.5)
Restriction of daily activities due to disease	Total n(%) 257(100)
Limited (not much)	26(10.1)
Fairly bit	131(51.0)
Quite a lot	23 (8.9)
No restriction	77(30.0)
Health institutions attended for health checks	Total n(%) 261(100)
Health Center	98(37.5)
State Hospital	73(28.0)
Social Security Org. Hospital.	39(14.9)
Medical Faculty Hospital	29(11.1)
Private Hospital (Private Clinics)	22 (8.5)
Method/status of use of medicine	Total n(%) 261(100)
By prescription	190(72.8)
Over the counter without prescription	4 (1.5)
Used before but not anymore	47(18.0)
Not used/using	20 (7.7)

The relationship between the elderly attending health checks

and their use of medicine is presented in Table 5. Of the respondents, 67.4% said that they were attending a health institution for health checks, 86.1% of which were already using medication, and 13.4% not. Most of those not using medication (86.6%) reported that they were also not attending any health care facilities ($p < 0.001$).

Figure 5

Table 5: The relationship between attendance of health checks and use of medicine

	Use of medicine		
	Yes n=194(74.3)	No N=67(25.7)	Total n=261(100.0)
Health control	$\chi^2=119.7$; $sd=1$; $p=0.000$		
Yes	167(86.1)	9(13.4)	176(67.4)
No	27(13.9)	58(86.6)	85(32.6)

The distribution of reasons for attendance at health institutions according to gender is given in Table 6. Female attendance to health institutions was higher than that of males (66.1% and 33.9%, respectively). Among the reasons given for attendance to health institutions, high blood pressure, rheumatism and osteoporosis figured highly (26.4%, 19.1% and 12.4%, respectively). Higher rates of women reported going to health institutions for hypertension, osteoporosis, diabetes, stomach complaints, multiple simultaneous complaints, and asthma. In contrast, men attended for heart and neurological diseases. We also investigated if male and female attendance differed according to the type of health problems, and found that it did for osteoporosis ($p < 0.001$), heart disease ($p < 0.05$), and neurological disease ($p < 0.05$).

Figure 6

Table 6: The distribution of the reasons for registering at health institutions according to gender

Diseases	Female n(%) 170(66.1)	Male n(%) 87(33.9)	Total n(%) 257(100.0)	
				$\chi^2=19.6$; $df=2$; $p=0.000^*$
High blood pressure (Hypertension)	47(69.1)	21(30.9)	68(26.4)	$\chi^2=0.36$; $df=1$; $p=0.546$
Rheumatism	36(73.4)	13(26.6)	49(19.1)	$\chi^2=1.45$; $df=1$; $p=0.229$
Osteoporosis	32(100)	-	32(12.4)	$\chi^2=18.7$; $df=1$; $p=0.000^*$
Heart disease	13(46.4)	15(53.6)	28(10.9)	$\chi^2=5.46$; $df=1$; $p=0.019^*$
Diabetes	13(56.5)	10(43.5)	23 (8.9)	$\chi^2=1.04$; $df=1$; $p=0.307$
Neurological disease	7(38.8)	11(61.2)	18 (7.1)	$\chi^2=6.42$; $df=1$; $p=0.011^*$
Gastrointestinal system disease	9(52.9)	8(47.1)	17 (6.6)	$\chi^2=1.42$; $df=1$; $p=0.234$
Multiple diseases	8(61.5)	5(38.5)	13 (5.1)	$\chi^2=0.13$; $df=1$; $p=0.719$
Asthma	5(55.5)	4(44.5)	9 (3.5)	$\chi^2=0.47$; $df=1$; $p=0.494$

The numbers of those smoking cigarettes and drinking alcohol in the elderly age bracket is given in Table 7. Of the sample, 12.3% reported that they smoked and 1.9% drank alcohol ($\chi^2=21.21$; $DF=1$; $p=0.000$).

Figure 7

Table 7: The use of cigarettes and alcohol by the elderly

	Cigarette n(%) 261(100.0)	Alcohol n(%) 261(100.0)
Yes	32(12.3)	5 (1.9)
No	53(67.5)	234(94.0)
Given up	176(21.4)	22 (8.4)

The distribution of the wishes of the respondents concerning how and where they wanted to die is presented in Table 8. The most frequently reported place was at home or in bed (67.6%), followed by at the side of loved ones and in residential care homes (17.6% and 14.8%, respectively). Women more widely reported wanting to die in their homes or their own beds (79.2% and 65.4%, respectively) ($p < 0.001$), whereas men wanted to be by the side of their loved ones (19.2% and 7.6%, respectively) ($p < 0.05$). However, the proportions of women and men wanting to die in residential care homes were similar (13.2% and 15.4%, respectively) ($p > 0.05$).

Figure 8

Table 8: The wishes of the respondents concerning how and where they want to die, according to gender

	Women n=173(100%)	Men n=88(100%)	Total n=261(100%)	χ^2 , SD ; p values
Place where the elderly want to die				10.41; 2; 0.000
At home (in their own bed)	137(79.2)	56(65.4)	177(67.6)	7.33; 1; 0.07
By the side of her/his loved ones	13 (7.6)	18(19.2)	46(17.6)	9.33; 1; 0.002
In residential care homes	23(13.2)	14(15.4)	38(14.8)	0.33; 1; 0.567

DISCUSSION

The high participation rate in our study, 76.3% (261/342), may reflect either the willingness of the elderly to contribute to research on the health and status of the elderly individual, or their sensitivity to old age.

Due to the average life expectancy in Turkey (67.5 years for men, 71 years for women), the majority of elderly (60.2%) interviewed were in the younger age group (60-69).

Unsurprisingly, participation from those in the second age group (80 and older) was rather low (5,17,18).

Women in Turkey play a traditional role in the extended family structure. This was reflected by the fact that more than half of the elderly interviewed in this study (56.7%) were housewives. Many women in Turkey are unable to find jobs because of lack of availability, or the prevailing notion that women should play traditional roles such as mother and homemaker. This lower status, alongside the lack of general unemployment insurance in Turkey, may explain the 20.3% of elderly women not in receipt of any income (18).

When questioned about satisfaction with the various social security institutions of Turkey, members of EMEKLI SANDIGI reported being the most satisfied (79.2%). EMEKLI SANDIGI is seen to offer the most accessible and regular service in Turkey. This finding is consistent with the results of another Turkish study (19).

The figure for those reporting ‘good health’ was 27.2%. This finding is in line with other studies conducted in Turkey (20,21,22). The majority (66.7%) of the elderly who evaluated their health status as ‘bad’ were in the age group of 70-79, whereas the majority (60.5%) of those evaluating ‘good’ were in the age group of 60-69. This finding may be connected to the age related rise in chronic diseases and weakness (7,8,9,22,23). In another study conducted into the medico-social problems of the elderly in another city of Turkey, researchers found that 23.7% of the elderly reported their health to be ‘good’, 22.3% ‘bad’, and furthermore that 8-25% had difficulty in maintaining daily activities rising to

40% in the older group (22).

Those living at home were more pleased with their place of residence compared to those living in residential care (64.4% and 42.3%, respectively). This finding is consistent with another study conducted in Turkey. Ozer (2004) (24), in a study conducted on 240 elderly individuals found that male and female elderly living at home or in the bosom of the family had much higher levels of life satisfaction than male and female elderly living in residential care homes (p<0.01). Institutions, such as residential care or old age homes, are prevalent in western communities, being accepted as good places to pass one’s final years. Due to the extended family structure of Turkey, these institutions are not broadly accepted, seen usually as places for those elderly either living alone or penniless (11,13,25).

Nearly 100% of the elderly (98.5%) in this study had some kind of health problem, a figure compatible with the results of some studies: In a study by Knowlton (2002) (26), it was found that older people are sick more often than younger people, and suffer more from being at the end stage of various chronic progressive degenerative diseases. In other studies, it was discovered that 80% of those over 65 had one or more chronic conditions (10,11).

Hypertension (26.1%), rheumatism (18.8%), and osteoporosis (12.3%) were the most frequently reported health problems. This result is compatible with studies conducted in Turkey (12,13,19) and the other countries (11,23,27). These results are significant when planning care service for the elderly.

The most often attended health institution for health checks was the health center (37.5%). In Turkey, the Law 224 ‘Socialization of the Health Services’ executes health services (28). According to this ruling, health centers constitute the first step of health services, with patients receiving free health services. Alongside this free service, the fact that each residential district has an accessible health center, there are no queues, examination and receiving of board of health prescriptions for necessary medicines is easier, and the close proximity of health centers for those of restricted movement are all possible reasons for the wider use of health centers by our participants.

Most of the elderly questioned reported that they were still taking medicine with or without prescription (74.3%). This finding is consistent with other studies in Turkey showing that a proportion of between 70.5%-77% of the elderly uses

medication with/out prescription (19,29). Furthermore, it has been indicated in numerous studies that drug use by the elderly is a prevalent problem (6,13,30,31,32). Recent estimates show that adults age 60 and older take an average of five prescription medications each day (33). In 1997, Stoehr et al (1997) (34) found that 87% of older individuals (mean age 74.5 years) reported regular use of at least one over-the-counter (OTC) medication. This is itself is a serious problem as the sheer amount used can attribute to the health problems old age causes.

67.4% of elderly interviewed said that they were attending health institutions for health checks. This result is compatible with another study showing that 52.8% of elderly aged 60 and over went for regular health checks (35). In our study, 86.1% of those attending health checks were already using medication. Researchers' recommendations that the elderly go for health checks and have some tests at least once a year seems to have been heeded (6,32). In our study, the rate of health checks was 54.7% (n=118) for women, and 45.3% (n=98) for men (Unshown data), in line with other studies indicating that registration for health services was higher in women than in men. The same studies also stated that the rates for both registration for health services and receiving inpatient hospital care due to acute reasons were higher in women than in men (13,36,37).

In our study, understandably higher rates of women reported attendance at health institutions for treatment of osteoporosis ($p<0.001$). Heart and neurological diseases, however, were the most reported causes for men ($p<0.05$, for each). This finding is compatible with a previous study result, also conducted in Turkey (38). It is important from the point of view that these results show the distribution of diseases in elderly women and men. In research it has been highlighted that these diseases are the most common causes among reasons leading to death in relation to age in both the female and male elderly (11,13,29).

Of the elderly, 12.3% reported that they smoked and 1.9% drank alcohol. This finding is similar to the results of other studies conducted in Turkey. In these studies, it was determined that 20%-40% of the elderly were still smoking and 0%-7% drinking (22,38,39). Moreover, epidemiological studies in other countries suggest that alcoholism is present in up to 4% of the elderly, and there is at least one report suggesting that the prevalence of alcoholism among older adults is on the rise (40,41). Every year in Turkey, approximately 100,000 people lose their lives due to

tobacco-related causes, as smoking causes more susceptibility to disease (39). Compared with younger people, older adults have an increased sensitivity to alcohol when taken at the same time as medications. Any alcohol use can be problematic for patients who use specific over-the-counter or prescription medications (42,43). The use of alcohol and cigarettes, however, is often not appreciated as relevant to the care of older adults (44,45). For these reasons, we consider an increase in the number of studies on ways to quit smoking and alcohol would be helpful.

In our study, 85.2% of the elderly indicated that they want to die at home or by the side of their loved ones. This result may be related to the general structural status of Turkey. For example, in America, being emotional and dependent causes discomfort for most American families, whereas mutual dependence and a showing of emotions are perfectly acceptable in Turkish society (46). According to the Turkish Family Survey, 63% of the elderly want to live in their own homes, and tradition, custom and patriarchal family structure has a big effect on unity within the family (47). In Turkey, the transformation from large family structure to core family, although it is observable in society has yet to fully materialize in the psychological sense (46). In a previous study conducted in Turkey, 78.5% of close relatives of the elderly reported that they felt an obligation to take care of their close relatives (48).

In our study, it was determined that the place where the elderly lived plays an important role in the perception of old age, with the exception of residential care homes. That a total of 85.2% of the elderly imagine death at home, in their own bed or by the side of her/his loved ones force us to draw the conclusion that most of the elderly want to live together with family individuals. Thus, in Turkish society, while plans for future health services are oriented more towards the elderly, provision of facilities that would allow the elderly to live in their own familiar environment in society rather than in institutional places, such as residential care homes, would be helpful.

In developed societies, campaigns to solve the problems of old age, affecting the majority of the population, have been initiated. The implementation of a Turkish educational program by primary care health services into protection of the elderly's health, and more widespread availability of educational facilities is necessary. Furthermore, that the elderly be informed about subjects such as factors affecting the aging process, necessary vaccinations, the benefits of

regular health checks and how to grow old healthily would contribute to the passing of their twilight years in a more comfortable way.

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