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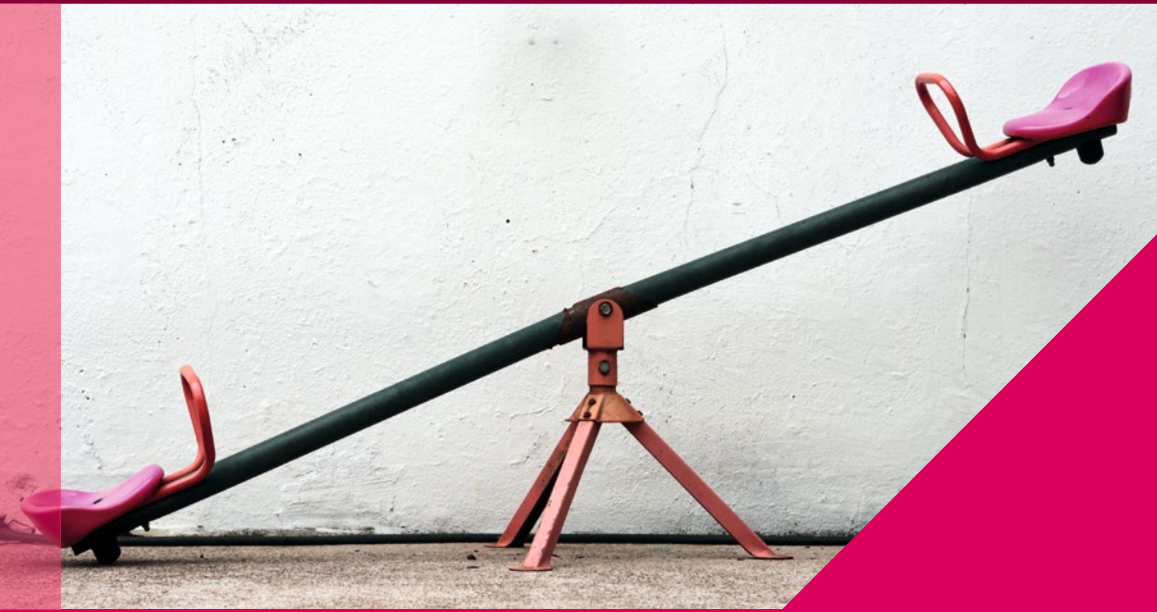

Care Poverty

When Older People's Needs Remain Unmet

Teppo Kröger

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For my mother Mirja Kröger, née Mäkinen (1937–2019)

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The concept of care poverty goes back to our EU FP5 SOCCARE project (2000–2003) led by my mentor Jorma Sipilä and partnered by Rossana Trifiletti, John Baldock, Karin Wall, and Claude Martin. In the great project team we analysed care arrangements of families in five different European countries, and in our discussions, we spoke about 'care-rich' and 'care-poor' families. After the project was already finished, I published an article analysing its lone parent interviews, first in Finnish in 2005 and five years later in English. Some of the lone parents were in a situation where, despite their best efforts, they could not get the childcare that they and their children needed. In the article, I used the term care poverty of their situation. I am thus indebted to my SOCCARE colleagues for both the data and the key idea of this original article.

When I was presenting the early versions of that paper to my Nordic colleagues, Marta Szebehely was quick to comment that the concept would actually fit better the study of care for older people. In a way, this book is an attempt to respond to the challenge raised by Marta on that day years ago. Over the years, I have given a large number of conference and seminar presentations on the ideas and contents of this book, and I am very grateful for all the comments that I have received. Both the encouragement and the critical comments have been necessary, on the one hand, giving me trust in the concept and approach but, on the other hand, challenging my thinking and pushing it forward. I cannot thank all

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In the 2015 ESA conference in Prague I went to the desk of Palgrave Macmillan and told them timidly about my book idea. Unfortunately I have already forgotten the name of the editor there, but her positive response to my idea was a huge encouragement. It took me five and half years to submit the book proposal, though. During the commissioning and the production of this book, co-operation with Sharla Plant and the rest of Palgrave staff has been excellent, thank you for that. I also thank the anonymous reviewers for perceptive comments and Louise Chapman at Lex Academic for polishing my English.

This book is dedicated to my mother. She was a wonderful person, and despite her MS, she lived a long and full life. Thanks to my father and the disability and care services of the City of Varkaus, she probably did not experience care poverty—I say ‘probably’ because I never asked her.

Praise for *Care Poverty*

"In face of ageing populations and the growing need for care, a lack of adequate care is an issue of critical importance. Building upon the innovative concept of care poverty, this book contextualizes the issue within a discourse about social inequality and welfare state policy. The book constitutes an important and exciting theoretical contribution to research regarding the relationship between care and social inequality."

—Birgit Pfau-Effinger, *Research Professor, University of Hamburg, Germany*

"Feminist social policy researchers were among the first to emphasise the importance of care services for achieving the equality goals of the welfare state. With the concept and measurement of 'care poverty', Teppo Kröger deepens and extends this insight, bringing new insights into the dimensions, causes and consequences of inequality in the distribution of care, and into the role of well-designed long-term care policies in ensuring older people can live decent and dignified lives."

—Gabrielle Meagher, *Professor Emerita, Macquarie University, Australia*

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About the Author

Teppo Kröger is Professor of Social and Public Policy at the Department of Social Sciences and Philosophy of the University of Jyväskylä in Finland and Professor II in the Centre for Care Research West in Bergen, Norway. He leads the Centre of Excellence in Research on Ageing and Care (CoE AgeCare), which is funded by the Academy of Finland in 2018–2025. His research analyses care policy from different conceptual and methodological perspectives, and his articles have appeared in journals like *Journal of Social Policy*, *Critical Social Policy*, *Health and Social Care in the Community*, and *International Journal of Social Welfare*. He has co-edited *Combining Paid Work and Family Care: Policies and Experiences in International Perspective* (2013), *Social Work and Child Welfare Politics: Through Nordic Lenses* (2010), and *Overstretched: European Families Up Against the Demands of Work and Care* (2005).

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Introduction

In February 2016 *Helsingin Sanomat*, the largest newspaper in Finland, reported a fire (Hakkarainen, 2016). The fire had broken out in the home of an 87-year-old woman and her 91-year-old husband. As the newspaper interviewed their son, he noted that his parents had health and physical challenges, such as dementia, diabetes, and mobility impairments, which had made their daily life difficult. The son lived elsewhere but visited his parents daily, and the couple also received two daily visits from municipal home care services. Nonetheless, both the son and the home care workers had come to the conclusion that this support was insufficient and the couple was actually in need of residential care.

The son had asked for placement in a residential unit for his parents but had been told by the local authority that his parents did not meet the criteria for institutional care because their needs were not extensive enough. The couple had themselves expressed that they did not want to move to 'a poor house', and this was used by the authorities, who stated respect for individual will as a reason to let the couple remain at home. The son replied that the decision only paid lip service to his parents' self-determination and actually deprived them of their human dignity. His mother did not have energy to go to the toilet, so the home had started

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to smell of excrement. Ill with dementia, his father had started shoving his wife. The son believed that residential care would restore his parents' dignity and joy in life, as earlier even short stays in a hospital had enhanced their condition. Still, his parents were never placed in residential care. Instead, on a Friday night in the end of January 2016, a fire broke out in their home and killed them both.

The media also regularly reports on violence between wearied family carers and the older people in their care. In February 2015, a 71-year-old man in Japan killed his wife who suffered from dementia. As he explained to police, 'I got too tired from looking after her. I wanted to take my own life, too' (Oi, 2015). In November 2019, a 72-year-old Japanese woman killed her 93- and 95-year-old parents-in-law as well as her husband due to exhaustion from taking care of all of them (*Japan Times*, 2019). Such cases have recently become so common in Japan that they have received a term of their own: 'care murder' (*kaigosatsujin*, 介護殺人). They are also recognised in the United States as 'family caregiver homicides' (Cohen, 2019).

In fact, dramatic and tragic accounts of the neglect of older people have been reported from all corners of the world. These older persons have been 'ageing in place', that is, continuing to live in their homes despite increasing need for care. Many had informal family carers, but in the absence of external support, these carers reached their limits. Some even received formal care, but it was insufficient to meet their needs. Each case is unique, and both the factors and contexts that led to tragedy are always specific. But overall, these accounts share a common feature: a lack of adequate care. If adequate support had been provided to these older individuals and their family carers, these news accounts would have never been written. The accounts show how the failure to meet care needs is not without repercussions. This failure imposes serious impacts on quality of life and sometimes leads to fatal consequences.

The purpose of this book is to highlight the critical importance of adequate care and to help direct the attention of researchers and policymakers to the question of whether or not older people who need care in their everyday lives actually receive such support. The book argues that the whole system of long-term care was created to address the care needs of the population and that the question whether this really happens in practice should be a key issue guiding research and policy-making. Are there older people whose care needs remain unmet? If so, who are they and which of their needs are particularly at risk of not being met? What policy measures would help ensure that the care needs of everyone are met in the future?

There is a stream of gerontological literature, mostly from the United States but increasingly from other places as well, that analyses the unmet needs of older populations (e.g., Allen & Mor, 1997; Kennedy, 2001; Busque & Légaré, 2012). These gerontological studies have examined unmet personal and practical care needs primarily at the individual level, measuring their prevalence, related factors, and sometimes their consequences. In the early twenty-first century, unmet care needs have been studied in a growing number of countries in Europe, Asia, and Africa (e.g., Gureje et al., 2006; Vlachantoni et al., 2011; Ashokkumar et al., 2012; Peng et al., 2015).

However, the results of these various studies have not yet been collected together. So, knowledge produced by research into unmet long-term care needs remains highly fragmented. One of the key objectives of this volume is to make an inventory of studies on unmet care needs and summarise their main findings. This stream of literature focuses almost exclusively on older people residing in the community, as does this book. Although cases of inadequate care can also occur in residential settings, research into such settings is very limited. This volume is thus likewise limited to the lack of adequate support only in community settings.

Studies on unmet care needs usually concentrate their analysis on the individual level. Although they regularly include socio-economic factors in their lists of independent variables, this research stream rarely discusses these differences as an expression of social inequalities that reflect disparities of access to formal and informal care across different social groups. Furthermore, study results are not often interpreted in their policy contexts to show interconnections between welfare policy designs and the inadequate coverage of care needs. Such analyses might be expected more from social researchers than from gerontologists, but so far the lack of adequate care has received only limited attention from social scientists.

Over the last few decades, care systems and care policies have managed to capture the attention of social policy scholars. For a long time, welfare state research focused almost exclusively on social security systems. Largely thanks to feminist scholars, however, care has since the 1990s been highlighted as a key field in welfare state research. During that decade, feminist and other social care researchers produced a number of pioneering studies that illuminated similarities and dissimilarities between the care systems of different nations (e.g., Lewis, 1992; Orloff, 1993; Alber, 1995; Anttonen & Sipilä, 1996).

This research stream has continued and further expanded. The last three decades have seen the flow of studies on care systems in Western nations gradually broaden to also include countries in East Asia, Latin America, and other parts of the world (e.g., Colombo et al., 2011; Leichsenring et al., 2013; Ranci & Pavolini, 2013). These studies have considerably extended the level of knowledge on national patterns of care provision. The earlier gap in social policy research has thereby largely been filled, establishing care policy research as a regular major area of social policy analysis. Aside from academic researchers, governments and international organisations such as the EU, the OECD, and the World Bank have also actively produced these studies, as demographic and labour market changes (especially ageing populations, declining birth rates, and growing female participation in the labour market) have remarkably heightened the financial and political significance of care (e.g., OECD, 2005; World Bank, 2016; European Union, 2021).

Upon closer examination of the care policy literature, one may however find that many publications overlap to a large extent. There is a particular set of indicators that is constantly reported: financial resources spent in care service provisions (measured as their share of GDP) and the volume of services (the share of users of both institutional and home care within 65+/75+/80+/85+ age groups) are almost always used to indicate the level of long-term care of a nation. These variables do provide important benchmarks for the international comparison of welfare policies. With figures on social expenditures, nations that invest heavily in care can be distinguished from those countries where public resources are used for other purposes. User rates specific to age groups further show how large parts of the older population are receiving at least some publicly funded support.

Still, knowing the share of GDP used on long-term care does not provide any information on what is done or achieved with those resources. Knowing the number of older people who use residential or home care services does not bring about any understanding of the effects of such services on people's lives. Above all, such variables do not answer the fundamental question of whether care services fulfil their basic function—that is, whether they meet the needs of their users. Care policy studies have mostly focused on analysing the volume of services and associated resources, not the outcome of services on individual lives.

This book aims to address the knowledge gap by collecting findings of gerontological studies on unmet long-term care needs and bringing them into contact with social policy discussions. Older people anywhere around the world may find themselves in a situation where they have substantial care needs but fail to receive adequate support. Like population ageing, the ongoing increase of care needs is a universal and global phenomenon. So, too, is the difficulty in covering needs. At the same time, different societies are in very different positions when faced with providing care for their older populations (WHO, 2015). Understanding unmet care needs in their policy contexts is thus a necessary first step when trying to find ways to tackle them. By collecting available evidence and knowledge from different parts of the world, the book aims to present the state of the art in the study of unmet long-term care needs: what we already know about the issue and where knowledge gaps are, or where further research is most urgently needed.

However, this book does not merely aim to collect existing empirical knowledge. It has also conceptual aspirations. Earlier research on unmet needs has very rarely been connected with research on social inequalities and welfare state policies. In order to build these connections, this book argues that a new conceptual starting point is needed. Bringing a novel perspective to the coverage of older people's care needs, the book introduces and employs a new key concept: *care poverty* (see Kröger et al., 2019; Hill, 2021). This is a situation, exemplified above by real-life examples, where older people need care and support but, for various reasons, do not receive adequate help. In such situations, individual care needs are more extensive than the help and assistance available from formal and informal sources. As a result, at least part of their needs remains uncovered.

Adopting the concept of care poverty highlights how unmet care needs denote the deprivation of a basic human need. As with food and shelter, care is vital for human dignity and even survival. This book further understands care poverty as a serious expression of social inequality, dividing older people into groups of those who have access to adequate care and those who do not. All of this means that, in a world of ageing populations and growing needs for care, the lack of adequate care is a serious issue of primary importance and urgency.

The chapters that follow aim to cast light on the issue of care poverty from different perspectives. *Chapter 2* clarifies the concept and its main features, comparing it to related concepts such as 'care gap', 'care deficit', and unmet needs or poverty. *Chapter 3* builds a framework for the analysis of care poverty. First, it considers the two main ways that care poverty can be measured. Second, it introduces three different domains for care poverty. *Chapter 4* uses the new framework to summarise research evidence available from different countries concerning the key question of how common it is for care needs to remain unmet among older people. *Chapter 5* draws from the framework and existing literature to continue the analysis by looking for factors that are associated with care poverty. *Chapter 6* keeps mapping the state of the art by collecting research evidence on the manifold negative consequences of care poverty. *Chapter 7* connects the empirical results on inadequate care to research on social inequalities, examining how different kinds of inequalities are reflected in care poverty. *Chapter 8* brings in welfare state analysis and discusses the findings on care poverty in the context of different long-term care systems. Finally, *Chap. 9* summarises the key knowledge attained on the phenomenon of care poverty, draws conclusions, and outlines lessons for policy as well as research.

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2

Concept of Care Poverty

Aside from summarising the state of empirical knowledge on the lack of adequate care, the goal of this book is to introduce the concept of *care poverty* and suggest it as a key approach for research and policy-making on care for older people. In the 2000s, I used the term when analysing the childcare arrangements of lone parents (Kröger, 2005, 2010), but, recently, our research team has introduced it also within the context of long-term care for older people (Kröger et al., 2019). The purpose of this chapter is to provide a detailed description of the meaning, subcategories, and background of the concept.

The concept of care poverty aims to combine and connect different strands of research literature that have remained largely separate until now. First, gerontological research studies the *unmet needs* of older people but mostly on the individual level. Second, sociological and social policy studies traditionally focus their attention primarily on the structures of the welfare state. Feminist social policy scholarship widened this approach showing how care is an essential area of welfare policy. Feminist social policy researchers also discussed the lack of care at the population level using concepts such as *care deficit* and *care gap*. Finally, poverty and inequality research serves here as a third stream of research literature

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behind the suggested new approach. Focused on deprivation and inequalities at both the individual and societal level, research into poverty and social inequalities holds promise as a way to bridge care policy and gerontology research.

The concept of care poverty is thus based on three different streams of research: feminist social policy research, gerontological research, and research into poverty and social inequalities. This chapter describes how the notion of care poverty brings them together.

Feminist Social Policy: Care Regimes and Care Deficits

For a long time, the main focus of social policy analysis was on welfare benefit transfers, such as pension and sickness leave systems, and their connections to labour markets. The post-WWII welfare states focused first on building social insurance programmes, and this was reflected in the realm of research. Esping-Andersen's *The Three Worlds of Welfare Capitalism* (1990) and its concept of *decommodification* captured the market-state axis—showing how pension, unemployment, and sickness benefits liberated people from a dependency on the forces of the labour market—that for decades had been the centre of attention in welfare state analysis.

In the 1970s, debates emerged on women's unpaid work at home (e.g., Wærness, 1978), and in the early 1980s, feminist scholars in Britain and Nordic countries, especially, extended these debates to bring forward care as an issue that should be placed on the mainstream agenda of social policy. In Britain, several books highlighted the importance of the unpaid work of family carers for older people and disabled children (e.g., Finch & Groves, 1983; Glendinning, 1983; Baldwin, 1985; Ungerson, 1987). These pathbreaking studies showed in detail the significant role that informal carers played in providing care, forming the 'invisible welfare state'. At the same time, they also showed how carer contributions were left without recognition and support. In Nordic countries, the focus of feminist social policy fell more on the lack of recognition for paid care workers whose work established the 'social service state', that is, the growing service provisions of Nordic welfare states (e.g., Hernes, 1987;

Wærness, 1984; Anttonen, 1990). But throughout the 1980s, these feminist discussions on care remained mostly separate from and overshadowed by mainstream social policy literature that focused on the relationship between the market and the welfare state.

Esping-Andersen's book (1990) proved to be a turning point. The work was the culmination of the labour market orientation of welfare state research, but at the same time, it drew extensive criticism from feminist scholars. They argued that the work—as well as the long tradition of social policy research behind the book—was gender-blind in that it ignored women's needs for the welfare state and disregarded the family-state axis of the welfare triangle (e.g., Lewis, 1992; Orloff, 1993; Lister, 1994, see Kröger, 2001). In this view, care is at the centre of women's relations with the welfare state, and it should therefore also be at the centre of welfare research: while men needed the welfare state to free them from a dependence on the labour market, women needed the welfare state to free them from economic dependence on their male relatives and to provide care for their family members (e.g., Langan & Ostner, 1991; O'Connor, 1993; Orloff, 1993). Esping-Andersen's decommodification was soon accompanied by the more gender-sensitive counter concept of *defamili(ali)sation*, which guided social policy research to analyse whether welfare states support women in their quest for economic independence and (partial) freedom from family care responsibilities (Lister, 1994; McLaughlin & Glendinning, 1994; see Kröger, 2011).

The feminist critiques were very influential. They led Esping-Andersen to reconsider and broaden his thinking, to adopt the concept of defamilisation, and to include the family-state relationship in his analysis (Esping-Andersen, 1999). The same kind of turn happened in social policy research in general. Feminist scholars had already emphasised the significance of informal and formal care in the 1980s, but it was only in the 1990s that research on care became generally recognised as a key area within welfare state research (see Kröger, 2001). The 1990s saw the rapid expansion of studies on the care systems of different nations, producing a number of international comparisons (e.g., Alber, 1995; Anttonen & Sipilä, 1996; Knijn & Kremer, 1997). Analyses of care policies and care systems, which included care for children and older people as well as formal and informal care, were established as a major area of social policy scholarship. This gradually grew into a global research field. The concept of *care regimes*—adapted from Esping-Andersen's 'welfare regimes' and defined by Simonazzi (2009, p. 216) to mean 'the ways in which the financing and provision of care are organized in the various systems'—has become widely used in recent comparative analyses (e.g., Bettio & Plantenga, 2004; Simonazzi, 2009).

Feminist social policy research has been predominantly critical in its approach, highlighting the inadequacies and underdevelopment of policies. It has also developed and launched several new concepts for critical care policy analysis (e.g., Hobson et al., 2002). One such concept is *care deficit*, which was coined by Hochschild in 1995. By care deficit, Hochschild (1995) meant growing proportions of older people and lone mothers in the population that were expanding the need for care even as supply contracted at the same time due to cuts in public funding for care policies. Hochschild thus refers to inconsistencies between societal population trends and policy changes, leading to a deficit of care at a societal level.

Care gap is another close concept. Often it is used specifically to stand for a growing lack of informal carers. For example, Pickard (2015) analysed demographic trends in England to conclude that the unpaid care gap will grow rapidly from 2017 onwards. At the same time, Knijn (2006, p. 160) used the care gap term to refer to a lack of professional care workers. She argued that demand for care is growing and more paid care workers are needed due to population ageing, women's entry into the labour market, and their consequent withdrawal from informal caring. According to her, there is a growing shortage of care professionals.

Thus when locating the care gap, some researchers have referred to informal care and others to formal care. In both cases, the term has been used almost synonymously with care deficit to highlight the increasing imbalance between the demand for and supply of care. These notions have focused on care at the societal and population levels to point out that despite growing needs for care in the population, societies are lagging behind and either unable or unwilling to provide the necessary amount of support. As a result, these discussions have mostly overlooked the level of everyday life. Aside from the care deficit in 'public life', for example, Hochschild (1995, p. 332) only briefly mentions a care deficit in 'private life':

> This has created a 'care deficit' in both private and public life. In private life, the care deficit is most palpable in families where working mothers, married and single, lack sufficient help from partners or kin.

Hochschild's attention mostly falls on childcare rather than care for older people, although she mentions the latter group in her text. But in any case, her concept shows, how in care both 'the public' and 'the private' are always present and fundamentally intertwined—an argument that has been central in feminist social policy scholarship (e.g., Ungerson, 1987). Through her analysis of conservative American policies from the early 1990s that cut down on public responsibilities and pushed the responsibility for care onto women, Hochschild demonstrates how macro-level changes in care policies have implications at the micro level in the everyday lives of families.

Hochschild and other writers have also used the concept of a care deficit to interpret the phenomenon of *global care chains*, that is, women moving from countries with lower levels of economic development to provide care for children and older people in more affluent nations. Hochschild (2000, p. 131) defined care chains as 'a series of personal links between people across the globe based on the paid or unpaid work of caring'. The care deficit of wealthy nations is filled by drawing women from poorer countries. Relocation requires these women to quit caregiving for their own family members, causing a care deficit in the sending countries. The so-called First World imports care work and, at the same time, exports its care deficits to the Third World based on unequal global structures (Ehrenreich & Hochschild, 2002). This global outsourcing of care work has been understood as an intersectional, classed, and racialised process that not only reproduces gendered social orders but does so through interplay with other forms of inequality (Vaittinen, 2014).

Through their research, feminist scholars have considerably broadened the agenda of welfare state research. Until the beginning of the 1990s, social policy research concentrated overwhelmingly on social transfer programmes and labour market policies, but care systems have since become recognised as a key area of welfare policy. Care regimes and defamilisation have become central concepts in comparative welfare state research, where terms such as care gap and care deficit highlight the shortcomings of care provisions in different countries. In addition to the state-market axis, the state-family axis of the welfare triangle is now also the focus of analysis. Researchers have paid attention to informal family carers and formal care workers, both of which mainly consist of women. The political has been shown to be personal and vice versa. Policy failures have been proved to have financial, emotional, and health costs for paid and unpaid carers.

In this stream of research, one group—and their perspectives—has received only limited attention to date: older persons themselves. Feminist social policy research has focused more on the needs and interests of formal and informal carers than on those of older people. Where the imbalance between care needs and care provisions has been illuminated, the main target of criticism has been the strenuous position of caregivers rather than that of older persons. Nor has feminist social policy emphasised the fact that women form the absolute majority of people in old age and in need of care. Additionally, the focus of this research has mostly been at the population level. While feminist social policy scholarship has hugely advanced research into informal and formal care, study of whether older people receive the care they need has not been a key issue in this research stream.

Gerontology: Functional Limitations and Unmet Needs

In contrast, the care needs of older people have been a primary object of study for gerontological research. Research into the prevalence, causes, and effects of different health conditions and functional limitations among the older population has been a key research area (e.g., Ostchega et al., 2000; Vaughan et al., 2016). As a multidisciplinary research field, gerontology encompasses a multitude of different approaches, including social and cultural gerontology. However, where the discussion concerns the long-term care needs of older people, health approaches have been particularly influential. In these research approaches, care needs are usually understood as stemming from the functional limitations of older individuals, which are often termed 'disabilities' (e.g., Williams et al., 1997; Wunderlich & Kohler, 2001; Carmona-Torres et al., 2019).

Gerontology has been a vanguard in recognising and analysing situations where older people do not receive the assistance they need. As early as the mid-1970s, the term *unmet need* was used in reference to an older person with 'insufficient care to fulfil his basic requirements for food, warmth, cleanliness or security', or for situations where 'care was provided only at the cost of undue strain of relatives' (Isaacs & Neville, 1976). The term was thus connected early on to basic physical needs as well as to situations involving informal family carers. The issue did not attract much empirical attention in the 1980s and early 1990s, but since the late 1990s a large number of gerontological studies have analysed the *unmet long-term care needs* of older people particularly in the United States (e.g., Allen & Mor, 1997; Desai et al., 2001; Lima & Allen, 2001; Gibson & Verma, 2006). In the 2000s and 2010s, studies of the unmet needs of older people have been increasingly conducted elsewhere, such as in Spain (e.g., Otero et al., 2003; García-Gómez et al., 2015), the UK (e.g., Vlachantoni et al., 2011; Brimblecombe et al., 2017), and China (e.g., Gu & Vlosky, 2008; Zhu, 2015).

In this growing body of literature, there are different definitions for the concept of unmet need. The definition offered by Williams et al. (1997, p. 102) is one of the most well known: 'Unmet need occurs in long-term care when a person has disabilities for which help is needed, but is unavailable or insufficient'. Methods to analyse unmet needs have likewise varied, but most start from measuring care needs on the basis of the functional limitations of older persons. These limitations usually concern their *Activities of Daily Living* (ADLs, which include personal care tasks such as eating, toileting, and getting out of bed) and the *Instrumental Activities of Daily Living* (IADLs, i.e. practical daily tasks such as transportation, cleaning, and managing medication) (e.g., Lima & Allen, 2001). Social researchers have argued that care needs are difficult to measure due to 'the complexity of need at the conceptual level' (Vlachantoni et al., 2011, p. 69) and because 'there is no golden standard definition of needs' (Lagergren et al., 2014, p. 714). However, American gerontologists constructed ADL and IADL scales already in the 1960s (Katz et al.

1963; Lawton & Brody, 1969), and these became 'the golden standard' for measuring the care needs of older people, put into overwhelming use all over the world.

When studying unmet needs, it is not enough to simply measure care needs; it is also necessary to assess whether those needs are eventually met or remain unmet. Most studies on the unmet needs of older people consist of survey questionnaires. These surveys regularly include items not just on functional limitations (measuring needs), but also on the receipt of informal care and the use of social and health care services. If respondents report having difficulties completing activities in everyday life but answer that they have neither received help from their families and social networks nor used any formal care, they are routinely categorised as having unmet needs (see Chap. 3). But if older people answer that they have received informal or formal care (or both), the situation is more unclear as they may or may not have all of their care needs covered.

Researchers have reacted to this ambiguity in two alternative ways (e.g., Lima & Allen, 2001). The first way has been to exclude this group altogether: if the persons concerned have received any informal or formal care, they are defined as not having unmet needs. The second way has been to ask older people if they themselves think they have received sufficient support. If they say no, they also are categorised as having unmet needs. Some studies have introduced additional terms, such as *undermet needs* or *partially met needs*, to describe this second group of older people who receive at least some informal or formal care but still report that not all of their care needs are met (e.g., Kennedy, 2001; Turcotte, 2014). Sometimes, such as in the case of people with severe memory problems, the question of the sufficiency of support is not posed to the older person but to proxy respondents (such as family members or care workers familiar with the person's situation) (see Chap. 3). This means that in earlier studies, unmet needs have been measured variably either by the absence of any informal or formal care or by self (or proxy) reports on the insufficiency of care.

Dissimilar methods produce dissimilar results. The methodological duality in assessing the 'unmetness' of needs has considerably complicated the accumulation of knowledge on the lack of adequate long-term care. There have been also many smaller variations in the methods used by these studies. Some consider ADLs only while others include IADLs as well; some studies require support gaps in at least two daily activities, while for other studies, inadequate coverage of even one care need is enough for an unmet need classification. The data used in these studies vary, too. Many studies are based on local or regional surveys. Nationally representative datasets have been unusual, and even rarer are international datasets that would make comparative international analyses of unmet care needs possible (see Chap. 8).

In gerontological research, the approach to care for older people has mostly differed from that of feminist social policy research. Welfare state research focuses primarily on the macro-societal level, on social policy systems and their structures. Feminist scholars have been very critical towards current care systems, showing how policies fail to support women in their family caregiver and care worker roles and how the gap between needs and provisions of care is widening at the level of the population. Many gerontological studies have instead focused their attention on the micro level, on ageing individuals, and analysed their functional limitations as if they existed in a societal vacuum. Socio-economic factors are regularly included in these analyses as background variables, but this has rarely led to discussions about social and gender inequalities or deficiencies in care policies. However, gerontology has directed specific attention to situations facing older adults—that is, to the issue that has been rather absent from social policy research. Studies on unmet needs, in particular, have highlighted the problematic situation faced by older people who do not receive adequate support and care. Still, these situations have only seldom been understood in relation to deprivation and disadvantage in society.

Poverty: Inequality and Deprivation

In general, the inequalities between different social groups, and policies that could mitigate these inequalities, have received increasing attention from researchers and policy-makers (e.g., Atkinson, 2015; Midgley, 2020). Inequalities arise from a number of factors, such as the unequal distribution of power and differences in opportunities, access, or entitlements.

Platt (2011a, p. 5) argues that 'inequalities are of fundamental importance to both the welfare of societies and the well-being of individuals'; thus, the 'investigation of inequalities is not an academic exercise but is fundamental to grasping how people live, how they relate to and are treated by others'. Inequalities are closely linked to social policies, because if social protection and welfare service systems are well designed and well implemented, they can reduce inequalities (Midgley, 2020).

All this concerns long-term care to a high degree. Platt (2011a) suggests analysing social inequalities by looking at whether people have equal rights and access to social protection and public services, whether the outcomes of social policy are equal, and whether it is actually possible for people to fulfil their potential. These suggestions are also very relevant to care policy research. Furthermore, widespread health inequalities can cause people with low socio-economic status to have a disproportionate amount of health issues (e.g., Marmot, 2003). Several studies have shown that health disparities do not disappear in old age. Instead, these disparities cause a socio-economic gradient in functional limitations and therefore in long-term care needs (e.g., Enroth et al., 2019; Kelfve, 2019). Aside from care needs, informal caregiving is also connected to socio-economic inequalities: low-income groups are overrepresented not just among people needing care, but also among those providing informal care (e.g., Tokunaga & Hashimoto, 2017; Cook & Cohen, 2018). Care for older people is thus intertwined with social inequalities in many ways. But in research on long-term care, inequality has only rarely been used as a conceptual lens (for exceptions, however, see e.g., Rodrigues et al., 2014; Ilinca et al., 2017).

Though they are distinct concepts, poverty and inequality are closely interrelated. Poverty focuses on the lower end of the distribution of resources (Platt, 2011b), and in Lister's (2004, p. 177) words, 'more unequal societies tend to be scarred by more widespread poverty'. In a way, poverty is an outcome of inequality. It results from the unequal distribution of resources across society, creating a part of the population that does not have adequate resources for everyday life. Without necessary resources, even basic needs such as food and shelter become jeopardised along with other needs, such as access to education and health care that is required for a good quality of life. However, there are many different definitions for poverty. While it is still most commonly seen as the deprivation of income and other material resources, it is increasingly conceptualised and measured as a multidimensional phenomenon (e.g., Laderchi et al., 2003; Alkire et al., 2015). Even the World Bank defines poverty nowadays not as economic deprivation but 'pronounced deprivation in well-being' (Haughton & Khandker, 2009, p. 1).

Research into poverty has a long tradition and a rich conceptual and methodological toolkit. Over time, this research has had a major impact on policy. Introduced in the nineteenth century when several Western nations were undergoing industrialisation, poverty research focused on the deficient living conditions for large parts of the growing working class in the expanding industrial centres of Europe. Since its inception in 1873, the German Verein für Socialpolitik produced studies of the poor living conditions and high social risks faced by workers. This work influenced the regime of German Chancellor Otto von Bismarck, which launched a series of ground-breaking social insurance programmes in the 1880s (Stolleis, 2013). In Britain, Charles Booth's in-depth studies from London together with Seebohm Rowntree's classic comprehensive study (1901) on poverty in the city of York received widespread attention and impacted the 1906–1914 social legislation ('liberal welfare reforms') that aimed to improve the living conditions of workers in English cities (Boyer, 2019). Research on poverty has thus been closely intertwined with the development of social policy from early on.

During the twentieth century, poverty research became firmly institutionalised as a major component of the field of international social science and economics. Conceptual frameworks on poverty diversified, and several subconcepts, such as absolute, relative, extreme, and global poverty, emerged (see Chant, 2010; Brady & Burton, 2016; Greve, 2020). National and global poverty lines were drawn, new measurements for poverty were developed, and poverty alleviation became a widely adopted policy goal both in the Global North and in the Global South (e.g., Hagenaars & de Vos, 1988; Ravallion, 1998; Craig & Porter, 2003). International organisations, such as the United Nations and the World Bank, adopted poverty as a key indicator of social development (Hill & Adrangi, 1999; Haughton & Khandker, 2009).

In the early twenty-first century, poverty remains high on the international political agenda. In 2000, the United Nations adopted the ambitious Millennium Development Goals (MDGs). Affirmed by all UN member states, each of the eight MDGs had specific targets and timetables. The very first development goal aimed to eradicate extreme poverty and hunger from the world. More specifically, its target was to halve the proportion of people living in extreme poverty by 2015 based on the global poverty line set by the World Bank at $1.25 a day (Greve, 2020). This target was met, although researchers have debated whether the World Bank poverty line was a valid measure of global extreme poverty, and whether it was the Millennium Goals or something else that actually brought about the change. For example, Fukuda-Parr (2017, p. 32) states that 'it is impossible to attribute the decline to the MDGs given the myriad other factors at work'.

Nonetheless, the MDGs brought a lot of global attention to poverty eradication. The same can be said about the 'Make Poverty History' campaign that started in the United Kingdom in 2005 to highlight the urgency of anti-poverty measures (Sireau, 2009). The campaign included what is probably the most famous speech ever against poverty, delivered by Nelson Mandela at London's Trafalgar Square. There, Mandela stated that:

> Like slavery and apartheid, poverty is not natural. It is man-made and it can be overcome and eradicated by the actions of human beings. And overcoming poverty is not a gesture of charity. It is an act of justice. It is the protection of a fundamental human right, the right to dignity and a decent life. While poverty persists, there is no true freedom. (Jeffery, 2005)

For more than a century and a half, poverty research has revealed how a large part of the population is left without adequate means for a decent life both within each nation and globally. From the very beginning, the discussion of poverty has been firmly grounded in research. Nascent social security programmes in the late nineteenth and early twentieth centuries were based on empirical evidence. Ever since, poverty research has substantially influenced the making of national and international social policy. Care policy could aim to follow this example, producing research that contributes to developing egalitarian long-term care policies for all in need. Empirical studies on the deprivation of adequate care combined with new conceptual approaches inspired by poverty research could push the research forward in this direction.

Health Care Poverty

The gerontological term 'unmet (long-term care) needs' has been developed and used in close connection to a parallel concept of *unmet health care needs*. In the mid-1970s, Carr and Wolfe (1976, p. 418) were among the first to use the term unmet needs in the field of health care, which they defined as 'the differences, if any, between those services judged necessary to deal appropriately with defined health problems and those services actually being received'.

This research stream has grown substantially during the recent decades. Questions on unmet health care needs are included in both the Survey of Health, Ageing and Retirement in Europe (SHARE) and the EU-SILC (European Union Statistics on Income and Living Conditions) survey. Self-reported unmet health care needs have become a key indicator of access to health care, used regularly by international organisations such as the Organization for Economic Cooperation and Development (OECD) and the European Union in their evaluations of the health care systems of their member countries (e.g., OECD, 2019; Scholz, 2020).

Unmet health care needs are measured in a variety of ways. Usual operationalisations include the availability of a medical doctor or wait times for health care. Researchers have observed that such needs are related to socio-economic status on the one hand, and mortality and health problems on the other. So, the concept has also been linked to research on health inequalities (Sanmartin et al., 2002; Shi & Stevens, 2005; Bryant et al., 2009).

From the perspective of this book, one particular study of unmet health care needs is especially interesting and relevant. In a 2006 article, Lisa Raiz introduces the concept of *health care poverty* in the context of health care in the United States. She focuses on 'underinsurance', which is a situation where people have health insurance but is inadequate to meet their health care needs. In the United States, underinsurance leads to lack of access to adequate health care, in her words to health care poverty. Raiz (2006, p. 88) sees health care poverty as partly—but only partly—a result of lack of economic resources:

> Health care poverty expands examination of issues related to health insurance and access to health care to additional, and significant, groups of individuals who are disenfranchised not solely due to poverty status and a complete lack of health insurance. It includes those who have private health insurance that is inadequate to meet their needs, regardless of their income level.

Raiz (2006, p. 89) wanted to shift the focus of the American health care discussion away from the question of whether one has health insurance towards the question of whether one has access to adequate health care. Her concept of health care poverty includes those who have health insurance but whose needs remain inadequately covered. Her approach thus comes close to those gerontological studies on unmet long-term care needs that include self-reported 'undermet needs' or 'partially met needs' in their analyses.

Raiz (2006, p. 90) argues that the framework of poverty should be applied to the analysis of the health care system. Her health care poverty term refers to lack of access to health care rather than economic deprivation. This means she is not doing poverty research, but instead applying its approach to the study of health care. She also wants to incorporate the concepts of *absolute* and *relative poverty* into her framework, that is into analysis of the lack of access to health care. Raiz (2006, p. 90) suggests that the term *absolute health care poverty* includes those who have no health insurance at all (and no access as a result) and the term *relative health care poverty* include underinsurance along with its negative effect on access to health care and utilisation of medical services. Here, Raiz again comes very close to discussions of unmet long-term care needs (e.g., Vlachantoni, 2019).

The above concept and the approach to analysis have provided inspiration for this book. Applying the concept of poverty to analyse unmet health care needs is an undertaking that is almost identical to the aim of this book, which applies the concept of poverty to study unmet long-term care needs. Still, there are several slight differences in the ways that the concept of poverty is used by Raiz compared to here. To begin, Raiz defines her health care poverty to mean lack of access to health care. This means she does not see health care as a resource in the same way that income and other material resources are usually understood in research literature on poverty. For her, health care is more an end in itself rather than a specific resource to fulfil certain underlying needs. In this book, care needs are a starting point and care is seen as a resource for meeting these needs.

Another difference in her usage of the term largely originates from the professional nature of health care. Unmet health care needs and health care poverty are about access to health care services—that is, to formal health care. But in long-term care of older people, informal care must also be taken into account. Where the approach of unmet health care needs (and thus that of health care poverty) analyses only the lack of formal health care, unmet long-term care needs and care poverty include the lack of both formal and informal care. In social policy and gerontology, several studies examine access to formal long-term care provisions and their adequacy using terms such as 'user satisfaction' or 'availability of care services'. However, these approaches are not broad enough to offer an answer to the question of whether older people receive the support they need. In order to answer that question, access to informal care must be included in the analysis alongside access to formal care.

But overall, the concept of health care poverty described by Raiz (2006) connects the discussions on unmet needs and poverty in a way that is very similar to what this book aims to do. In particular, Raiz applies the concept of poverty to mean deprivation of needed health care rather than deprivation of economic resources. That application is analogous to the goals of this volume.

Care Poverty

In this book, *care poverty* means the deprivation of adequate coverage of care needs resulting from interplay between individual and societal factors (Kröger et al., 2019). It is a situation where people in need of care do not receive sufficient assistance from either informal or formal sources. Care poverty results from twofold micro-macro interactions, because care needs and resources have both individual and structural origins. Needs for care result from individual characteristics and life courses, but at the same time, these needs also result from societal structures. For example, there are distinctive health inequalities across different social groups. In the same way, care resources depend on individual factors such as actual family relations. Yet the opportunities for older people to have their care needs met are also determined by societal structures and social policies.

In combining individual and societal levels of analysis, the notion of care poverty aims to go beyond earlier conceptualisations. The concept of unmet needs used regularly in gerontology directs attention to the micro level, to the specific characteristics of older individuals, while largely ignoring the macro level. Moreover, this term fails to capture how non-coverage of care needs indicates the presence of social inequalities and the deprivation of a basic human need. On the other hand, the concepts of care deficit and care gap emphasise the macro level and the inability of social policy systems to provide coverage of care needs for the population but focus only limited attention to the micro level of older people's care needs. Finally, research into poverty and social inequalities specialises in the study of deprivation. However, it has not analysed inequalities in the allocation of care and support among the older population.

The notion of care poverty is indebted to feminist social policy because it was feminist scholars who managed to bring care on the primary agenda of social policy research and welfare state development. This research has addressed the gap between care needs and provisions at a systemic level. For its part, gerontology has highlighted the importance of the unmet care needs of older people and provided methods for study. Poverty and inequality research has drawn attention to access to resources, focusing on the unequal distribution of these resources across various social groups.

The concept of care poverty aims to bridge these three different strands of research literature. It looks at the lack of care from both individual and societal perspectives, understands informal and formal care as resources, and analyses their unequal distribution. Inadequate coverage of care needs is understood as a result of the interplay between individual and structural issues. Identifying those population groups left without adequate care thus becomes critical. The notion of care poverty follows Raiz's (2006) concept of health care poverty in terms of the inclusion of poverty. Her health care poverty is not about a lack of economic means but lack of access to health care. In the same way, care poverty is not about material deprivation but about the deprivation of informal and/or formal long-term care.

Introducing the concept of care poverty is not part of a recent tendency to refract material poverty into different types, such as fuel, period, and funeral poverty. This conceptual development has been criticised as fragmenting the concept of poverty by focusing on the lack of specific items, which weakens the understanding of poverty as a lack of resources (Crossley et al., 2019). In care poverty, care is not simply one more specific item that people cannot afford. Instead, it is seen as a vital, non-material resource necessary for well-being in the same way as economic resources in poverty research. Care poverty is not a subconcept of poverty that leads to its fragmentation. Rather, it is a parallel notion.

A lack of material resources may well be connected with the lack of care. It is actually very probable that such a connection exists. Clearly, people with high incomes have more financial resources to purchase private and public care services. But care poverty is a question of scarcity in care—not financial—resources. Care poverty is thus understood here as a distinct phenomenon rather than just a dimension or expression of economic poverty. While poverty may well prove to be a factor in care poverty, the latter can be expected to have additional individual and societal determinants as well.

Conclusions

This chapter has introduced the concept of care poverty and the three strands of research literature behind the notion. Feminist social policy analysis has shown how care is a major social policy issue that should be placed at the top of the agenda for welfare state policy-making and research, just like social security. Feminist research has also brought up the gendered reality of care, highlighting the unrecognised and weakly supported position of informal family carers and formal care workers. Gerontology has directed considerable attention to the care needs of older people and analysed whether or not these needs are met. Gerontological research has further shown how population ageing implicates a dramatic demographic shift that will bring about a considerable increase in care needs. The third strand, research on poverty and social inequality, provides an analytical model that can be applied to study care. Care can be understood as a resource, and the distribution of this resource can be analysed across different population groups. As in the case of poverty, specific attention must be directed to those population groups left with insufficient resources to meet their basic needs. While the concept of care poverty has three different roots, it has only one two-part mission: to help identify inequalities in access to adequate care and to contribute to the creation of policies that can eradicate these inequalities.

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3

Framework of Care Poverty

Care is a complex phenomenon that is difficult to measure. In order to know whether there is an imbalance between care needs and their coverage, two things are required: (1) knowledge of care needs, and (2) an assessment of the match between needs and available support (García-Gómez et al., 2015). The level of available care resources alone does not define care poverty. It is only together with knowledge about the level and kinds of needs that an understanding of the match between care needs and resources can be achieved.

There are already complications with the first of the above-mentioned tasks, as care needs are a demanding object to capture. In poverty research, it is possible to make a list of basic goods necessary for survival and subsistence and then determine a monetary value for this basket. But what items should be placed in the basket of basic care needs, and how should they be weighted? Research literature shows a variety of different kinds of needs and a range of ways that they have been measured in studies of unmet needs. How can this diverse array of definitions and approaches be handled in order to reach a coherent understanding of the level of care needs?

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The second task is not any easier. It is far from clear how to evaluate whether or not the care needs of an older person have been met. There are two main competing methodological approaches used in studies of unmet needs. The first one is said to measure unmet needs 'subjectively' because it is based on self-reporting from older people rating their own care as inadequate; the second one measures unmet needs more 'objectively' because older people are not asked about the sufficiency of the support they receive (Lima & Allen, 2001). However, both approaches have been criticised—the first for a potential self-reporting bias, and the second for underestimating unmet need by failing to include situations in which older people receive insufficient help (Lima & Allen, 2001; Shea et al., 2003). There is no consensus among researchers how the 'unmetness' of care needs should be assessed.

To deal with these complications, this chapter outlines a framework that helps organise earlier literature on unmet needs and summarise its key findings. In order to achieve the analytical clarity needed here, care needs are organised under three different domains, which then leads to a categorisation of three different domains for care poverty. As mentioned above, earlier research has measured unmet needs in two primary ways. This adds a methodological dimension to the framework. The chapter thus builds its framework for the study of care poverty on three domains and two measurement approaches.

Domains of Care Poverty

Discussion of the nature and definition of care has continued for decades. According to Fine (2007, p. 2), a definition for care has remained elusive because 'it refers at once to an ideal set of values and a series of concrete practices'. Many writers, especially within the ethics of care literature, have emphasised the normative dimensions of care. For example, Sevenhuijsen (1998, p. 19) views care as a social practice in which different sorts of moral considerations and vocabularies may be expressed. Other writers have focused more on the tasks or activities that are included. For instance, Knijn and Kremer (1997, p. 330) define care by stating that it 'includes the provision of daily social, psychological, emotional, and physical attention for people'. A definition that is likely the broadest comes from Fisher and Tronto (1990, p. 40), who see care as 'a species activity that includes everything that we do to maintain, continue, and repair our 'world' so that we can live in it as well as possible'—adding that the 'world' refers here to 'our bodies, our selves, and our environment'.

The approach of this book follows the latter task- and activity-oriented perspective, though in a much narrower sense than the definition provided by Fisher and Tronto. Here, the focus is on the practices that are performed in order to meet the care needs of older people. This is not to deny the normative character and moral foundations of care. It is indisputable that care is closely interrelated with its cultural and normative contexts (e.g., Daly & Lewis, 2000; Pfau-Effinger, 2005). But as this book focuses on the lack of adequate support, it is necessary to concentrate on care as concrete assistance given to older people in order to meet different kinds of care needs.

As mentioned earlier, there is already a considerable and growing body of literature on the unmet care needs of older adults. Yet due to its terminological and methodological diversity, summarising its results and describing its state has been difficult. Part of the problem has been how different studies take different care needs as the basis for their analysis. When referring to unmet needs, researchers could have taken more care to elaborate exactly what needs they were analysing. Rather than mixing all needs together, could they be categorised into certain groups or domains? Could such categorisation bring more conceptual coherence and clarity, making it easier to accumulate knowledge? Specific kinds of unmet needs may be determined by specific kinds of factors and processes. Thus, a more detailed analysis might help researchers better understand the origins of care poverty. For the purpose of this book, three different domains for care poverty are distinguished: personal care poverty, practical care poverty, and socio-emotional care poverty.

Personal Care Poverty

In spite of the variety and ambiguity of care needs, gerontologists have been actively trying to define and measure them. In the early 1960s, Katz et al. (1963) in the United States developed the scale of ADLs. This has since become by far the most popular way to capture the needs of older people. In their original article, the researchers listed six basic daily functions (bathing, dressing, going to the toilet, transferring that meant moving in and out of bed and chair, continence, and feeding) and built up a summary index for these six activities. They created their approach specifically to evaluate the outcomes of treatments and the prognosis of older hip fracture patients. However, they also recommended their model for broader use. Their ambitions were certainly realised as their instrument has been applied to general use in long-term care research and practice all over the world.

One key reason why the ADL approach has become so widely and internationally applied is that the invention of Katz and his colleagues shifted attention away from specific health conditions and impairments to focus instead on functional abilities and their limitations. From the perspective of care needs, it is not so important to know why the functional abilities of older people have narrowed. Instead, it is crucial to learn what the person in question is and is not able to do. Medical care focuses primarily on illnesses, trying to diagnose and cure them. But long-term care concentrates on providing assistance for those everyday activities that older persons are unable to perform alone. The ADL framework has suited this purpose well.

The ADL approach is widely used not only at the practice level to assess the needs of older people, but also in long-term care research. The framework has been developed into several versions and undergone several modifications with slightly different lists of daily activities. Nevertheless, ADLs remain the starting point for most studies on unmet care needs. As ADLs include basic everyday activities such as eating, dressing, and toileting, limitations in performing these activities lead almost unavoidably to care needs that must be covered either informally or formally. When these needs are not met, the well-being, health, and ultimately life of the older person fall under threat.

Due to their fundamental importance, several researchers have described these activities as the basic activities of daily living (BADLs) or personal activities of daily living (PADLs) (e.g., Tennstedt et al., 1994; Davey et al., 2013). Whatever term is used, limitations in performing these activities create needs for personal care. Due to their importance for survival and well-being, they form the basis of all care needs. For the same reason, the inadequate provision of support for these needs can be seen as the hard core of care poverty. Here, a lack of coverage for these needs is called *personal care poverty*. It is understood as the first and most significant domain of care poverty.

Practical Care Poverty

The most important addition to the ADL approach was introduced by the end of the 1960s. Lawton and Brody (1969) launched another list of activities, the IADLs. They argued that the ADL scale was necessary but insufficient to assess older and disabled people's opportunities to continue to live in their homes and avoid ending up in institutional care. They then created a list of more complex daily activities and skills to supplement the original ADLs. Lawton and Brody's IADL list included the ability to use a telephone, shop, prepare food, do housekeeping and laundry, use some mode of transportation, take responsibility for personal medications, and handle finances. In accordance with typical gender roles of the time, shopping, cooking, and doing laundry were thought to assess the functional competence of women, and the use of transportation and ability to handle money were understood as suitable indicators for men's level of competence (Lawton & Brody, 1969, p. 180).

The IADLs considerably broadened the understanding of functional skills that are necessary in everyday life. Rather than focus solely on bodily care, the IADLs showed that the practical needs of daily life were also important. Unmet IADL needs impacted a person's quality of life, though usually they have a less adverse effect on individual physical integrity or health status than unmet ADL needs (Vlachantoni et al., 2011). Although IADLs are not as fundamental as ADLs in terms of daily activities, daily life becomes very difficult without these abilities. IADLs also usually recognise functional difficulties at an earlier phase than ADLs. Difficulties in performing practical tasks emerge before difficulties in personal care tasks. This is because the IADLs are located at a higher level of function than the ADLs, requiring not just considerable physical but also mental capacity (Vlachantoni et al., 2011).

Together, the ADLs and IADLs form the basic toolbox and dominant method for assessing and evaluating the long-term care needs of older people. They are widely used in different parts of the world, even though their application often requires some adaptation and update for specific cultural and societal contexts. For example, the differential treatment of women and men when assessing IADLs has become outdated and abandoned (Williams et al., 1997). The role of IADLs has been to highlight that, aside from limitations in basic self-care, difficulties in performing practical household tasks can also cause care needs. Though not immediately life-threatening, inadequate coverage of these practical needs still poses a major risk to the well-being and health of older people. Here, a lack of help in meeting these needs is called *practical care poverty* and seen as another major domain of care poverty.

Socio-emotional Care Poverty

Older people's needs however go beyond personal and practical care needs. The I/ADL framework has been especially criticised for failing to capture social and emotional needs (e.g., Sihto & Van Aerschot, 2021). Feelings of belonging and connection to others contribute to the meaning of life for older adults. They are positively associated with health status and can solve the problems of alienation, isolation, and loneliness (Ten Bruggencate et al., 2018). When the social needs of older people are unsatisfied, this jeopardises their quality of life and can lead to mental and physical health problems. For example, research shows that older people's unmet social and emotional needs are connected to depression (Someşan & Hărăguş, 2016).

Social interaction easily decreases in old age, when mobility impairments start to limit opportunities to leave the home and thus meet new people (Gabriel & Bowling, 2004). Furthermore, a growing number of communication impairments can make the maintenance of social relations difficult for many in old age. Satisfaction of older people's needs involves emotional support (Rodrigues et al., 2012, p. 15), but the availability of emotional support regularly decreases in old age due to retirement or the deaths of partners and friends. Furthermore, formal care services often focus exclusively on meeting personal care needs at the expense of the social and emotional needs of older people (Meagher et al., 2019). Overall, older people are at particular risk of not having their psychosocial and emotional needs met.

Studies on the unmet social and emotional needs of older people have often been carried out in the context of specific illnesses or health problems, such as cancer (Williams et al., 2019), HIV (Ogletree et al., 2019), dementia (Hansen et al., 2017), and joint pain (Hermsen et al., 2018). This research routinely focuses on how different groups of health care professionals respond to the risks posed to the social and emotional wellbeing of their patients. The usual finding of such studies is, variably and overall, not so well (e.g., Convery et al., 2017; Hansen et al., 2017). In social and health care, psychosocial needs are regularly prioritised at a lower level than physical needs. Often, professionals will even say that it is not their responsibility to provide psychosocial support or that the task belongs to family and friends (e.g., Hansen et al., 2017). However, many older people do not have access to social and emotional support from family or social networks.

Within gerontology, concepts in the area of social relations that have received the most research attention are social isolation and loneliness. Social isolation is usually defined as lack of social contacts. For example, Wenger et al. (1996, p. 333) define social isolation as 'the objective state of having minimal contact with other people'. Loneliness has been defined, for instance, as 'a self-perceived state in which a person's network of relationships is either smaller or less satisfying than desired' (Jones, 1981, p. 295). For both concepts, there is a multitude of slightly different definitions. In general, however, social isolation has been understood as an objective characterisation of the weakness of a person's social networks. In turn, loneliness has been seen as a person's subjective perception or experience of social relationships of inadequate quality and/or quantity.

While social isolation is not necessarily always experienced as negative, loneliness is. Some people may, in some situations, prefer solitude at least temporarily (Yang, 2019), but loneliness is, according to De Jong Gierveld et al. (2018, p. 391), the 'negative experience of a discrepancy between the desired and the achieved personal network of relationships'. Such a definition comes very close to the notion of care poverty: when it comes to an essential area of human need, there is a gap between the level desired and the level achieved. Not surprisingly, loneliness has been connected to unmet social and emotional needs. For example Shaver and Buhrmester (1983, p. 259) see it as 'an emotional state that arises when certain social needs go unmet'. Loneliness is thus understood here as an expression of unmet social or emotional needs and, thus, of care poverty.

Whatever terms are used for these needs—whether social, emotional, and psychosocial needs, or needs for belonging, intimacy, social interaction, and social support—gerontological research has made clear that they are crucial in old age. The risks of having these needs unmet increase with age as many issues make social interaction more difficult for older people, especially when they start to have mobility or communication difficulties. Needs for respect, love, and belonging do not disappear in old age. When these needs go unsatisfied, they carry negative implications for the physical and mental well-being of older people. Sometimes the situation even leads to a suicide attempt (Lebret et al., 2006).

Due to their importance, unmet social and interactional needs should be included in the care poverty framework. While their measurement is even more complicated than that of unmet personal and practical care needs, this is not a valid reason to exclude them from the framework. Here, unmet social and emotional needs are understood as a third domain of care poverty called *socio-emotional care poverty*, complementing the domains of personal care poverty and practical care poverty.

In this book, the examination of care poverty is limited to these three domains. However, it is recognised that these domains do not cover all of the needs of older people. Unmet health care needs might well be listed as another domain. So, too, could support needs caused by cognitive impairments. But here, the focus will remain on personal, practical, and socio-emotional care needs because these three domains are essential for everyday life of older people. There is also a substantial body of research literature for each domain that can be mined to summarise key findings on the rates, factors, and consequences of care poverty.

Measurement of Care Poverty

After identifying care needs, the research has to discover whether an imbalance exists between these needs and received support. It is crucial to know whether available informal and formal care manage to cover the care needs of the older population. Knowledge of care needs is not enough by itself. Neither is information about the availability of formal care, not even when combined with the availability of informal care. Care poverty is fundamentally about a relationship between needs and resources. So, the question is whether available informal and formal care cover existing care needs. When measuring care poverty, the key is to examine this match between needs and resources.

The definition and measurement of poverty has been a source of debate for more than 150 years. At present, there are many competing definitions and subconcepts, each with their own operationalisations. These discussions are not merely academic in nature as different measurements produce different results, and different results have different implications for policy (Hagenaars & De Vos, 1988; Laderchi et al., 2003). Many poverty instruments measure the level of individual or family income and, focused on resources, do not necessarily examine needs. However, some poverty measurements do conceptualise poverty as a gap between needs and resources.

Seebohm Rowntree's (1901) seminal study showed that the incomes of more than a quarter of the population of York were insufficient to secure a subsistence level of existence, that is, to purchase the basic necessities of fuel, light, rent, food, clothing, and both household and personal items. Rowntree defined his poverty line based on careful analysis of the cost of these necessities. The *basic needs perspective* later followed the same line of thinking, defining poverty as a deprivation of the absolute minimum resources necessary for long-term physical well-being (Streeten, 1981). *Absolute poverty* was similarly defined by the Copenhagen UN Social Summit as meaning the severe deprivation of basic human needs (UN, 1996). Unlike those poverty measurements focused solely on income, the above-mentioned approaches have understood poverty as a relation between needs and available resources. In order to measure care poverty, a similar approach is necessary.

Aside from absolute poverty, the concept of *relative poverty* is also worthy of attention when thinking about the measurement of care poverty. Raiz (2006) used the terms absolute and relative health care poverty in her analysis, and Vlachantoni (2019) wrote about absolute and relative unmet need. For relative poverty, taking the social environment into account is key: the poverty line is defined relative to a given context (Laderchi et al., 2003). The national context is used as a frame of reference because people's material resources are compared to the general level within each nation. Here, these two poverty concepts—absolute poverty and relative poverty—are applied to the study of care poverty.

Absolute Care Poverty

Despite the variable nature of long-term care needs, gerontological research has aimed to capture them—especially through the use of the I/ADL framework. Gerontologists have also developed methods to measure whether or not these needs are met. Data from these studies come from questionnaire surveys that include questions about the limitations of older people as relates to ADLs and/or IADLs. They also include questions about whether the respondents receive informal or formal care.

In these studies, one usual way to determine whether older people have unmet needs is to categorise respondents with I/ADL limitations into two groups: those who have limitations in their functional abilities and receive at least some informal or formal assistance, and those who have limitations in their daily activities but do not receive any informal or formal help with these activities. The second group is then defined as having unmet needs, while the first group is understood as having their needs met. In this case, unmet needs are defined as the presence of care needs (based on I/ADLs) in the absence of any kind of support for these needs from family members, social networks, and public, non-profit, or for-profit services (e.g., Tennstedt et al., 1994; Lima & Allen, 2001).

Vlachantoni (2019) calls the situation where an older person has care needs but fails to receive any formal or informal support as *absolute unmet need*. She defines this term as 'a difficulty with a certain task combined with the complete lack of support with such task' and explains that she chose this approach for her study because it points to a part of the older population most in need of support (Vlachantoni, 2019, 661). This 'absolute' approach to operationalise unmet care needs has been used by many other researchers, as well (e.g., Allen et al., 2014; Davey et al., 2013).

The term absolute unmet need comes close to the notion of absolute poverty. Absolute poverty was defined by the UN 1995 Social Summit as the severe deprivation of basic human needs, including food, safe drinking water, sanitation facilities, health, shelter, education, and information (UN, 1996, p. 38). Absolute unmet need means the deprivation of any kind of support for basic care needs: even people unable to adequately perform ADLs such as toileting and feeding fail to receive formal or informal care. In this volume, the full absence of help for care needs is called *absolute care poverty*.

Relative Care Poverty

Despite its clarity, classifying people into two clear-cut categories, the absolute method for studying unmet needs does not satisfy all researchers. The approach captures those whose needs are left fully uncovered, but only those. People whose needs are only partially covered are not included in the definition. Referring to absolute care poverty as 'objective unmet needs', García-Gómez et al. (2015, p. 150) encapsulate this shortage by saying the measurement 'may not capture those individuals receiving insufficient services, as the probability of objective unmet needs when the individual receives any type of service is zero'. Aside from excluding those older persons who receive any formal care service, the absolute approach also excludes all those who receive any informal care. Such a measurement leads to significant underestimation of the extent of unmet needs because receiving some informal or formal support does not guarantee that the older person receives sufficient care and assistance (Shea et al., 2003, p. 716).

As a response, some researchers have developed another method to identify unmet needs: in addition to asking respondents about limitations on their daily activities, they are also directly asked whether they receive adequate support to cover their care needs. In this approach, all who answer that they do not receive sufficient care are categorised as having unmet needs—regardless of whether they receive any formal or informal care (see, e.g., Williams et al., 1997; Lima & Allen, 2001). Consequently, this method captures unmet needs more comprehensively than the absolute approach.

However, this measurement approach has been claimed to suffer from self-reporting bias (García-Gómez et al., 2015; Yang & Tan, 2021). Self-reporting is based on subjective perceptions, and these are said to be conditioned by contextual characteristics, such as characteristics of the long-term care system or cultural norms and values concerning care responsibilities (Rogero-García & Ahmed-Mohamed, 2014, p. 405). Due to their professional training and experience, assessments made by professionals are sometimes considered more accurate than self-reporting.

But when researchers asked long-term care staff to complete the surveys and then compared those answers to the ones self-reported by older people, they found that it was the staff—not the older persons—who more often reported unmet needs (Morrow-Howell et al., 2001). After Brimblecombe et al. (2017) likewise asked not just the older adults but also their informal carers to fill the questionnaire, the researchers noticed that older people underestimated the level of needs and unmet needs compared to their carers. Researchers have somewhat dissimilar views on how these differences should be interpreted and whose evaluations are more objective in the end. Rogero-García and Ahmed-Mohamed (2014) argue that older people's self-reports are more reliable than proxy respondents. Manton et al. (1993), as well, state that proxy respondents are less accurate in reporting needs. On the other hand, Morrow-Howell et al. (2001) conclude that the ratings from both groups are valid but not interchangeable, because they are based on different standards and different values. Still, one thing seems to be clear: in general, older people do not overestimate their care needs and unmet needs.

Some researchers have used the term 'subjective' when referring to this self-reporting approach and the term 'objective' when referring to the absolute approach (e.g., García-Gómez et al., 2015; Laferrère & Van den Bosch, 2015). But while these two terms may be applicable in poverty research (Siposne Nandori, 2014), they do not fit in the analysis of unmet needs. In poverty research, material resources can be quantified and measured in an objective manner. In care research, however, it is questionable whether it is possible to measure care needs and care resources objectively due to their interpretational character. Even the reporting of I/ADLs is based on human perceptions. The same goes for the receipt of informal and formal care: for example, distinguishing informal care from other family interaction is complicated and based on interpretation. Measurements for care always depend on human observations and interpretations, which then are susceptible to influence from cultural and societal contexts. As the term 'objective' is therefore not appropriate when speaking of care poverty, neither is 'subjective'.

But how about the term 'relative'? In poverty research, the concept of *relative poverty* is one of the most widely used approaches to analysing material deprivation. Townsend (1979, p. 915) connected poverty to the concept of *relative deprivation*, which is when people are deprived of the conditions of life that ordinarily define membership in a society. The concepts of relative deprivation and relative poverty have given rise to a large and influential research strand that understands people to be in poverty when they lack certain commodities common to the society in which they live (Hagenaars & De Vos, 1988, p. 215). In the relative poverty approach, poverty is thus defined in relation to general consumption patterns and the general income level of each society.

Over the past several decades, the concept of relative poverty has become very widely used—especially in the Global North, where the basic needs of the population are usually satisfied (e.g., Brady, 2005; Rosenfeld, 2010). In this approach, the level of material resources accessed by an individual or family is compared not to some minimum subsistence threshold, but to the resources of other people in the same society. Typically, poverty lines are defined as 50–60% of the general median income level. This notion has served to highlight the persistence of inequality within wealthy societies, in particular (Wolff, 2015).

Yet it is difficult, if not impossible, to fully follow the methodological approach of relative poverty in the study of care needs. In poverty research, the whole population serves as the reference group, but for the study of unmet care needs, it is not justified to include those who do not have care needs in the analysis. When identifying relative poverty, the resources of an individual or a family are compared to those of all others. When speaking about relative unmet care needs, however, those with unmet needs are to be compared only to those with care needs—not the general population.

Nevertheless, the term relative care poverty could maybe still fit the second measurement approach, where older people are asked whether they receive sufficient care. The reason why no global poverty threshold is used in relative poverty measurements is due to understanding the importance of the social and economic environment for poverty. Measurements are done within each society, and the poverty threshold varies across countries. When it comes to care, measurements are always based on interpretation, but these interpretations are done within the cultural context of each society. What is understood as sufficient vs. insufficient care depends on people's expectations. In turn, their expectations depend on the values and norms prevalent in the nation. Because the second measurement approach is based on self-reporting that is necessarily related to the national context, it is open to these contextual factors.

The second measurement approach is thus relative in nature, which also means that the actual situations of people who self-report (or are proxy-reported) as having their care needs unmet may be different across countries. This is a feature of the measurement approach, and it recalls the case of relative poverty, where the poverty threshold always depends on the national context. Although the second approach to measuring unmet long-term care needs is not fully identical to the one of relative poverty, there are distinctive similarities between them. It is thus called the relative approach here, while phenomenon that it identifies is called *relative care poverty*.

Conclusions

The framework for the analysis of care poverty is structured according to two dimensions. On the one hand, it is built on three domains of care needs and thus of care poverty: personal care poverty, practical care

Table 3.1 Care poverty framework

Care poverty domain	Care poverty measurement	
	Absolute care poverty	Relative care poverty
Personal care poverty	Absolute personal care poverty	Relative personal care poverty
Practical care poverty	Absolute practical care poverty	Relative practical care poverty
Socio-emotional care poverty	Absolute socio-emotional care poverty	Relative socio-emotional care poverty

poverty, and socio-emotional care poverty. On the other hand, these domains cut across two different ways to measure care poverty: the absolute approach and the relative approach. When cross-tabulated, these two dimensions produce six different categories of care poverty (Table 3.1).

The absolute approach can be used in any care poverty domain to measure personal, practical, and socio-emotional care needs that are fully unmet to indicate absolute personal, practical, and socio-emotional care poverty. The same goes for the relative approach: based on self-reporting from older people (and the views of proxy respondents), insufficient support can be identified in any domain to document relative personal, practical, and socio-emotional care poverty.

In the following chapters, this framework guides the inventory of findings from existing research into unmet care needs. It aims to make the range of methodological and conceptual choices found in this body of work more manageable. The framework thus sums up the state of the art of current knowledge on care poverty in terms of its rates (Chap. 4), factors (Chap. 5), and consequences (Chap. 6).

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4

Rates of Care Poverty

Almost every study on unmet long-term care needs has examined their prevalence. However, datasets differ. Some are local, some national, some have tens of thousands of respondents while some have only a few dozen. Some data are purposefully collected for the study of unmet needs, while others are general population surveys. Measurements of unmet needs differ, as well. But practically all of these studies report the number or share of respondents whose care needs are not met.

In order to understand the importance of a social issue, it is always necessary to know its scale. This has also been the starting point for research into unmet care needs. Many studies go on to analyse the factors and consequences of unmet needs, but reporting their prevalence or, in the language of this book, the rate of care poverty is almost always the first research task. The term of *care poverty rate* follows, once again, the example of poverty research. For instance, the OECD (2021) defines the poverty rate as the ratio of people in a given age group whose income falls below the poverty line. Here, care poverty rate means the ratio of people, in a given group of people with care needs, whose care needs are not met.

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So how widespread is care poverty? What part of the older population does not receive the support they need? How do care poverty rates differ across countries? These questions are straightforward but answering them is not, as different studies report a quite dissimilar prevalence of unmet needs even when examining the same nation. These studies tend to recall each other: typically, they involve survey questionnaires and examine the coverage of ADL- and IADL-based needs for older people. At the same time, there is variation in how they define and measure unmet care needs. This has made it difficult to compare and summarise their findings.

It is here where the framework outlined in Chap. 3 comes into use. Distinguishing between different domains of care needs and only comparing the results that focus on the same domain can be expected to improve the accumulation of knowledge. In the same way, it is also essential to note which measurement is used and to distinguish between absolute and relative approaches. Furthermore, it is also necessary to note which studies are based on proxy-respondent data as self-reporting and proxy-reporting seem to produce dissimilar results.

This chapter aims to report the available rates of care poverty in different countries based on existing studies of unmet needs. However, this summary should be seen as preliminary because it does not include all studies that examine the unmet care needs of older people—mostly due to language barriers and the availability of these publications. Several studies of unmet needs have also been deliberately left out for various reasons (such as if their samples concentrate on children or adults below the age of 65, or if they focus only on lack of formal care and exclude informal care from their analyses). Nonetheless, the objective here is to review such a number of studies that some initial conclusions can be drawn about the state of the art concerning care poverty rates in different parts of the world. This chapter begins with personal care poverty rates and continues with rates of practical care poverty. But before concluding with socio-emotional care poverty rates, the chapter needs to take a detour because there are a number of studies that do not make a distinction between personal and practical care needs.

Rates of Personal Care Poverty

Out of the three domains of care needs and care poverty, the domain of personal care is most often studied. It could be argued that this domain is also the most basic: it includes vital everyday needs and ignoring them leads to serious problems for the health and well-being of older people. Personal care activities, such as feeding, can even be critical for survival.

Here, the findings on absolute care poverty are reported first, followed then by a review of results on relative care poverty. The overwhelming majority of the studies on personal care poverty are based on self-reporting, as proxy-based studies have proven to be rare and, in the case of absolute care poverty, practically non-existent. In several cases, the original figures for unmet needs reported in publications have been counted in a way different from that of the care poverty rate. For example, the level of unmet needs may be counted for the whole sample rather than only among those who have care needs. For each of these studies, I have recounted the care poverty rate based on figures provided in the publication. Furthermore, some studies report only activity-specific rates for individual ADLs or IADLs rather than the general level of all unmet needs. In these cases, the highest reported activity-specific level is used as an estimate for the general care poverty rate. In the tables, results are reported country by country in chronological order.

Rates of Absolute Personal Care Poverty

The term of unmet needs has been used most widely in long-term care research in the United States. There, the absolute approach has been in active use since the late 1980s. Well-known early studies by Manton (1989) and Tennstedt et al. (1994) nevertheless produced quite different figures for the level of unmet needs: 9% vs. 35% (Table 4.1). The difference between these figures is at least partly explained by the longitudinal setting for the study by Tennstedt et al. While Manton's research was cross-sectional, Tennstedt et al. gathered baseline data among community-dwelling older people in 1984–1985. However, their results included only those who had survived and still lived in the community during a

Table 4.1 Rates of absolute personal care poverty

Country	Study	Age group	Sample size	Data from year(s)	Care poverty rate (%, rounded)
US	Manton (1989)	65+	3499	1984	35
US	Tennstedt et al. (1994)	70+	235	1984	9[a]
US	Sands et al. (2006)	70+	2943	1992–1997	18
US	Davey et al. (2013)	65+	2422	2004	41
US	Freedman and Spillman (2014)	65+	8077	2011	27/48[a,b]
Spain	Tomás Aznar et al. (2002)	75+	351	1998	22
Canada	Carrière (2006)	65+	28,672	2003	42[c]
UK	Vlachantoni et al. (2011)	65+ 65+	3356 4916	2001–2002 2008	52[a,c,d] 50[a,c,e]
UK	Whalley (2012)	65+	4231	2011–2012	76[a,c]
UK	Maplethorpe et al. (2015)	65+	2067	2014	87[a]
UK	Dunatchik et al. (2016)	65+	2090	2012–2013	70[c]
UK	Marcheselli and Ridout (2019)	65+	2253	2018	87[a]
UK	Vlachantoni (2019)	65+	5591	2014–2015	55
Malaysia	Momtaz et al. (2012)	60+	400	2003–2005	14[c]
NZ	Wilkinson-Meyers et al. (2014)	75+[f]	3753	2008–2009	7
China	Zhu and Österle (2017)	45+[g]	3682	2013	31[a]

[a] Recounted based on information provided in publication

[b] Depending on whether or not the category of 'has some limitations but does not experience difficulty or receive help' is interpreted as having care needs

[c] As the publication reports only activity-specific rates, the table shows the highest activity-specific level of unmet needs (for Dunatchik et al., 2016, the figure is based on levels reported in the Appendix, Table A2)

[d] Based on GHS dataset

[e] Based on ELSA dataset

[f] 65+ for Māori participants

[g] The publication reports results only for the whole sample, but the majority (54%) of the sample was aged 65+

follow-up in 1988–1989. The age groups and the sample sizes for the two studies were also different. More recent studies display mostly results that are closer to those of Manton (1989), though these are not without exception (18% in Sands et al., 2006).

Within the literature reviewed here, the second country to use the absolute approach for examining the prevalence of unmet needs was Spain. However, Tomás Aznar et al. (2002) used it in an unusual way: if older people answered that they received support for their ADLs 'never' or 'less than weekly', they were categorised as having unmet needs; 22% of respondents with ADL-based support needs gave either of these two responses. In Canada, based on a national health survey, Carrière (2006) reported that 42% of older people with ADL needs did not receive any support.

The absolute approach has also been applied in several studies in the United Kingdom. Vlachantoni et al. (2011) used two general population surveys (English Longitudinal Study of Ageing [ELSA] and General Household Survey [GHS]) to find that at least half of the older population with care needs was left without any help (50% and 52%). Using more recent ELSA data, Vlachantoni (2019) acquired a rather similar result (55%). However, a study by Dunatchik et al. (2016) shows a higher figure (70%). Recounts of other studies that have used HSE (Health Survey on England) data also show very high absolute personal care poverty rates for Britain (76% in Whalley, 2012; 87% in Maplethorpe et al., 2015; 87% in Marcheselli & Ridout, 2019).

Finally, studies made by Momtaz et al. (2012), Wilkinson-Meyers et al. (2014) and Zhu and Österle (2017) demonstrate the recent spread of unmet need research to Asia and Oceania. New Zealand has a very low rate of absolute personal care poverty (7%), and Malaysia has a rather low figure (14%) as well, while the rate for China is higher (31%).

Rates of Relative Personal Care Poverty

Next, we move from absolute personal care poverty to the insufficiency of available support for personal care needs—that is, relative personal care poverty (Table 4.2). A couple of studies that use proxy respondents are also included.

An early study by Allen and Mor (1997) as well as research by Komisar et al. (2005) showed high relative care poverty rates (40% and 58%). However, other American researchers ended up with considerably lower figures ranging from 17% (Kennedy, 2001) to 27% (DePalma et al., 2013). There were some dissimilarities in the questions used by different studies. For example, Desai et al. (2001) asked about needs at the present time, while Allen and Mor (1997) queried about the situation for the preceding month. The high figure reported in Komisar et al. (2005) is probably at least partly explained by that they studied 'dual eligibles', that is low-income older people who are eligible for both Medicare and Medicaid programmes. 'Dual eligibles' have poorer health and more extensive care needs than other American people in old age. In his study, Kennedy (2001) introduced a differentiation between 'unmet needs' (no support) and 'undermet needs' (insufficient support). This distinction has later become used by several researchers. It is also consistent with the double concept of absolute vs. relative care poverty.

For Spain, the two studies report somewhat different levels of unmet needs (29% vs. 40%). The first is a local study from Madrid carried out in the early 1990s (Otero et al., 2003), while the second is a large and more recent national-level survey (Rogero-García & Ahmed-Mohamed, 2014).

The new millennium has seen Chinese researchers actively entering the field of unmet needs research. Their results are very similar to one another, showing a very high relative personal care poverty rate ranging between 55% (Peng et al., 2015) and 61% (Zhen et al., 2015). However, the unanimity of their findings is not surprising as all these studies used the same CLHLS (Chinese Longitudinal Healthy Longevity Survey) dataset that originally focused on centenarians and only gradually extended to younger cohorts of people aged 65+.

In Canada, Dubuc et al. (2011) asked health professionals to define the needs of older persons and state whether these needs were met or not. This study belongs to a small body of research that uses proxy respondents to examine the unmet care needs of older people. The researchers themselves were surprised by the resulting high figure (47%), which they attributed to the use of these professional proxy assessments and a purposive sample that included only older people 'at risk of functional decline'.

Table 4.2 Rates of relative personal care poverty

Country	Study	Age group	Sample size	Data from year(s)	Care poverty rate (self-reported, %, rounded)	Care poverty rate (proxy-reported, %, rounded)
US	Allen and Mor (1997)	65+	632	1993–1994	40[a,b]	
US	Desai et al. (2001)	70+	9447	1995	21	
US	Kennedy (2001)	65+	499	1995–1996	18[b]	
		75+	317	1995–1996	17	
US	Komisar et al. (2005)	67+	2123	1999	58	
US	Newcomer et al. (2005)	18+[c]	3493	1994–1997	20[b]	
US	Li (2006)	65+	275	1999	25	
US	DePalma et al. (2013)	65+	844	1994–2004	27	
US	He et al. (2015)	65+	6730	1994–2004	21	
Spain	Otero et al. (2003)	65+	1135	1993	40	
Spain	Rogero-García and Ahmed-Mohamed (2014)	65+	3390	2008	29[b]	
		80+	1668	2008	29	
China	Gu and Vlosky (2008)	65+	15,593	2005	60	
China	Peng et al. (2015)	80+	10,289	2005	61[b]	
		80+	11,720	2008	55[b]	
China	Zhen et al. (2015)	65+	3089	2005	61	
China	Zhu (2015)	80+	2938	2005	59[b]	
		80+	2919	2008	55[b]	
		80+	1647	2011	56[b]	
Canada	Dubuc et al. (2011)	75+	433	2005		47
Taiwan	Liu et al. (2012)	65+	6820	2002	21[a]	
NZ	Wilkinson-Meyers et al. (2014)	75+[d]	3753	2008–2009	12	

(continued)

Table 4.2 (continued)

Country	Study	Age group	Sample size	Data from year(s)	Care poverty rate (self-reported, %, rounded)	Care poverty rate (proxy-reported, %, rounded)
UK	Brimblecombe et al. (2017)	0+[c]	150	2012–2013	55	73
Finland	Kröger et al. (2019)	75+	2910	2010–2015	17	

[a] As the publication reports only activity-specific rates, the table shows the highest activity-specific level of unmet needs

[b] Recounted based on information provided in publication

[c] Publication reports results only for the whole sample, but the majority of the sample was aged 65+ (53% in Newcomer et al., 2005, 60% in Brimblecombe et al., 2017)

[d] 65+ for Māori participants

In Taiwan, Liu et al. (2012) analysed the database of the Long-Term Care Need Assessment system. This meant that respondents were all applying for a long-term care service. The observed care poverty rate (21%) is an underestimation for two reasons: the study did not include older people without a family caregiver and used a very strict definition of need (requiring several activity limitations). Meanwhile, a study from New Zealand shows only a low rate of relative personal care poverty (12% in Wilkinson-Meyers et al., 2014).

In Britain, Brimblecombe et al. (2017) made a unique study using a sample that included 150 carer/care receiver dyads who were asked whether the older/disabled person has the right amount of support or services. The answers of care receivers were compared to those of their informal carers. The findings showed that carers estimated the level of unmet needs distinctively higher (73%) than older and disabled people did (55%). Lastly, our study from Finland used survey data from two cities to observe a rather low care poverty rate among people aged 75+ with ADL-based needs (17% in Kröger et al., 2019).

Activity-Specific Rates of Personal Care Poverty

Some of the above-mentioned studies report not only the general level of unmet needs but also activity-specific results on individual ADLs (Table 4.3). Comparison of exact activity-specific figures across studies is not justified due to differences in their methodological details and general levels of care poverty. Instead, it is worthwhile to look at whether the order of ADLs is similar across studies and whether some daily activities seem more prone to care poverty than others. Not all studies used exactly the same list of ADLs, which complicates the comparison. Some daily activities reported in only a couple of studies have also been excluded from the table.

No single daily activity received the highest rates in all studies, but activities related to moving seem to be problematic most often. Walking through a room (called 'moving inside' in some studies) has the highest level of unmet needs in five studies. Getting out of bed (or transferring) receives the same result. Four studies found using the stairs the most difficult task, even though only five studies include this activity in their ADL list. Two studies found toileting the most problematic activity, as with bathing and dressing. One study reports grooming as having the highest activity-specific personal care poverty rate.

At the same time, it is easy to identify the ADL activity with the lowest extent of care poverty: eating. No study reports eating to be most difficult, while as many as 13 studies list it to having the lowest level of unmet needs. Dressing comes next, ranked least problematic by three studies.

All in all, moving (including using the stairs and getting out of bed) clearly seems to have the highest level of unmet needs most often. Conversely, the ADL with the lowest level of care poverty is eating. Other activities are placed in between.

Summary: Personal Care Poverty Rates

Comparing the findings on absolute vs. relative personal care poverty rates of the countries remains rather difficult. The data collection methods of individual studies on absolute personal care poverty still differ in

Table 4.3 Activity-specific personal care poverty rates

Country	Study	Bathing/ Showering	Dressing	Toileting	Transferring/ Getting out of bed	Eating	Grooming	Moving/ Walking through a room	Using the stairs
Absolute personal care poverty									
US	Manton (1989)	9	2	28	2	1		2	
UK	Vlachantoni et al. (2011)[a,b]	44	50						
UK	Vlachantoni et al. (2011)[a,c]	46	52		52				
UK	Whalley (2012)[a]	47	43	60	48	30		57	76
UK	Dunatchik et al. (2016)	50	56	66	67	38		70	86
UK	Vlachantoni (2019)[a]	54	58	71	63	53		73	
India	Ashokkumar et al. (2012)[a]		59	35	67	59		36	
Malaysia	Momtaz et al. (2012)	8	7		9	5	9	5	14
Relative personal care poverty									
US	Allen and Mor (1997)[a]	36	37	37	40	31		34	
US	Desai et al. (2001)	17	13	18	20	10		19	
US	Kennedy (2001)[a,b]	16	14	19	18	18		21	
US	LaPlante et al. (2004)[d]	36	28	15	26	10		32	

US	Komisar et al. (2005)	46	46	41	47	39		52	
US	Newcomer et al. (2005)[a,e]	15	14	17	18	12		19	
US	Li (2006)	16	7	6	7	2		6	
US	Schure et al. (2015)[f]	39	68	21	29	48	46	24	
Spain	Otero et al. (2003)	28	28	22	32	15	21	34	
Canada	Dubuc et al. (2011)	25	3	3	3	6	34	6	6
Taiwan	Liu et al. (2012)	11	10	9		6	6	13	21
Finland	Kröger et al. (2019)	14	12	16	16	14			

[a] Recounted from unweighted figures provided in the publication

[b] Based on ELSA dataset

[c] Based on GHS dataset

[d] The majority of respondents of this study may be younger than 65

[e] Unmet needs among the whole 18+ sample as specific results for older people are not available

[f] The study analysed unmet needs among Native Americans using a sample aged 55+ (instead of 65+) at the request of tribal stakeholders and because life expectancy is shorter for this group than for other ethnic groups in the United States

several ways, and the same goes for research on relative care poverty. Furthermore, unmet needs have not been examined using both approaches in every country. For research on New Zealand and Finland, we have only studies that apply the relative approach; for Malaysia, the sole study applies the absolute approach. Only a couple of proxy-based studies on personal care poverty were located, one from Canada and the other from the United Kingdom.

Relative care poverty figures can generally be expected to be higher than absolute figures. This is because relative figures include not only those who are not receiving any support despite their care needs, but also those who are receiving at least some informal or formal care—and find it inadequate. Spanish findings go well together with this principle as the reported rate of absolute care poverty (22%) is lower than relative care poverty rates (29–40%). In Canada, the relative figure is only slightly higher (42% vs. 47%), and even this difference is probably due to the use of proxy respondents. The results from Britain go against the expectation as reported levels of absolute personal care poverty are already very high (50–87%). The only available self-reported relative figure (55%) does not go beyond them. Neither does the proxy-reported relative figure (73%).

Findings from the United States are split into two parts. On the one hand, Manton's (1989) absolute care poverty rate (35%) fits well with Allen and Mor's (1997) and Komisar et al.'s (2005) rather high relative rates (40% and 58%). On the other hand, other relative rates are considerably lower (17–27%) as are the absolute rates reported by Tennstedt et al. (1994: 9%) and Sands et al. (2006: 18%). The second group of studies thus provides an alternative and considerably less negative depiction of the level of personal care poverty in the United States.

From China, several studies display very high levels (55–61%) of relative personal care poverty. However, the rate recounted from the only located study using the absolute approach is clearly lower (31% in Zhu & Österle, 2017). The absolute rate from Malaysia is very modest (14%), taking into account the scarcity of formal care provisions in the country. Relative rates reported from New Zealand (12%) and Finland (17%) are also low.

Putting nations into a rank order based on these studies remains complicated and needs to be done only with reservations as the studies use different kinds of methods and datasets. In general, it can nevertheless be said that Britain shows extremely high levels of personal care poverty (50–87%) and that the Chinese rates (31–61%) are high, as well. The two reviewed studies on personal care poverty from Canada report slightly lower but still high figures (42–47%). For the United States, there is a huge spread in the results (9–58%). Spain displays medium-level results (22–40%), while single studies from Taiwan (21%), Finland (17%), Malaysia (14%), and New Zealand (12%) show lower rates of personal care poverty. However, major caution needs to be taken when drawing conclusions about national levels of personal care poverty, especially in cases where only one or two studies are available from a country.

Rates of Practical Care Poverty

The second domain widely included in studies on unmet needs is practical daily activities that are most often measured through the IADL framework. The exact list of these activities varies somewhat between different studies but cleaning, cooking, taking medications, managing finances, transportation, and shopping are typically included. Difficulties in performing these activities usually occur considerably earlier than limitations in performing ADLs. This means that among the older population, IADL-based needs for practical care are much more common than ADL-based needs for personal care. Unlike ADL limitations, difficulties in performing IADLs rarely pose an immediate threat to the life or health of older people. But as IADLs are also essential to daily life, their limitations create a need for informal or formal support. If such support is not available to older persons or if the available support is inadequate, practical care poverty emerges, and this will, at least in the long run, bring about problems in well-being and health.

Unmet practical care needs have most often been studied in the same way as unmet personal care needs, using survey questionnaires where older people or proxy respondents report on needs as well as the receipt and adequacy of informal and formal support. However, not all studies distinguish IADLs from ADLs in their analysis, which makes it impossible to report separate rates of personal care poverty and practical care poverty. Furthermore, as rather few researchers have examined only unmet practical care needs, there are not many studies available for review here.

Rates of Absolute Practical Care Poverty

All studies reviewed in this section were already included in the list of studies analysing absolute personal care poverty. No studies examining only absolute practical care poverty were thus located. From the United States, two rather recent studies report a somewhat higher prevalence of unmet practical care needs (28% in Davey et al., 2013; 24%/33% in Freedman & Spillman, 2014) than Tennstedt et al. (1994), who reported 11% and 15% (Table 4.4). But by far, the highest rate of absolute practical care poverty in North America comes from Canada (67% in Carrière,

Table 4.4 Rates of absolute practical care poverty

Country	Study	Age group	Sample size	Data from year(s)	Care poverty rate (%, rounded)
US	Tennstedt et al. (1994)	70+ 74+	235 235	1984 1988	11[a] 15[a]
US	Davey et al. (2013)	65+	2422	2004	28
US	Freedman and Spillman (2014)	65+	8077	2011	24/33[a,b]
Canada	Carrière (2006)	65+	28,672	2003	67[c]
UK	Vlachantoni et al. (2011)	65+	4916	2008	16[a,c]
UK	Whalley (2012)	65+	4231	2011–2012	27[a,c]
UK	Maplethorpe et al. (2015)	65+	2067	2014	54[a]
UK	Marcheselli and Ridout (2019)	65+	2253	2018	51[a]
UK	Vlachantoni (2019)	65+	5591	2016	24
Malaysia	Momtaz et al. (2012)	60+	400	2003–2005	12[c]

[a] Recounted based on information provided in the publication

[b] Depending on whether the category of ‘has some limitations but does not experience difficulty or receive help’ is interpreted as having care needs or not

[c] As only activity-specific rates are reported in the publication, the table shows the highest activity-specific level of unmet needs

2006). From the United Kingdom, three studies show a medium level of unmet needs (16%–27%). However, two others report high rates of 51% and 54% (Maplethorpe et al., 2015; Marcheselli & Ridout, 2019). Finally, a low rate of absolute practical care poverty is reported from Malaysia (12% in Momtaz et al., 2012).

Rates of Relative Practical Care Poverty

The number of studies that use the relative approach to measure unmet practical care needs is even smaller than those using the absolute approach (Table 4.5). The three available publications from the United States display quite different care poverty rates, ranging from 18% to 45%. By

Table 4.5 Rates of relative practical care poverty

Country	Study	Age group	Sample size	Data from year(s)	Care poverty rate (self-reported, %, rounded)	Care poverty rate (proxy-reported, %, rounded)
US	Allen and Mor (1997)	65+	632	1993–1994	45[a,b]	
US	Kennedy (2001)	18+[c]	25,805	1995–1996	18	
US	Newcomer et al. (2005)	18+[c]	3493	1994–1997	25[b]	
Spain	Otero et al. (2003)	75+	1135	1993	12	
Canada	Dubuc et al. (2011)	75+	433	2005		12
Finland	Kröger et al. (2019)	75+	2910	2010–2015	26	

[a] As only activity-specific rates are reported in the publication, the table shows the highest activity-specific level of unmet needs

[b] Recounted based on information provided in the publication

[c] In the publication, results are reported only for the whole sample, but the majority of the sample was aged 65+ (53% of the sample in Newcomer et al., 2005, 51% of those with unmet needs in Kennedy, 2001)

coincidence, the only studies from Spain and Canada show an identical low level (12%), though the Canadian figure results from proxy responses. A considerably higher figure (26%) is reported from Finland.

Activity-Specific Rates of Practical Care Poverty

Despite the lack of studies reporting general rates of practical care poverty, as many as 15 available studies have reported activity-specific levels of unmet IADL-based needs (Table 4.6). Here, activities that were included only in one or two of the publications have been excluded from the table. The list of included IADLs is longer than the earlier one of ADLs, but at the same time, the studies differ greatly in terms of which specific activities were included in their analysis.

Four studies report cleaning/housekeeping as having the highest level of unmet needs. According to three publications, walking outside has the highest care poverty rate. Another three identify heavy housework as the most challenging practical care task. Two studies report that small home repairs, transport, managing finances, and light housework are each the most problematic IADLs, while cooking is given the highest care poverty rate once. None of the publications show taking medicines, grocery shopping, or using the telephone as the most problematic instrumental activity in daily life.

Taking medications is clearly the least challenging IADL, as seven studies report its unmet needs to be the lowest. This is followed by managing finances (four studies) and shopping (three studies). Two studies identify cooking, and one study identifies cleaning as the least problematic practical care need. No publication reports small repairs, light housework, walking outside, or using the telephone to have the lowest level of care poverty.

Overall, cleaning/housekeeping is the most problematic IADL. Walking outside and heavy housework are also challenging practical tasks. At the other end, taking medications is without a doubt the practical care need that has the lowest level of unmet need. Managing finances and grocery shopping seem to be the next least problematic activities.

Table 4.6 Activity-specific practical care poverty rates

Country	Study	Taking medication	Cooking	Housekeeping/ Cleaning and laundering	Small repairs or refurbishments at home, gardening	Managing financial affairs	Grocery shopping	Transport/ Going to hobbies or activities or visiting other people	Light housework	Heavy housework	Walking outside	Using the telephone
Absolute practical care poverty												
US	Tennstedt et al. (1994)	2	1	7			3	0.4				
UK	Vlachantoni et al. (2011)[a]				16		8					
UK	Whalley (2012)[a]	8		27		16	21				25	
UK	Dunatchik et al. (2016)	16			31		18				69	
Malaysia	Momtaz et al. (2012)	7	9	12		12	10					
NZ	Wilkinson-Meyers et al. (2014)		4			8	3	4	7	6		
Relative practical care poverty												
US	Allen and Mor (1997)[a]		27	45			28	36	45	36		
US	Kennedy (2001)[a,b]	8	13			8	10	12	18	17		10
US	Newcomer et al. (2005)[a,b]	7	16			7	12	14	17	16	19	8
US	Schure et al. (2015)	9	21			17	21	22	29	36	32	14

(*continued*)

Table 4.6 (continued)

Country	Study	Taking medication	Cooking	Housekeeping/Cleaning and laundering	Small repairs or refurbishments at home, gardening	Managing financial affairs	Grocery shopping	Transport/Going to hobbies or activities or visiting other people	Light housework	Heavy housework	Walking outside	Using the telephone
Spain	Otero et al. (2003)[a]		10			9	7	10	7	5		
Canada	Carrière (2006)		39				51		48	67		
Canada	Dubuc et al. (2011)	6	5	2		1	0.3				11	3
Canada	Busque and Légaré (2012)[a]		7	12	18	3	6	5				
NZ	Wilkinson-Meyers et al. (2014)			3		3	8	12	13	21		
Finland	Kröger et al. (2019)	8	15	20	20	10	15	24				

[a] Recounted based on figures provided in the publication

[b] Unmet needs among the whole 18+ sample, as specific results for older people are not available

Summary: Practical Care Poverty Rates

As the number of studies focused only on unmet IADL needs is very limited, findings on practical care poverty are rarer than those on personal care poverty. The largest stock of studies comes again from the United States, where absolute practical care poverty rates range between 11% and 33% and relative rates between 18% and 45%, which sounds logical. The five British studies show absolute care poverty rates between 16% and 54%, which is a very wide variation. The lone Spanish and Malaysian studies both report a low level of 12%, just like Dubuc et al. (2011) from Canada. However, Carrière (2006) paints a totally different picture of the Canadian situation by reporting an absolute rate as high as 67%. Our Finnish study shows a medium level (26%) of practical care poverty.

Here, comparing countries is even more difficult than in the case of personal care poverty. If Carrière's (2006) results are to be trusted, Canada has much higher practical care poverty than any of the other studied countries. The United States, the United Kingdom, and Finland all seem to have medium levels, while Spain and Malaysia display rather low levels of practical care poverty. However, the number of studies is so limited that firm conclusions should be avoided.

Rates of Personal-Practical Care Poverty

As mentioned earlier, several publications do not report one rate for unmet ADL needs and another for unmet IADL needs. Instead, they mix these two domains together. Results from these studies are reviewed here under the term 'personal-practical care poverty'. In addition to publications that only record combined figures, some of the aforementioned studies that present specific results for personal and/or practical care poverty also provide combined personal-practical figures. They, too, are included in this detour before we go to socio-emotional care poverty rates.

Rates of Absolute Personal-Practical Care Poverty

Now the list of included countries becomes extended though, as usual, the United States has the largest number of studies (Table 4.7). Lima and Allen (2001) provide the lowest American figure so far: based on their dataset, only 3% of respondents with personal or practical care needs are in absolute care poverty. Results from Gibson and Verma (2006) are rather close (8% and 11%), with those of two other studies somewhat higher (18% in Tennstedt et al., 1994, and 22% in Shea et al., 2003). However, three American studies show much higher levels of absolute care poverty (41% in Freedman & Spillman, 2014, and 53% in both Davey & Patsios, 1999, and Davey et al., 2013).

The two studies from the United Kingdom display rather similar high figures of absolute care poverty (44% in Davey & Patsios, 1999, 58% in Dunatchik et al., 2016). Furthermore, the two publications addressing the situation in Sweden show very close—and extremely low—results (1% in Shea et al., 2003, 5–6% in Davey et al., 2007).

Nigeria has practically no formal care provisions, but it shows only a medium level of care poverty (20%), as with Malaysia (18%). The two studies from China—another country with limited formal care services—display a somewhat higher figure (34%). The Spanish (25%) and Slovenian (32%) rates are at the same level, while France (51%) and Ireland (63%) display considerably higher rates of absolute care poverty. Besides Ireland, only India shows a care poverty rate that exceeds 60%. At the other end, New Zealand (4%) joins Sweden in reporting a very low figure.

Rates of Relative Personal-Practical Care Poverty

The list of studies using the relative approach to analyse combined rates of unmet personal and practical care needs is shorter than the list of those using the absolute approach (Table 4.8). It also includes one study that used proxy respondents.

For the United States, relative care poverty rates are more consistent (21–34%) than the rates of absolute care poverty. Only the figures of an early study by the General Accounting Office (1986) and Schure et al.'s

Table 4.7 Rates of absolute personal-practical care poverty

Country	Study	Age group	Sample size	Data from year(s)	Care poverty rate (%, rounded)
US	Tennstedt et al. (1994)	70+	235	1984	18
US	Davey and Patsios (1999)	70+	1847	1994	53
US	Lima and Allen (2001)	65+	4466	1995–1996	3[a]
US	Shea et al. (2003)	75+	4583	1992	22
US	Gibson and Verma (2006)	60+	449	2002	11[a]
		70+	203	2002	8[a]
US	Davey et al. (2013)	65+	2422	2004	53
US	Freedman and Spillman (2014)	65+	7609	2011	41[a]
UK	Davey and Patsios (1999)	70+	1203	1994	44
UK	Dunatchik et al. (2016)	65+	584	2013	58[b]
Sweden	Shea et al. (2003)	75+	1378	1994	1
Sweden	Davey et al. (2007)	75+	1242	1994	5
		75+	1466	2004	6
Nigeria	Gureje et al. (2006)	65+	2152	2003–2004	20
France	Gannon and Davin (2010)	65+	1166	2006–2007	51
Ireland	Gannon and Davin (2010)	65+	458	2006–2007	63
India	Ashokkumar et al. (2012)	60+	305	2005–2006	62[a]
Malaysia	Momtaz et al. (2012)	60+	400	2003–2005	18
NZ	Wilkinson-Meyers et al. (2014)	75+[c]	3753	2008–2009	4
Spain	García-Gómez et al. (2015)	16+[d]	21,267	2008	25
Slovenia	Hlebec et al. (2016)	65+	1458	2013	32[a]
China	Zhu and Österle (2017)	45+[e]	3682	2013	34[a]
China	Hu and Wang (2019)	60+	1324	2013–2014	34

(continued)

Table 4.7 (continued)

[a] Recounted based on information provided in the publication
[b] According to the 'wider definition' of unmet needs used in the publication, which is rather close to the absolute approach
[c] 65+ for Māori participants
[d] In the publication, results are reported only for the whole 16+ sample, but the majority (60%) of the sample were aged 65+
[e] In the publication, results are reported only for the whole 45+ sample, but the majority (54%) of the sample were aged 65+

Table 4.8 Rates of relative personal-practical care poverty

Country	Study	Age group	Sample size	Data from year(s)	Care poverty rate (self-reported, %, rounded)	Care poverty rate (proxy-reported, %, rounded)
US	GAO (1986)	65+	36,000	1982	41	
US	Lima and Allen (2001)	65+	4466	1995–1996	21[a]	
US	Newcomer et al. (2005)	18+	3493	1994–1997	27[a,b]	
US	Gibson and Verma (2006)	60+ 70+	449 203	2002 2002	30 27	
US	Schure et al. (2015)	55+[c]	505	2006–2008	34	
France	Davin et al. (2006)	60+	8727	1999	13	
Canada	Dubuc et al. (2011)	75+	434	2003–2004		67[d]
Canada	Busque and Légaré (2012)	65+	4142	2002	18	
Spain	Rogero-García and Ahmed-Mohamed (2011)	60+ 75+ 85+	3718 2463 813	2008 2008 2008	28[a] 28[a] 26[a]	
NZ	Wilkinson-Meyers et al. (2014)	75+[e]	3753	2008–2009	30	
Finland	Kröger et al. (2019)	75+	2910	2010–2015	26	

[a] Recounted based on information provided in the publication
[b] In the publication, results are reported only for the whole 18+ sample, but the majority (53%) of the sample were aged 65+
[c] The sample consisted of Native Americans
[d] Besides ADLs and IADLs, this figure includes unmet needs for communication and mental functions
[e] 65+ for Māori participants

(2015) research into rates among Native Americans go beyond 30%. The care poverty rate from France (13%) is the lowest of all countries. Busque and Légaré's (2012: 18%) result from Canada is low as well, but once again, another Canadian study shows a very high figure (67% in Dubuc et al., 2011). The reported relative personal-practical care poverty rates from Finland and Spain are almost identical (26–28%), and this time they are slightly lower than the figure for New Zealand (30%).

Summary: Personal-Practical Care Poverty Rates

Looking at the results for personal-practical care poverty, the general view remains fragmented and somewhat illogical. Spain shows a logical pattern as its rate of absolute care poverty (25%) is lower than its rate of relative care poverty (29%). In New Zealand, the situation is the same with an even larger gap between the absolute and relative figures (4% and 30%). But France is an opposite case with its rate of absolute care poverty (51%) substantially higher than its relative figure (13%). The absolute French rate comes from the SHARE dataset, though, which regularly gives rather high levels of unmet needs for many countries (see Chap. 8).

Besides Spain, New Zealand, and France, the United States is the only other country from which both absolute and relative results are available. Lima and Allen (2001) as well as Gibson and Verma (2006) report both absolute (3–11%) and relative figures (21–30%). These are, as expected, well in line with each other. Furthermore, the absolute results of 18–22% from two other studies (Tennstedt et al., 1994; Shea et al., 2003) fit rather well together with the relative levels of 34–41% reported in two publications (GAO, 1986; Schure et al., 2015). However, the high absolute rate of 53% (in Davey & Patsios, 1999, and Davey et al., 2013) remains an outlier. The same could perhaps be said about Lima and Allen's (2001) aforementioned very low absolute rate (3%).

For other countries, only absolute or relative figures are available. The high Irish absolute figure (63%) and the Slovenian result (32%) also originate from SHARE data. Once again, Canada has one extremely high proxy-based rate (67%) and another substantially lower self-reported rate (18%). For Malaysia (18%) and Nigeria (20%), absolute levels are rather low—especially when taking into account that formal provisions in both countries are very limited. China (34%) shows here a somewhat higher level of care poverty. Spain, Finland, and New Zealand all remain at a medium level (25%–30%).

Based on the reviewed studies, Sweden and New Zealand are probably the nations with the lowest levels of personal-practical care poverty (although the relative rate for New Zealand is not so low and no relative figure is available for Sweden). Malaysia and Nigeria also display rather low levels. Finland, Spain, Slovenia, and China seem to have medium levels of personal-practical care poverty. For the United States, there is once again wide variation in results. The position of France depends fully on which of the two reviewed studies is taken as the reference point, and the same goes for Canada. Britain displays high levels of unmet needs. There were only sole studies available for review from Ireland and India, which both show very high care poverty rates.

Rates of Socio-emotional Care Poverty

Compared to personal and practical care needs, it is rare for studies of unmet needs to focus on socio-emotional needs. Literature concerning unmet emotional and social needs among people in old age is thus very limited (for exceptions, see McInnis-Perry et al., 2013; Someşan & Hărăguş, 2016). Even when the research addresses these needs, studies are usually focused on some specific subgroups of older people such as cancer patients, people with dementia, or people with HIV (Hansen et al., 2017; Ogletree et al., 2019; Williams et al., 2019). Even though social and emotional needs have become recognised as essential to the well-being of older people, there is a major knowledge gap concerning the unmet socio-emotional needs of people in old age.

At the same time, loneliness among older people has become a popular area of gerontological research (Yang, 2019). In recent decades, this research has extended from North America and Western Europe to Southern and Eastern Europe, Asia, and Africa (De Jong Gierveld et al., 2018). Loneliness studies have followed the same kind of trajectory of geographical expansion as studies on unmet needs, but their volume has overshadowed the unmet need literature. Although both are practised within the discipline of gerontology and they gained popularity mostly simultaneously and in a similar vein, research on unmet needs and research on loneliness have rarely had close contact. De Jong Gierveld and Tesch-Römer (2012, p. 287) discuss loneliness as a result of unfulfilled social needs, calling this the 'deficit approach' to loneliness. Ten Bruggencate et al. (2018, p. 1746) also mention how when the social needs of older people go unsatisfied, this can lead to loneliness and social isolation. In general, however, it has been unusual to see these two research areas integrated or loneliness conceptualised as an unmet need.

As mentioned in Chap. 3, this volume understands older people's loneliness as an expression of their unmet socio-emotional care needs. The concept of loneliness as a self-perceived discrepancy between desired and actual social interaction (De Jong Gierveld et al., 2018) fits well with the framework of care poverty, especially its relative measurement approach. Though the absence of loneliness does not guarantee that all of the socio-emotional needs of older people are being met, loneliness can nevertheless be understood as an indicator of care poverty—of relative socio-emotional care poverty, to be exact. This definition makes it possible to refer to loneliness literature in the study of care poverty, especially in a situation where other research on the unmet socio-emotional care needs of the older population is scarce.

Rates of Relative Socio-emotional Care Poverty

There are hundreds of studies reporting on the prevalence of loneliness among older people in different countries. This means it is not possible to review all or even a major part of them here. However, a number of reviews of loneliness studies have been published in the past few decades (e.g., Wenger et al., 1996; Routasalo & Pitkälä, 2003). More recently, even reviews have tended to become specialised by not addressing all loneliness studies. They focus instead on only a certain aspect of this research, such as the relationship between loneliness and heart disease (e.g., Valtorta et al., 2016), or by reviewing the literature from only one country (e.g., Chen et al., 2014).

Loneliness studies are more established than unmet need studies, and there already are several international (particularly European) datasets providing harmonised data for comparative research into loneliness while reliable international data on unmet needs are still missing. The SHARE dataset has had a question on loneliness since its first wave (2004–2006), for instance, while it still has no question about unmet need; this dataset has served as a basis for comparative research into loneliness. Other international datasets with one or more questions on loneliness in their design include the European Social Survey (ESS) and the Generations and Gender Survey (GGS).

The loneliness question in SHARE asks, ‘How often have you experienced the feeling of loneliness over the last week?’ Possible answers include ‘almost all of the time’, ‘most of the time’, ‘some of the time’, and ‘almost none of the time’ (Sundström et al., 2009, p. 269). The first two answers are usually considered ‘frequent loneliness’. For the ESS, both the question and possible answers are almost identical (Yang & Victor, 2011, pp. 1375–1376). The GGS instead uses the De Jong Gierveld Loneliness Scale, which consists of six different questions and a resulting summary index (Hansen & Slagsvold, 2016).

Findings from five studies, which are based on the analysis of these three international survey datasets, are reviewed here. First, there are three comparative studies using the SHARE data. Sundström et al. (2009) analyse data from the first wave of SHARE, which was collected from 12 countries in 2004–2006. Their analysis uses subsample of people aged 65 years or older, including 14,012 respondents. Vozikaki et al. (2018) analyse data from the first wave as well, covering the same 65+ age group. However, their subsample includes only 5129 respondents and excludes Israel. Fokkema et al. (2012) examine data from the second wave, which was gathered from 14 countries in 2006–2007. Unlike the two previously mentioned studies, this study includes all respondents aged 50 years and over (12,248 in total). Next, Yang and Victor (2011) analyse data from the third round (2006–2007) of the ESS. They include all 47,099 respondents, aged 15–101, in their analysis but report separate national loneliness figures for the 60+ age group. Finally, Hansen and Slagsvold (2016) analyse GGS data collected over the period of 2004–2011, comprising 33,832 respondents aged 60–80 from 11 countries. As the researchers want to focus on a serious and problematic level of loneliness, they raise the loneliness cut-off point for the De Jong Gierveld Loneliness Scale index score from the commonly used 2 to 6.

Several mostly Northern or Western European countries (Austria, Belgium, Denmark, France, Germany, the Netherlands, Spain, Sweden, and Switzerland) are included in four or all five of these studies (Table 4.9). It is no surprise that the three SHARE studies offer rather similar results, but findings from studies of the ESS and GGS data are not very dissimilar, either. The ESS figures used by Yang and Victor (2011) seem slightly lower in some cases than those from the other four studies, but this is not systematic for all countries. Although the GGS results use a brand-new cut-off threshold, they are often very close to those of the other studies. Yet if we look at countries that are included in only two or three studies (Bulgaria, Czechia, Greece, Ireland, Italy, Norway, Poland, Romania, and Russia), gaps between the figures are often larger. For example, the difference between the three figures from Greece is 10 percentage points. Finally, there are several countries with a result from only one of the studies (Cyprus, Estonia, Finland, Georgia, Hungary, Israel, Latvia, Lithuania, Portugal, Slovakia, Slovenia, Ukraine, and the United Kingdom).

Based on these comparative loneliness studies, which countries have the highest relative socio-emotional care poverty? The highest figure comes from Georgia (38%), based on the GGS study, followed by Bulgaria (34%), Lithuania (28%), Romania (27%), Czechia (23%), and Russia (21%) (Hansen & Slagsvold, 2016). For their part, Yang and Victor (2011) show a very high loneliness figure for Ukraine (34%) and substantial levels also for Russia (24%) and Hungary (21%). Vozikaki et al. (2018) report high levels of loneliness for Italy (28%) and Greece (26%). All in all, countries that have at least one value over 20% include Bulgaria, Czechia, Georgia, Greece, Hungary, Italy, Lithuania, Romania, Russia, and Ukraine. All of these countries come either from Southern Europe or from (Central) Eastern Europe, which confirms the findings from earlier studies highlighting the spread of loneliness especially in these parts of Europe (e.g., Jylhä & Saarenheimo, 2010).

The middle category of countries, which display at least one result at the 11%–20% level of loneliness, is more varied in terms of geographical location. This group includes Austria, Belgium, Germany, Estonia,

Table 4.9 Rates of socio-emotional care poverty (%)[a]

	Study				
Country	Sundström et al. (2009)	Fokkema et al. (2012)	Vozikaki et al. (2018)	Yang and Victor (2011)	Hansen and Slagsvold (2016)
Austria	10	11	12	11	
Belgium	13	13	12	9	11
Bulgaria				19	34
Cyprus				10	
Czechia		16			23
Denmark	6	6	6	3	
Estonia				14	
Finland				6	
France	15	18	13	11	11
Georgia					38
Germany	9	9	14	7	11
Greece	21	16	26		
Hungary				21	
Ireland		12		5	
Israel	15				
Italy	18	25	28		
Latvia				19	
Lithuania					28
Netherlands	9	8	11	6	
Norway				5	8
Poland		20		20	12
Portugal				15	
Romania				19	27
Russia				24	21
Slovakia				20	
Slovenia				15	
Spain	14	16	14	12	
Sweden	7	10	8	7	
Switzerland	4	8	5	5	
Ukraine				34	
UK				7	

[a] Based on comparative loneliness studies

France, Ireland, Israel, Latvia, the Netherlands, Poland, Portugal, Slovakia, Slovenia, and Spain. Here, almost all parts of Europe are represented: Western, Central, Eastern, and Southern Europe (plus the non-European country of Israel).

Finally, there is a smaller group of European countries where the loneliness level is reported to be 10% or below: Cyprus, Denmark, Finland, Norway, Sweden, Switzerland, and the United Kingdom. With the exceptions of Cyprus and Switzerland, these countries are all from Northern Europe. All four Nordic nations included in the reviewed studies were placed in this country group.

With the exception of Israel, only European countries are included in the above-mentioned datasets and studies. However, many loneliness studies have certainly been carried out for the non-European nations included in earlier sections of this chapter examining the prevalence of unmet personal and practical care needs (Table 4.10). From the United States, China, India, and New Zealand, there are reviews of loneliness literature available (Chen et al., 2014; Ong et al., 2016; Wright-St Clair et al., 2017; Hossain et al., 2020). For Taiwan, Malaysia, Nigeria, and Canada, only individual studies on the prevalence of loneliness among older people were located (Tsai et al., 2013; Teh et al., 2014; Menec et al., 2019; Igbokwe et al., 2020).

Here, this literature is used to provide results on the level of socio-emotional care poverty in these countries. Rates vary from 4–8% in Taiwan to 5–77% in India. In the other countries, the prevalence of loneliness among older people is reported between 8% and 29%. However, it is important to remember that the figures from non-European countries are not comparable to those from European ones as they were determined through the use of non-harmonised methods and measurements. For example, some of these publications do not make a distinction between infrequent and frequent loneliness.

Rates of Absolute Socio-emotional Care Poverty

Here, loneliness studies have been used to gain knowledge of relative socio-emotional care poverty. But is there a way to operationalise loneliness research to determine absolute socio-emotional care poverty, as well? Absolute care poverty means a situation where, despite care needs, there is no informal or formal support available. In the case of socio-emotional care needs, it would mean that the person has no access to any emotional

Table 4.10 Rates of care poverty

Continent	Country	Absolute personal care poverty (%)	Relative personal care poverty (%)	Absolute practical care poverty (%)	Relative practical care poverty (%)	Absolute personal-practical care poverty (%)	Relative personal-practical care poverty (%)	Relative socio-emotional care poverty (%)[a]
North America	CAN	42	47[b]	67	12[b]		18–67[b]	11
	USA	9–48	17–58	11–33	18–45	3–53	21–41	25–29
Europe	AUT							10–12
	BEL							9–13
	BGR							19–34
	CHE							4–8
	CYP							10
	CZE							16–23
	DEU							7–14
	DNK							3–6
	ESP	22	29–40		12	25	26–28	12–16
	EST							14
	FIN		17		26		26	6
	FRA					51	13	11–18
	GBR	50–87	55–73[b]	16–54		44–58		7
	GEO							38
	GRC							16–26
	HUN							21
	IRL					63		5–12
	ITA							18–28
	LTU							28
	LVA							19
	MLD							6–11

	NOR							5–8
	POL							12–20
	PRT							15
	ROU							19–27
	RUS							21–24
	SVK							20
	SVN					32		15
	SWE					1–6		7–10
	UKR							34
Asia	CHN	31	55–61			34		9–25
	IND					62		5–77
	ISR							15
	MYS	14		12		18		21
	TWN		21					4–8
Oceania	NZL	7	12			4	30	8–13
Africa	NGA					20		22

[a] Based on loneliness studies

[b] Proxy-reported (the only or the higher figure)

or social support. This is the situation in full social isolation. When a person has zero social contacts, they are receiving zero social support. Accordingly, absolute socio-emotional care poverty could be operationalised to include those people who do not receive any emotional or social support from anyone—that is, who are in full social isolation. However, comparative international literature on the prevalence of social isolation among older people seems limited. Thus, no information on the rates of absolute socio-emotional care poverty can be provided here.

Summary: Socio-emotional Care Poverty Rates

Here, loneliness is taken as an expression of unmet emotional and social needs—and thus of socio-emotional care poverty. Socio-emotional care poverty is a more multidimensional issue than loneliness: different groups of older people may need different kinds of support, which can range from professional psychosocial care to the satisfaction of intimacy needs. Research on these issues within the older population is still unable to yield a solid stream of literature. As a substitute, research into loneliness can be used to indicate the rates of socio-emotional care poverty among older people. Care poverty means the deprivation of basic human needs, which threatens the well-being and health of older people. That is why results indicating frequent loneliness are used here.

A summary of the findings from five comparative loneliness studies does not bring many surprises: in Europe, socio-emotional care poverty is most widespread in the eastern and southern parts of the continent, although there are positive exceptions (e.g., Portugal and Slovenia) in these regions. Western and Central European countries are mostly placed in the middle category, while loneliness levels seem to be lowest in the Nordic countries, Switzerland, the United Kingdom, and the Mediterranean exception Cyprus.

Concerning less harmonised studies from non-European countries, India displays very high (but at the same time varying) rates. The United States, China, Malaysia, and Nigeria show a rather high prevalence of socio-emotional care poverty among their older populations, while rates for Canada and New Zealand are somewhat lower but still higher than those for Taiwan. Differences in the measurements used by these studies reduce their comparability.

Conclusions

So in the end, how widespread is care poverty? Does it vary between countries? The answer to the second question is yes, it certainly varies. However, it is not possible to provide definitive national care poverty rates. Findings based on the absolute vs. the relative measurement approach obviously differ from each other, as do results from the three different domains (Table 4.10). Findings from different studies vary even within the same domain for the same nation. In some countries, such as Spain, several studies of the same domain show rather similar findings. But for other countries, the United States in particular, the results display large within-domain variations.

In general, it is the scarcity of research that poses the most substantial barrier to drawing conclusions about national levels of care poverty. The most salient feature of the summary table for existing studies is the overwhelming number of empty cells (Table 4.10). It is very probable that several studies on unmet needs have unintentionally dropped out of view, and as mentioned earlier, a number of unmet need studies were unusable here as a care poverty rate could not be calculated from their figures. Nonetheless, studies of unmet needs are still rare.

Despite the expansion of publications particularly in the 2010s, studies are still conducted in only a minority of nations. Within Europe, a majority of countries lack research on the unmet personal and practical care needs of their older populations. Furthermore, comparative analyses performed with reliable international data are conspicuous in their absence, with the notable exception of loneliness studies. While the breadth of loneliness research makes it possible to fill in the last column of the summary table for every included country, not even half of the cells can be completed for any other column—and only those countries where at least some research on unmet care needs is available were included in the table in the first place.

Caution is needed, but some observations can be made about the reviewed studies by looking at the results from different domains in each country. In Canada, personal and practical care poverty seem to be considerably more common than loneliness. As stated already, the United States has huge variation in almost every care poverty domain. Several (but not all) studies report high levels of personal as well as practical care poverty. Loneliness seems to be somewhat rarer, though still substantial.

In Spain, personal (and personal-practical) care poverty rates are higher than those for practical care poverty and especially for socio-emotional care poverty. In Finland, practical care poverty is clearly more typical than personal care poverty, while frequent loneliness is exceptional. Results from France are inconsistent. The United Kingdom shows a very low rate of loneliness, but very high rates of personal care poverty. Rates of practical care poverty are slightly lower yet remain high. Both Ireland and Slovenia have rather high levels of personal-practical care poverty, but much lower levels of socio-emotional care poverty. Of all included countries, Sweden has the lowest rates of personal-practical care poverty, and its loneliness level is low, too.

The relative levels of personal care poverty are very high in China, while absolute personal and personal-practical care poverty are both at a medium level. Indian care poverty rates are high, but available only for personal-practical and socio-emotional domains. Malaysia has low or medium levels of personal, practical, and personal-practical care poverty, while its rate for socio-emotional care poverty is higher. Taiwan is reported to have a very low level of loneliness, but a medium level of personal care poverty. New Zealand has mostly very low rates of care poverty. Finally, Nigeria has rather low levels of personal-practical and socio-emotional care poverty. Overall, the three domains appear to be rather independent from each other, as countries may have high care poverty rates in one domain, but not in another.

If we compare the rates of absolute vs. relative care poverty, the assumption was that relative rates would be considerably higher, as they include all who assess their care as inadequate. However, the results do not support such a clear logic. In Britain, the highest rates come from absolute personal care poverty. In Canada, they come from absolute practical care poverty (although relative personal-practical care poverty is equally high).

In Spain, relative rates are slightly higher than absolute rates. In China, there is a clear difference between the absolute and relative rates of personal care poverty. Despite the wide variation of results in the United States, the ranges of relative rates are somewhat higher than those of absolute rates. However, conclusions made here remain preliminary, as only very few countries have results from both measurement approaches and from the same care poverty domain.

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5

Factors of Care Poverty

Care poverty is a global plight that disturbs the everyday lives of people with care needs in different parts of the world. But what factors are behind it? Can care poverty be predicted by poverty itself, or is the lack of economic resources just one contributing factor among many others? Do women suffer from care poverty more than men? Is it indeed the very oldest people in society who most often find their care needs unmet?

These questions are interesting in more than just an academic sense. An understanding of the individual and societal factors causing care poverty is prerequisite to developing policies that might address them. If the roots of care poverty remain unknown, measures to eradicate it will be taken at random and most likely prove futile. It is also important to know whether care poverty is associated with the same factors in different social and cultural contexts.

Most studies of unmet needs analyse not just their prevalence, but also their associated or predicting factors. The list of factors examined varies across different studies: basic background variables such as age, gender, and living arrangement are included in almost every study, while some other variables such as region or home ownership are only sometimes included. Not even the key variables of income and health status are

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included in every study. This chapter reviews the findings concerning the factors that are included most often, organised into three variable groups: (1) health and functional status (including self-reported health and the number of reported I/ADL limitations); (2) socio-demographic background (including age, gender, marital status, ethnicity, income, education level, home ownership status, and residential area); and (3) the availability of informal and formal care (including the indicators of living arrangements, informal networks, the primary source of care, region, and level of access to formal care).

This chapter sums up existing knowledge for this issue; that is, it outlines the key factors of care poverty based on the available literature. This knowledge is particularly needed to discover who among the older population is currently left without adequate support and thus needs more help. As with Chap. 4, this chapter follows the care poverty framework introduced in Chap. 3. First, it examines the factors of personal care poverty. Then, it reviews the factors connected to practical (and personal-practical) care poverty and, finally, socio-emotional care poverty.

Factors of Personal Care Poverty

Health, age, gender, and living arrangement are among the variables included in the analysis of unmet personal care needs most regularly. Several other aforementioned variables (e.g., region, informal networks) are examined only exceptionally. Furthermore, studies on the factors of personal care poverty are available only from a few countries, which restricts the interpretation of their findings. The number of studies per country is also low, with the exception of the United States.

Looking first at absolute personal care poverty, the most unanimous results concern living arrangement, residential area (i.e., urban vs. rural), and levels of education and income (Table 5.1). Eight out of nine analyses found a significant association between living alone and being without any formal or informal support while having an ADL-based need. On the contrary, none of the three studies looking at residential area identified it as having a significant association to care poverty. As well, only Zhu and Österle (2017) reported income and educational level to be

Table 5.1 Factors of absolute personal care poverty

Country	*Study*	*Correlation or regression analysis*	*Health (poorer)*	*I/ADL limitations (more)*	*Age (older)*	*Gender (female)*	*Marital status (not married)*	*Ethnicity (minority)*	*Income (lower)*	*Education (lower)*	*Home ownership (rented)*	*Residential area (rural)*	*Living arrangement (alone)*	*Informal networks (weaker)*	*Primary source of care (informal)*	*Access to formal care (no)*
US	Tennstedt et al. (1994)	Regr			NS								NS	NS	NS	
US	LaPlante et al. (2004)	Regr		SIG	NS			NS	NS				SIG			
US	Sands et al. (2006)	Corr			NS	NS		SIG[a]		NS			SIG			SIG
Spain	Tomás Aznar et al. (2002)	Corr	NS		NS	SIG[b]				NS			SIG[b]			
Spain	Tomás Aznar et al. (2002)	Regr	NS		NS	SIG[b]				NS			SIG[b]			
India	Ashokkumar et al. (2012)	Corr		SIG	SIG	NS	SIG		NS	NS			SIG	NS		
Malaysia	Momtaz et al. (2012)	Corr	SIG	SIG	NS	SIG[b]	NS	SIG[b]	NS			NS				

(*continued*)

Table 5.1 (continued)

Country	*Study*	*Correlation or regression analysis*	*Health (poorer)*	*I/ADL limitations (more)*	*Age (older)*	*Gender (female)*	*Marital status (not married)*	*Ethnicity (minority)*	*Income (lower)*	*Education (lower)*	*Home ownership (rented)*	*Residential area (rural)*	*Living arrangement (alone)*	*Informal networks (weaker)*	*Primary source of care (informal)*	*Access to formal care (no)*
Malaysia	Momtaz et al. (2012)	Regr	SIG	NS	NS	SIG[b]	NS	NS	NS			NS				
UK	Dunatchik et al. (2016)	Regr	NS		SIG[c]	NS			NS	NS	NS		SIG	NS		
UK	Vlachantoni (2019)	Corr	SIG[d]		NS[d]	NS[d]	SIG[d]			NS[d]	SIG[d]		SIG[d]			
UK	Vlachantoni (2019)	Regr	SIG[c]		SIG[c]	SIG[c]	SIG			NS	SIG[c]		SIG			
China	Zhu and Österle (2017)	Regr	NS		NS	NS	NS		SIG[c]	SIG[c]		NS		SIG		NS
Total[e]			**SIG/NS**	**SIG**	**NS**	**SIG/NS**	**SIG/NS**	**SIG/NS**	**NS**	**NS**	**SIG/NS**	**NS**	**SIG**	**NS**	**NS**	**SIG/NS**

SIG significant association, *NS* no significant association

[a] Significant association for Asian, but not for Black or Hispanic minorities

[b] Significant association only for women who live alone

[c] Significant association, but in opposite direction (Zhu & Österle, 2017, observe the highest likelihoods among those with the highest levels of income and, concerning education, among those with either primary school or high/vocational school education)

[d] In comparison to the whole sample (including those with no care needs)

[e] SIG: Most analyses show a significant association. SIG/NS: Around half of the analyses show a significant association. NS: Most analyses show no significant association

connected to unmet personal care needs, and furthermore, in their study it was actually people with high income and education who were at increased risk of unmet needs.

Three out of four analyses showed the number of I/ADL limitations associated with absolute personal care poverty. In terms of age, the clear majority of studies did not find a significant association, and in two of the three studies that identified age as a factor, it was actually younger age groups that had a higher level of unmet needs. For self-reported health, gender, marital status, ethnicity, home ownership, and access to formal care, results were mixed as only around a half of the studies observed a connection. Nearly all of the rather few analyses that included informal networks or the primary source of care found no association to unmet ADL-based needs. None of the studies examined variation across different parts of the country.

Somewhat more studies address the factors of relative personal care poverty (Table 5.2). Here, a majority find that five factors have a significant relation to care poverty. The most undisputed case is the number of functional limitations, as almost all studies identify a significant association. Although 4 analyses failed to show that living alone increases the likelihood of relative personal care poverty, as many as 11 studies did prove the connection. Residential area was actively examined, as well, and six out of eight analyses confirmed an association (though in one case, it was urban rather than rural areas that were more prone to care poverty). Five analyses connected poor health in older people to increased care poverty, while one linked care poverty to good health in old age. This time, the majority of studies also showed a significant association between care poverty and low levels of income. Researchers were more divided on the importance of informal networks, the primary source of care, region, and access to formal care. Age, gender, marital status, ethnicity, education, and home ownership were mostly found not to be significantly related to relative personal care poverty.

If we compare the results for absolute and relative personal care poverty, two variables attract the eye. While income and residential area have no relation with absolute care poverty, they are significantly associated with relative personal care poverty. When older people whose support is inadequate are included alongside those who lack every kind of support,

Table 5.2 Factors of relative personal care poverty

Country	*Study*	*Correlation or regression analysis*	*Health (poorer)*	*I/ADL limitations (more)*	*Age (older)*	*Gender (female)*	*Marital status (not married)*	*Ethnicity (minority)*	*Income (lower)*	*Education (lower)*	*Home ownership (rented)*	*Residential area (rural)*	*Living arrangement (alone)*	*Informal networks (weaker)*	*Primary source of care (informal)*	*Region*	*Access to formal care (no)*
US	Allen and Mor (1997)	Regr		SIG	NS	NS	NS	NS	NS	NS			NS	SIG			
US	Desai et al. (2001)	Corr		SIG	NS	SIG		NS	SIG	SIG			SIG				
US	Desai et al. (2001)	Regr		SIG					SIG				SIG				
US	Kennedy (2001)	Regr	SIG	SIG	NS	NS		SIG	NS				SIG		SIG		
US	Newcomer et al. (2005)	Regr	SIG	SIG	NS	NS		SIG	NS	NS	NS	SIG^{a}	SIG	NS	SIG		NS
US	Li (2006)	Regr		SIG	NS	NS	NS	NS		NS		NS			NS		SIG
Spain	Otero et al. (2003)	Corr	NS		NS				SIG	NS			SIG		NS		
Spain	Otero et al. (2003)	Regr	NS		NS	NS			SIG	NS			SIG				
Spain	Rogero-García and Ahmed-Mohamed (2014)	Corr		SIG	NS	SIG			SIG	SIG		SIG ^{b,c}	SIG				
Spain	Rogero-García and Ahmed-Mohamed (2014)	Regr		SIG	SIG	SIG			SIG	NS		SIG^{c}	SIG		SIG^{d}		
China	Gu and Vlosky (2008)	Regr			NS	NS	NS	SIG	NS	NS		SIG	SIG	SIG		SIG	SIG
China	Peng et al. (2015)	Regr	SIG	SIG	NS	SIG/ NS^{b,e}	NS		SIG	NS		SIG	SIG	SIG/NS^{e}			SIG/NS^{e}

China	Zhu (2015)	Regr	SIG	SIG/NS[f]	SIG/NS[f]	SIG/NS[b,e]		NS	SIG	NS			NS				SIG/NS[f]
Taiwan	Liu et al. (2012)	Regr	SIG[b]	SIG[b]						SIG			SIG			SIG	NS
UK	Brimblecombe et al. (2017)	Corr		SIG		NS		NS									
UK	Brimblecombe et al. (2017)	Regr		SIG/NS[g]		NS											
Finland	Kröger et al. (2019)	Corr	SIG		NS	NS			NS	NS		NS	NS			NS	
Finland	Kröger et al. (2019)	Regr	NS		NS	NS			NS	NS		SIG	NS			SIG/NS[h]	
Total[i]			**SIG**	**SIG**	**NS**	**NS**	**NS**	**NS**	**SIG**	**NS**	**NS**	**SIG**	**SIG**	**SIG/NS**	**SIG/NS**	**SIG/NS**	**SIG/NS**

SIG significant association, *NS* no significant association

[a] Unmet needs more likely in non-metropolitan areas

[b] Significant association, but in opposite direction

[c] According to population size of municipality

[d] The order of alternatives from highest to lowest odds was mix of formal, informal, and private care; formal care; mix of formal and informal care; mix of informal and private care; informal care; private care

[e] Significant association in rural but not urban areas

[f] Significant association in urban but not rural areas

[g] Different results for self-reporting and proxy-reporting

[h] No statistical difference between the two cities, but unmet needs more common among those living outside city centres

[i] SIG: Most analyses show a significant association. SIG/NS: Around half of the analyses show a significant association. NS: Most analyses show no significant association

living in a rural area and having low levels of income become a risk for care poverty. Health status, too, showed a significant association to relative care poverty. On the other hand, gender, marital status, ethnicity, and home ownership are clearly not predictive of relative care poverty, but when it comes to these factors and absolute care poverty, researchers are divided. For the factors of informal networks, and primary source of care, the results are more mixed in terms of relative care poverty.

Factors of Practical Care Poverty

When turning to look at IADL-based needs, the most striking observation is how few studies have examined the factors of unmet practical care needs. Only five studies were located; two use the absolute while three use the relative approach. Hence, the findings of all the available studies are presented in only one table (Table 5.3).

This time, there is no hesitation about whether a low level of income is a significant factor of unmet needs: all available analyses confirm the connection, although none use the absolute approach. The only other factors proven to have a significant relation to practical care poverty by the majority of studies are health status and number of IADL limitations (the latter analysed by only one study). Still, some of these studies used varying measurements, and one shows those in good health as more likely to have unmet needs. Conversely, several variables are found to not explain practical care poverty: gender, ethnicity, education, home ownership, residential area, and region (though for four of these variables, evidence is available from a single study only). Results are mixed for age, marital status, living arrangement, informal networks, and primary source of care.

When comparing the results for practical care poverty to those for personal care poverty, some dissimilarities emerge. Living alone seems to have a stronger connection with personal care poverty than with practical care poverty. In both domains, income level can explain relative care poverty but not necessarily absolute care poverty. Meanwhile, education does not explain either kind of unmet need. However, the lack of studies restricts the possibilities to draw conclusions.

Table 5.3 Factors of practical care poverty

Measurement of care poverty	*Country*	*Study*	*Correlation or regression analysis*	*Health (poorer)*	*IADL limitations (more)*	*Age (older)*	*Gender (female)*	*Marital status (not married)*	*Ethnicity (minority)*	*Income (poorer)*	*Education (lower)*	*Home ownership (rented)*	*Residential area (rural)*	*Living arrangement (alone)*	*Informal networks (weaker)*	*Primary source of care (informal)*	*Region*
Absolute	US	Tennstedt et al. (1994)	Regr			SIG^{a}								SIG	SIG	SIG	
Absolute	UK	Vlachantoni (2019)	Corr	SIG^{b}		NS^{b}	SIG^{b}	SIG^{b}			NS^{b}	NS^{b}		SIG^{b}			
Absolute	UK	Vlachantoni (2019)	Regr	SIG^{a}		SIG^{a}	SIG^{a}	SIG^{a}			NS	NS		NS			
Relative	US	Allen and Mor (1997)	Regr		SIG	NS	NS	NS	NS	SIG	NS			NS	NS		
Relative	Spain	Otero et al. (2003)	Corr	SIG/NS^{c}		NS				SIG	SIG/NS^{c}			SIG/NS^{c}		NS	
Relative	Spain	Otero et al. (2003)	Regr	NS		SIG/NS^{c}	NS			SIG	SIG/NS^{c}			NS			

(*continued*)

Table 5.3 (continued)

Measurement of care poverty	*Country*	*Study*	*Correlation or regression analysis*	*Health (poorer)*	*IADL limitations (more)*	*Age (older)*	*Gender (female)*	*Marital status (not married)*	*Ethnicity (minority)*	*Income (poorer)*	*Education (lower)*	*Home ownership (rented)*	*Residential area (rural)*	*Living arrangement (alone)*	*Informal networks (weaker)*	*Primary source of care (informal)*	*Region*
Relative	Finland	Kröger et al. (2019)	Corr	SIG		SIG	NS			SIG	NS		NS	SIG			NS
Relative	Finland	Kröger et al. (2019)	Regr	SIG		SIG	NS			SIG	NS		NS	SIG			NS
Total[d]				**SIG**	**SIG**	**SIG/NS**	**NS**	**SIG/NS**	**NS**	**SIG**	**NS**	**NS**	**NS**	**SIG/NS**	**SIG/NS**	**SIG/NS**	**NS**

SIG significant association, *NS* no significant association.

[a] Significant association, but in the opposite direction

[b] In comparison to the whole sample (including those with no care needs)

[c] Significant association for ‘weekly needs’, but not ‘monthly needs’

[d] SIG: Most analyses show a significant association. SIG/NS: Around half of the analyses show a significant association. NS: Most analyses show no significant association

Factors of Personal-Practical Care Poverty

As seen in Chap. 4, many studies analyse unmet care needs without making a clear distinction between ADL- and IADL-based needs. Among them, the number of studies using the absolute approach is rather close to those using the relative approach. Within research using the absolute approach, three studies analysed factors of unmet needs in two different countries.

In most studies, five variables are proven significant for absolute personal-practical care poverty: health, number of functional limitations, marital status, living arrangement, and informal networks (Table 5.4). However, the evidence is not always very strong. Health was included only twice and informal networks four times (and in the latter case, one of the studies connected strong networks, not weak ones, with unmet needs). In the case of functional limitations, three studies report different results for ADL limitations and IADL limitations. Once again, care poverty was not explained by gender, education level, or home ownership. This time income proved insignificant, as well. The situation was less clear for age. Other unclear cases involved the variables of ethnicity, residential area, region, and access to formal care.

In the case of relative personal-practical care poverty, for the first time, a clear majority of the variables prove to be significant factors of a lack of adequate care (Table 5.5). Only education and home ownership (with the latter analysed in just one study) do clearly not associate with unmet needs. For marital status, ethnicity, informal networks, and access to formal care, the evidence is mixed. According to most findings, all other factors are associated with unmet needs. So this time, there are as many as nine significant factors of care poverty; gender, age, primary source of care, and region are included in this list for the first time.

Evidence is strongest for functional limitations and income in that each had only one analysis fail to confirm a connection to unmet needs. The same goes to region and health status, but they were included in fewer studies. Primary source of care was connected to unmet needs, but it was those with a mix of formal and informal care, not those who had only informal carers, who most typically were in care poverty. Living alone was once again identified as a factor of unmet needs. Gender and

Table 5.4 Factors of absolute personal-practical care poverty

Country	*Study*	*Correlation or regression analysis*	*Health (poorer)*	*I/ADL limitations (more)*	*Age (older)*	*Gender (female)*	*Marital status (not married)*	*Ethnicity (minority)*	*Income (poorer)*	*Education (lower)*	*Home ownership (rented)*	*Residential area (rural)*	*Living arrangement (alone)*	*Informal networks (weaker)*	*Region*	*Access to formal care (no)*
US and UK	Davey and Patsios (1999)	Regr	SIG	SIG	NS	NS					NS			SIG		
US	Lima and Allen (2001)[a]	Regr		SIG/ NS[b]	NS	NS	SIG	SIG/NS[c]	NS	NS			SIG[d]			SIG
US	Gibson and Verma (2006)[a]	Corr		SIG[e]	SIG[e]	NS	SIG	SIG	SIG	SIG[e]		SIG	SIG		SIG	NS
US	Gibson and Verma (2006)[a]	Regr			NS	NS		NS	NS	NS		NS	SIG		NS	SIG
US	Davey et al. (2013)	Corr		SIG	NS	NS		NS		NS			SIG		SIG	
US and Sweden	Shea et al. (2003)	Regr		SIG/ NS[b]	SIG[e]	NS				NS			SIG			
France and Ireland	Gannon and Davin (2010)	Regr		SIG/ NS[b]	NS	SIG[e]			SIG	NS			NS			
India	Ashokkumar et al. (2012)	Corr	SIG	SIG	SIG	NS	SIG		SIG/NS[f]	NS			SIG	NS		
Slovenia	Hlebec et al. (2016)	Regr		SIG[g]	SIG	NS			NS	NS		SIG	NS[h]	SIG[e,i]		

China	Zhu and Österle (2017)	Regr		SIG	SIG	SIG[e]	SIG		NS	SIG		NS		SIG		
China	Hu and Wang (2019)	Regr[j]		NS			SIG					NS	SIG			NS
China	Hu and Wang (2019)	Regr[k]		SIG			NS					SIG	NS			SIG
Total[l]			**SIG**	**SIG**	**SIG/NS**	**NS**	**SIG**	**SIG/NS**	**NS**	**NS**	**NS**	**SIG/NS**	**SIG**	**SIG**	**SIG/NS**	**SIG/NS**

SIG significant association, *NS* no significant association.

[a] Compared not to those with needs met, but to those having ‘inadequate help’ (i.e., those in relative care poverty)

[b] Different results for ADLs and IADLs

[c] People with unmet needs were more likely to be Black or ‘other’, but not Hispanic

[d] Fewer persons in household

[e] Significant association, but in the opposite direction

[f] Connection with financial status (fully dependent or not), but not with family income (under or over 4350 Rs per month)

[g] GALI (Global Activity Limitation Indicator) limitations

[h] Not living with a spouse

[i] Three or more persons in household

[g] Probit regression

[k] Poisson regression

[l] SIG: Most analyses show a significant association. SIG/NS: Around half of the analyses show a significant association. NS: Most analyses show no significant association

Table 5.5 Factors of relative personal-practical care poverty

Country	*Study*	*Correlation or regression analysis*	*Health (poorer)*	*I/ADL limitations (more)*	*Age (older)*	*Gender (female)*	*Marital status (not married)*	*Ethnicity (minority)*	*Income (poorer)*	*Education (lower)*	*Home ownership (rented)*	*Residential area (rural)*	*Living arrangement (alone)*	*Informal networks (weaker)*	*Primary source of care (informal)*	*Region*	*Access to formal care (no)*
US	Lima and Allen (2001)	Regr		SIG	SIG[a]	SIG	SIG	SIG	NS	NS			SIG[b]				NS
US	Gibson and Verma 2006	Corr		SIG	SIG[a]	SIG	SIG	SIG	SIG	SIG[a]		SIG[a]	SIG			SIG	SIG
US	Gibson and Verma (2006)	Regr			NS	NS		NS	SIG	NS		SIG[a]	SIG			SIG[c]	SIG
US	Schure et al. (2015)	Regr	NS	SIG[d]	NS	NS	NS			NS			NS	SIG[a]			
Canada	Lévesque et al. (2004)	Corr	SIG		SIG	SIG	NS						NS	NS			
Canada	Lévesque et al. (2004)	Regr	SIG		SIG	SIG											
Canada	Carrière (2006)	Corr													SIG[e]		

Canada	Busque and Légaré (2012)	Regr		SIG	SIG[f]	NS			NS			NS		SIG[g]
France	Davin et al. (2006)	Regr			SIG[a]	NS		SIG	NS		NS	SIG		
Spain	Rogero-García and Ahmed-Mohamed (2011)	Corr		SIG	NS	SIG		SIG	SIG		SIG[a,h]	SIG		
Spain	Rogero-García and Ahmed-Mohamed (2011)	Regr		SIG	NS	SIG		SIG	NS		SIG[a,h]	SIG	SIG[i]	
New Zealand	Wilkinson-Meyers et al. (2014)	Regr	SIG	NS[j]	SIG	SIG	NS		NS	NS	NS	SIG		NS

(continued)

Table 5.5 (continued)

Country	*Study*	*Correlation or regression analysis*	*Health (poorer)*	*I/ADL limitations (more)*	*Age (older)*	*Gender (female)*	*Marital status (not married)*	*Ethnicity (minority)*	*Income (poorer)*	*Education (lower)*	*Home ownership (rented)*	*Residential area (rural)*	*Living arrangement (alone)*	*Informal networks (weaker)*	*Primary source of care (informal)*	*Region*	*Access to formal care (no)*
Total[k]			**SIG**	**SIG**	**SIG**	**SIG**	**SIG/NS**	**SIG/ NS**	**SIG**	**NS**	**NS**	**SIG**	**SIG**	**SIG/NS**	**SIG**	**SIG**	**SIG/ NS**

SIG significant association, *NS* no significant association

[a] Significant association, but in the opposite direction

[b] Fewer persons in household

[c] Unmet needs most likely in eastern and southern parts of the country

[d] Unmet needs most likely among those who have at least five I/ADL limitations

[f] Unmet needs most likely among those receiving a mix of formal and informal care, and less likely among those receiving either formal or informal care

[g] Age groups 70–74 and 75–79 had a higher likelihood of unmet needs than groups aged 65–69, 80–84, and 85+

[h] Unmet needs most likely in Quebec and British Columbia

[i] According to population size of municipality

[j] Order of alternatives from highest to lowest odds was mix of formal, informal, and private care; formal care; mix of formal and informal care; mix of informal and private care; informal care; private care

[k] Nottingham Everyday Activities of Daily Living (NEADL)

[l] SIG: Most analyses show a significant association. SIG/NS: Around half of the analyses show a significant association. NS: Most analyses show no significant association

age were proven, for the very first time, to be significant in most studies; however, the people found most likely to have unmet needs were often not in the oldest age groups. Residential area was a significant factor, as well, but it was urban—not rural—areas that were at higher risk for care poverty.

As already mentioned, the results for absolute and relative personal-practical care poverty are different in some respects. Gender and income that were non-significant for absolute care poverty were significant factors of relative care poverty. As well, a few factors that had mixed results for absolute care poverty (age, residential area, and region) turned out to be significant in the case of relative unmet care needs. There are also a number of similarities. Health status, functional limitations, and living arrangement affected absolute as well as relative personal-practical care poverty. Educational level and home ownership status remained non-significant for both.

If the results for personal-practical care poverty are juxtaposed with those for personal and practical care poverty, demonstrably influential factors are partly the same and partly different. Health and functional limitations are significant in almost all areas. The same goes for living arrangements. Income seems to be associated with relative care poverty more strongly than absolute care poverty across domains. Overall, several socio-demographic variables as well as indicators of the availability of care are connected with personal-practical care poverty, especially when measured using the relative approach. Informal networks, region, and primary source of care all emerge more visibly than before as factors of personal-practical care poverty. The same may be said for marital status and age. Education and home ownership remain non-significant here, and the evidence remains mixed for gender, ethnicity, and access to formal care.

Factors of Socio-emotional Care Poverty

In Chap. 4, rates of socio-emotional care poverty were sought from research literature on loneliness. So, too, are its factors in this chapter. As this literature includes hundreds or possibly thousands of individual studies, a complete review is beyond the scope of this chapter. Factors associated with loneliness—and thus, socio-emotional care poverty—are identified here based on the five international comparisons of loneliness referred to in Chap. 4. Of these five publications, one (Yang & Victor, 2011) does not analyse factors of loneliness. While the four other studies run multivariate regression analyses for this issue, their findings are reported in slightly different ways: Hansen and Slagsvold (2016), Fokkema et al. (2012), and Vozikaki et al. (2018) report factors at only an international level, while Sundström et al. (2009) report findings at only a national level (Table 5.6). The studies also use somewhat dissimilar sets of independent variables. These sets exclude several of the factors that were included in studies of unmet personal and practical care needs.

Sundström et al. (2009) found that both poor health and living alone explain loneliness most consistently across different countries. For every country subject to study, living arrangement was a factor of loneliness; self-rated health was also significant in all but three nations. On the other hand, age was shown to have a significant association with loneliness in only one country. Likewise, gender was significant in no more than three nations. Level of education was a significant factor in 4 of the 11 countries.

Both using SHARE data, Fokkema et al. (2012) identified more factors of loneliness than Sundström et al. (2009) did: in addition to poor health, they found that age (older), gender (female), marital status (not married), and level of income (lower) all explained the rates of loneliness found in their international data. The number of IADL limitations was significantly linked to loneliness, but the number of ADL limitations was not. Vozikaki et al. (2018) used SHARE data as well, albeit from another wave. They included a mostly different set of independent variables in their analysis. Their findings show that, aside from living alone, marital status and the combined number of ADL/IADL limitations can be significant factors of loneliness. For their part, Hansen and Slagsvold (2016) analysed GGS data to identify health, income level, education, and living arrangement as significant factors of loneliness within the population group aged 60–80 years.

The four studies tested the explanatory power of somewhat different independent variables. Not all of them report non-significant relations, either, and both issues complicate drawing conclusions. Nevertheless, all

Table 5.6 Factors of socio-emotional care poverty

Study	*Country*	*Health (poorer)*	*I/ADL limitations (more)*	*Age (older)*	*Gender (female)*	*Marital status (not married)*	*Income (lower)*	*Education (lower)*	*Living arrangement (alone)*
Sundström et al. (2009)	Austria	SIG		NS	NS			NS	SIG
	Belgium	SIG		NS	NS			NS	SIG
	Denmark	NS		NS	NS			NS	SIG
	France	SIG		NS	SIG			SIG	SIG
	Germany	SIG		NS	NS			SIG	SIG
	Greece	SIG		NS	SIG			NS	SIG
	Israel	SIG		NS	NS			SIG	SIG
	Italy	NS		NS	NS			NS	SIG
	Netherlands	SIG		NS	NS			NS	SIG
	Spain	SIG		NS	SIG			SIG	SIG
	Sweden	NS		SIG	NS			NS	SIG
	11 countries[a]	SIG		NS	NS			NS	SIG
Fokkema et al. (2012)	14 countries	SIG	SIG/NS[b]	SIG	SIG	SIG	SIG	NS	
Hansen and Slagsvold (2016)	11 countries	SIG					SIG	SIG	SIG
Vozikaki et al. (2018)	11 countries		SIG			SIG			SIG
Total[a]		**SIG**	**SIG**	**SIG/NS**	**SIG/NS**	**SIG**	**SIG**	**SIG/NS**	**SIG**

Based on loneliness studies

SIG significant association, *NS* no significant association

[a] SIG: Most analyses show a significant association. SIG/NS: Around half of analyses show a significant association. NS: Most analyses show no significant association

[b] Results differ for ADLs (NS) and IADLs (SIG)

studies support living arrangements and health as significant factors of loneliness in a rather large number of countries. A low level of income is also an indisputable factor. Being married seems to be a protective factor against loneliness, which is not surprising. The role of a number of functional limitations remains a bit open, and it may be that loneliness is linked to practical care needs more closely than personal care needs. For age, gender, and education level, the verdict is not unanimous, and their impacts vary across countries.

When these results are compared to existing reviews of loneliness studies, the same factors emerge. For example, Routasalo and Pitkälä (2003) observe that population-based studies link loneliness most strongly to age, living alone, a lack of physical function, and poor health. Evidence on gender and marital status was contradictory, while evidence for the impact of income and education remained weak. A more recent review by Cohen-Mansfield et al. (2016) summarised findings from 38 loneliness studies to conclude that the following variables are mostly strongly associated with loneliness of older adults: gender, marital status, age, level of income, level of education, living arrangement, quality of social relationships, self-reported health, and functional status.

Conclusions

When the factors for all domains and measurements of care poverty are gathered together, many similarities emerge (Table 5.7). Most factors seem to explain either (nearly) all of the domains for care poverty or none of them. Those factors with contradictory results are usually found in more than one domain.

The domains of care poverty are explained most consistently by health and functional status. This is not surprising but not self-obvious, either: while the level of care needs is closely connected to health status and functional limitations, the level of unmet needs need not be. When people with long-term care needs have access to necessary support, those with poorer health and more functional limitations need not have a higher likelihood of care poverty than anyone else. But in reality, functional status is significantly connected to all three domains of care poverty, and the results are very similar for health status.

Table 5.7 Factors of care poverty

	Health and functional status		*Socio-demographic factors*								*Availability of informal and formal care*				
	Health (poorer)	*I/ADL limitations (more)*	*Age (older)*	*Gender (female)*	*Marital status (not married)*	*Ethnicity (minority)*	*Income (lower)*	*Education (lower)*	*Home ownership (rented)*	*Residential area (rural)*	*Living arrangement (alone)*	*Informal networks (weaker)*	*Primary source of care (informal)*	*Region*	*Access to formal care (no)*
5.1 Absolute personal care poverty	SIG/NS	SIG	NS	SIG/NS	SIG/NS	SIG/NS	NS	NS	SIG/NS	NS	SIG	NS	NS		SIG
5.2 Relative personal care poverty	SIG	SIG	NS	NS	NS	NS	SIG	NS	NS	SIG	SIG	SIG/NS	SIG/NS	SIG/NS	SIG/NS
5.3 Practical care poverty	SIG	SIG	SIG/NS	NS	SIG/NS	NS	SIG	NS	NS	NS	SIG/NS	SIG/NS	SIG/NS	NS	
5.4 Absolute personal-practical care poverty	SIG	SIG	SIG/NS	NS	SIG	SIG/NS	NS	NS	NS	SIG/NS	SIG	SIG		SIG/NS	SIG/NS
5.5 Relative personal-practical care poverty	SIG	SIG	SIG	SIG	SIG/NS	SIG/NS	SIG	NS	NS	SIG	SIG	SIG/NS	SIG	SIG	SIG/NS
5.6 Socio-emotional care poverty	SIG	SIG	SIG/NS	SIG/NS	SIG		SIG	SIG/NS			SIG				
Total	**SIG**	**SIG**	**SIG/NS**	**NS**	**SIG/NS**	**NS**	**SIG**	**NS**	**NS**	**SIG/NS**	**SIG**	**SIG/NS**	**SIG/NS**	**SIG/NS**	**SIG/NS**

SIG most studies show significant association, *SIG/NS* around half of the studies show a significant association, *NS* most studies show no significant association

Despite some variation across socio-demographic factors, they generally prove not to be the strongest factors of care poverty. Nevertheless, income is associated with different domains of care poverty—especially when measured using the relative approach. On the one hand, several studies show a significant association between care poverty and the following factors: age, marital status, and residential area. On the other hand, these same factors are very regularly demonstrated not to predict the level of unmet need. Marital status explains lack of socio-emotional care and absolute personal-practical care, but not relative personal care. Age explains care poverty in terms of relative personal-practical care, but not absolute or relative personal care. Residing in a rural area is significantly connected to care poverty in terms of relative personal and personal-practical care, but not absolute personal care or practical care. The results thus vary not just across domains, but also across absolute and relative measurements within certain domains.

Out of all of the socio-demographic factors, the following generally seem not to predict care poverty: education level, home ownership, ethnicity, and gender. The results for education and home ownership are almost fully consistent in this respect, but gender and ethnicity show somewhat more variation. This is because ethnicity is not a clear factor of any domain and age is only a factor of relative personal-practical care poverty. Chapter 7 will further discuss the connections between socio-demographic factors and care poverty.

Finally, the third group of factors indicating the breadth of informal and formal support show rather contradictory findings. Living arrangement holds explanatory power in almost all domains of care poverty: evidence showing its strength as a key factor of unmet care needs is almost fully consistent. But the findings are considerably less clear for the other care availability factors. They were included in only a few studies and measured rather variably, and they received variable results. The existence of informal networks seems to explain care poverty in terms of absolute personal-practical care poverty, but not absolute personal care. The same goes for the primary source of care. Region is associated with care poverty in terms of relative personal-practical care, but not practical care. Results concerning access to formal care are mixed in all domains. We will come back to this factor in Chap. 8, which looks at care poverty across different long-term care systems.

Almost all publications concerning unmet needs include a literature review, listing factors that earlier research has identified as factors of unmet care needs. For example, Li (2006, 169–170) writes:

> Empirical evidence has shown that unmet needs are determined by a combination of demographic, socio-economic, functional and physical health, health insurance coverage, support network, and cultural factors. Researchers have found that older adults who are older, female, impoverished, and of minority status are at the particular risk of not having their service needs met. Researchers also have found that clients' functional and physical health factors are consistently related to their unmet needs for home care services.

Usually, these reviews cover literature that is limited and mostly American. This chapter has provided a broader review of the research carried out in different parts of the world. It has aimed to compare like with like—to organise studies according to the domains of need they examine and the approach to measurement they use. Nevertheless, the conclusions of this chapter are still very much in line with those of Li (2006) and other earlier studies. The factors proven to influence the likelihood of unmet needs most universally are neither surprising nor new: health status, functional status, living arrangement, and income level. Significant factors are mostly the same across different care poverty domains, as well as for both absolute and relative care poverty. Even different national contexts do not introduce radical differences to these results.

Evidence shows that a low level of income is a significant factor, which means that poverty and care poverty are interlinked. The strength of this connection varies, however; for all domains, it is absent or unclear for absolute care poverty but substantial for relative care poverty. People with a low level of income are thus at particular risk for relative unmet care needs. Still, income is not the only or even the strongest factor of care poverty. Self-reported poor health, living alone, and the number of functional limitations are the most undisputed factors across different domains of care poverty. In terms of the three different kinds of care needs, people with these conditions consistently make up the primary risk groups for receiving insufficient support or no assistance at all.

Education level and home ownership were systematically shown not to be associated with care poverty, which was unanticipated. Even more unexpectedly, gender and ethnicity proved insignificant in most studies. Some studies even show that men are more likely to have unmet needs than women. When other variables (especially health and functional status) are controlled, ethnicity and gender do not independently influence care poverty. While older women still make up the majority of people with unmet needs and while care poverty is widespread among racial and ethnic minorities, it is other factors—living alone, poor health, a high number of I/ADL limitations, and low-income—that statistically explain their care poverty.

Other variables included in the review proved to be more context dependent. The country, specific sample, care poverty domain, and measurement approach affected the explanatory strength of age, marital status, residential area, informal networks, primary source of care, region, and access to formal care. In some cases, these factors were significant. In other cases, they were not.

All in all, the findings show that care poverty is due to several factors. A low level of income is among the key factors. However, it is joined by health and functional status as well as living arrangement. Older people with major care needs who live alone are at highest risk for care poverty. When they also have a low income level, the hazards of unmet care needs are exacerbated.

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6

Consequences of Care Poverty

Care poverty results from a number of different factors, many of which are permeated by social inequalities. But does care poverty actually matter? That is, does it have consequences for the everyday life of older people or for society in general? It could be that even though some older people fail to receive adequate support, this failure has little effect on their overall well-being and health. Perhaps this condition does not actually bring about any noteworthy negative implications for social and health care systems, either. If care poverty has no negative consequences for older people or society at large, it is not a major social problem after all. This would mean that it does not deserve much attention from researchers or policy-makers. So, the question of whether or not care poverty has major consequences becomes decisive. What does the evidence say?

The consequences of the unmet needs of older people are not studied in gerontology as regularly as their factors or their prevalence. Several studies have nonetheless examined the issue—once again, most often in the United States, though some research is also available from Canada, the United Kingdom, Spain, China, and Malaysia (Table 6.1). When it comes to factors that cause care poverty (Chap. 5), studies typically use a

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Table 6.1 Consequences of personal and practical care poverty

Domain of care poverty	Measurement of care poverty	Country	Study	Adverse consequences (more)	Depression (more)	Emotional well-being (lower)	Mortality (higher)	Health care use (more)	Residential care placements (more)
Personal	Relative	US	Allen and Mor (1997)	SIG	SIG			SIG	
Personal	Relative	US	Desai et al. (2001)	SIG					
Personal	Absolute	Spain	Tomás Aznar et al. (2002)		SIG[a]				
Personal	Relative	Spain	Otero et al. (2003)		SIG[a]			SIG	
Personal	Relative	US	Gaugler et al. (2005)				SIG		SIG
Personal	Relative	US	Komisar et al. (2005)	SIG					
Personal	Absolute	US	Sands et al. (2006)		NS			SIG	SIG
Personal	Relative	US	Xu et al. (2012)					SIG	
Personal	Relative	US	DePalma et al. (2013)					SIG	
Personal	Relative	US	He et al. (2015)				SIG/NS[b]		

Personal	Relative	China	Zhen et al. (2015)				SIG/NS[c]	
Practical	Relative	US	Allen and Mor (1997)	SIG	SIG			NS
Practical	Relative	Spain	Otero et al. (2003)		SIG/NS[d]			
Personal-practical	Relative	US	LaPlante et al. (2004)	SIG				
Personal-practical	Relative	Canada	Lévesque et al. (2004)			SIG		SIG/NS[e]
Personal-practical[f]	Relative	US	Li et al. (2005)			SIG[g]		SIG
Personal-practical	Absolute and relative	US	Gibson and Verma (2006)			SIG		SIG
Personal-practical	Absolute	Malaysia	Momtaz et al. (2012)					
Personal-practical[f]	Relative	US	Allen et al. (2014)	SIG				
Personal-practical	Absolute and relative	US	Freedman and Spillman (2014)	SIG				
Personal-practical	Absolute and relative	Canada	Turcotte (2014)			SIG		

(*continued*)

Table 6.1 (continued)

Domain of care poverty	Measurement of care poverty	Country	Study	Adverse consequences (more)	Depression (more)	Emotional well-being (lower)	Mortality (higher)	Health care use (more)	Residential care placements (more)
Personal-practical[f]	Absolute	UK	Dunatchik et al. (2016)			NS			
Personal-practical	Absolute	China	Hu and Wang (2019)		SIG/NS[h]				
Total[i]				**SIG**	**SIG**	**SIG**	**SIG/NS**	**SIG**	**SIG**

SIG: Significant association; NS: No significant association

[a] Significant association, but in opposite direction

[b] Significant association with one or two (but not with three or more) ADL limitations

[c] Significant association in urban areas for both 65–84 and 85+ age groups. In rural areas no significant association for the 65–84 age group; for the 85+ age group significant association, but in opposite direction

[d] Significant association with some part of the unmet IADLs ('monthly needs'), but not with other parts ('weekly needs')

[e] Significant association for emergency department visits, but not for hospital admissions

[f] Unmet needs not measured by I/ADLs

[g] Emotional strain for informal caregiver

[h] Significant association in rural areas, but not in urban areas

[i] SIG: Most analyses show a significant association. SIG/NS: Around half of the analyses show a significant association. NS: Most analyses show no significant association

roughly similar and lengthy list of variables (e.g., health status, socio-economic factors, living arrangements) in their analyses. But when it comes to research on the consequences of care poverty, studies usually focus on a limited number of issues. For example, they might concentrate on older people's depression or on their use of social and health care. Some studies use the term ‘adverse consequences’, which covers a number of different negative outcomes related to unmet needs.

Both the narrower focus and limited number of studies mean that there is considerably less evidence regarding the consequences of care poverty compared to its rates or factors. As a result, the studies are in this chapter presented in a way that is different from earlier chapters. Instead of organising sections mainly according to care poverty domains and measurement approaches, the chapter is structured around specific negative consequences—starting with so-called adverse consequences, continuing with other consequences to health and well-being, and concluding with consequences for the use of social and health care.

Adverse Consequences

Allen and Mor (1997, p. 1135) were among the first researchers to analyse whether unmet care needs have negative consequences, writing about ‘consequences or adverse events attributable to inadequate help at home’. The authors outlined a list of potential consequences that could be caused by inadequate help with specific ADLs and IADLs, then tested whether older people (or younger, disabled people) suffered from these consequences. A number of other, mostly American researchers have later followed the same approach, shortening the term to ‘adverse outcomes’ or ‘adverse consequences’. Concerning these outcomes of care poverty, some separation of the findings into different domains is even possible. As earlier, we begin with personal care poverty before moving to practical care poverty and socio-emotional care poverty.

Adverse Consequences of Personal Care Poverty

The pioneer study of Allen and Mor (1997) showed that people often experience several negative consequences of unmet needs (Tables 6.2 and 6.3). They found that the most common ADL-based 'adverse events' were wetting or soiling oneself (33% of people aged 65+ with need for help in the ADL), being unable to bathe as often as one would like (29%), falling (22%), and feeling uncomfortable due to being unable to go to the toilet (21%). Of personal care needs, toileting, bathing, and transferring were thus most likely to bring problems to older people. Almost all tested consequences showed a statistically significant increase among respondents with unmet needs.

Soon after, Desai et al. (2001) followed with their analysis of the 'adverse outcomes' of unmet needs among people aged 70+. Nearly half (48%) of those with unmet ADL needs reported experiencing a negative consequence. The study reported the prevalence of negative consequences among those with unmet need, while the Allen and Mor (1997) figures indicated the spread of adverse consequences across all with need. Nevertheless, toileting (51%), bathing (42%), and walking (40%) again topped the list of ADLs most likely to have adverse consequences. The study observed that, compared to those with one to two ADL-based care needs, those with three to four needs had twofold odds (OR = 2.04) of experiencing negative consequences. Meanwhile, those with five to seven needs had more than fourfold odds (OR = 4.67). Additionally, the likelihood of adverse outcomes was almost three times (OR = 2.78) greater among those whose annual income was under $20,000 compared to those with higher incomes.

LaPlante et al. (2004) examined the incidence of as many as 53 different adverse consequences of unmet needs. Interestingly, their findings also showed that according to self-reporting, the group without any unmet needs actually experienced many negative consequences. Regardless, the incidence of adverse consequences was still significantly higher among those with unmet needs. Serious consequences, such as wetting/soiling oneself (30%) or being dehydrated (12%), were also significantly more likely among those with unmet personal care needs. Living alone further increased the risk of negative consequences.

Freedman and Spillman (2014) found that one-third (32%) of community-dwelling older people with a care need experience at least one adverse consequence, which happens to be the same figure arrived at by Beach et al. (2020) in their study. Freedman and Spillman (2014) also observed that the share of older people having adverse consequences was highest among those who received formal home care (57%); compared to those who received only informal care (and those in residential care), the difference was statistically significant. Adverse consequences proved connected to most socio-demographic variables, being more common among low-income, non-married, and non-white groups of older people. For their part, Beach et al. (2020) found that older people with high care needs (having multiple chronic conditions or probable dementia, or nearing the end of life) experience adverse consequences of unmet needs more often than those whose needs are not so extensive.

'Dual eligibles', that is, low-income older people who are eligible to services from both Medicare and Medicaid, are a specific object of unmet need studies in the United States. Adverse consequences among this population have also been subject to study. Results from Komisar et al. (2005) recall the findings of the aforementioned studies on the general older population: wetting/soiling oneself (56% of those with the corresponding unmet need), falling out of bed or a chair (48%), and being unable to take a shower (42%) once again proved to be the most common adverse consequences of unmet care needs. Roughly one-quarter (23%) were unable to put on clean clothes, while nearly one-fifth (18%) went hungry. Overall, more than half (56%) of 'dual eligibles' with at least one unmet personal care need reported at least one of the five above-mentioned adverse consequences. Allen et al. (2014) likewise report that wetting/soiling oneself (43%) and being unable to move around indoors (26%) are the most typical adverse consequences. When compared to older people eligible only for Medicare, 'dual eligibles' make up a significantly higher share of people having to stay in bed and going without getting dressed.

Overall, almost all studies show wetting/soiling oneself to be the most typical adverse consequence of unmet personal care needs (Table 6.2). Negative consequences that are also very widespread include experiencing a fall or being unable to move inside, take a bath, or use the bathroom.

Table 6.2 Adverse consequences of personal care poverty

Country	Study	Age group	Wetting/ soiling oneself	Unable to use bathroom	Unable to bathe	Unable to get dressed	Went hungry	Went without clean clothes	Unable to get out of bed	Falls	Unable to move inside
US	Allen and Mor (1997)[a]	65+	33	21	29		5	7		22	5
US	Desai et al. (2001)[b]	70+		51	42	20	21				40
US	LaPlante et al. (2004)[b]	18+[c]	30	27	35	20	15	16	23	55	52
US	Komisar et al. (2005)[b, d]	67+	56/15		42/33	23/14	18/3			48/28	
US	Allen et al. (2014)[a]	65+	43		13	8	4		12		26
US	Freedman and Spillman (2014)[a]	65+	43		13	8	4		12		26
US	Beach et al. (2020)[a]	65+	8		4	3	1		5		10

[a] Share (%) of people with adverse consequence among those with care needs

[b] Share (%) of people with adverse consequence among those with unmet care needs

[c] The average age of the subsample with unmet needs was 60.4 years; it thus included many older people

[d] The first figure indicates the share (%) of people with adverse consequences among those with a related and specific unmet ADL need. The second figure indicates the share (%) of people with adverse consequences among those with any unmet ADL need

Adverse Consequences of Practical Care Poverty

Research into the adverse consequences of unmet practical care needs is very rare. No study focusing exclusively on this topic was located, but four of the aforementioned studies included IADLs in their analysis.

Allen and Mor's (1997) early study also examined unmet practical care needs to observe feeling distressed because housework was not done (31% of respondents with a care need) and being unable to go places for recreation (26%) as the most widespread IADL-based adverse consequences (Table 6.3). Thus in terms of practical care poverty, it was housekeeping and transportation in particular where failures seemed to cause negative consequences most regularly. LaPlante et al. (2004) found very similar results.

Two other analyses centred on mostly different consequences (Allen et al., 2014; Beach et al., 2020). They found that the most typical adverse consequences of practical care poverty were being unable to get out and making mistakes with medications. Being unable to go to places was also confirmed as a common negative consequence. While other consequences were more rare, a considerable group also missed doctor's appointments or went without groceries and clean laundry.

Allen and Mor (1997, p. 1144) conclude that 'both the serious and the more 'innocuous' consequences of inadequate help, such as not being able to bathe as often as one would like, having to wear dirty clothes, and living in a messy environment have serious quality-of-life implications for people with ongoing chronic conditions'. This highlights how the adverse consequences of unmet practical care needs can be equally serious as those for unmet personal care needs.

Adverse Consequences of Socio-emotional Care Poverty

Despite the massive volume of studies on loneliness among older people, the theme of adverse consequences is almost absent from this stream of literature. Recently, the term was mentioned in connection to loneliness and social isolation, but without a clear definition (Valtorta & Hanratty,

Table 6.3 Adverse consequences of practical care poverty

Country	Study	Age group	Distress of undone housework	Went without clean laundry	Went without groceries	Unable to get out	Unable to go to places due to lack of help	Made a mistake in taking medicines	Missed a doctor's appointment
US	Allen and Mor (1997)[a]	65+	31	3	7		26		12
US	LaPlante et al. (2004)[b]	18+[c]	39				22		13
US	Allen et al. (2014)[a]	65+		5	6	30	26	20	
US	Beach et al. (2020)[a]	65+		2	3	12		7	

[a] Share (%) of people with adverse consequence among those with care needs

[b] Share (%) of people with adverse consequence among those with unmet care needs

[c] The average age of the subsample with unmet needs was 60.4 years, and thus included many older people

2012; Smith & Victor, 2019). Empirical research on the issue is still at an early phase. This is actually unsurprising as in the unmet needs literature, adverse consequences specifically refer to the outcomes of lacking help with certain ADL-based (and in a few cases IADL-based) needs. For example, wetting/soiling oneself is clearly a result of inadequate help with toileting—not of inadequate socio-emotional support. The 'adverse consequence' term was thus originally created for a use that does not fit easily into research on socio-emotional deprivation. Nevertheless, some researchers such as Hwang et al. (2020), for example, have recently mentioned issues such as reduced sleep and suicide attempts as adverse consequences of social isolation and loneliness. The term 'adverse consequences' in the context of socio-emotional care poverty thus seems to refer to somewhat different content than in the case of unmet personal and practical care needs. However, this research is only emerging.

Cognitive Function and Physical Health

For the area of adverse consequences, there is more research into personal and practical care poverty than socio-emotional care poverty. Still, there are other consequences that have been examined considerably more in the context of loneliness and social isolation than of unmet personal and practical care needs (Table 6.4).

Cognitive function is one such topic: reviews confirm that loneliness and social isolation are significant risk factors for dementia and cognitive decline (Routasalo & Pitkälä, 2003; Luanaigh & Lawlor, 2008; Crewdson, 2016). Mushtaq et al. (2014) conclude that loneliness is associated with a more than twofold risk of dementia, while a meta-analysis by Kuiper et al. (2015) finds a 58% increase in the risk of dementia among lonely older people (RR = 1.58). Hawkley and Cacioppo (2010) further confirm that, left unattended to, loneliness has serious consequences for cognition. Social isolation has also been associated with weaker cognitive function late in life (Evans et al., 2019). One systematic review reports that loneliness is significantly and negatively correlated with cognitive function, but controlling for other demographic and psychosocial risk

Table 6.4 Consequences of socio-emotional care poverty[a]

Measurement of care poverty	Study	Cognitive function (poorer)	Physical health (poorer, more problems)	Depression (more)	Emotional well-being (weaker)	Mortality (higher)	Health care use (more)	Residential care placements (more)
Absolute	Ouimet et al. (2001)			SIG				
Absolute	Routasalo and Pitkälä (2003)	SIG				SIG		
Relative	Routasalo and Pitkälä (2003)	SIG	SIG			SIG	SIG	SIG
Relative	Luanaigh and Lawlor (2008)	SIG	SIG	SIG	SIG			
Relative	Hawkley and Cacioppo (2010)	SIG	SIG	SIG	SIG	SIG		
Absolute	Steptoe and Kivimäki (2013)		SIG					
Relative	Mushtaq et al. (2014)	SIG	SIG	SIG	SIG			
Relative	Boss et al. (2015)	SIG/NS						

Absolute	Holt-Lunstad et al. (2015)					SIG	
Relative	Holt-Lunstad et al. (2015)					SIG	
Absolute[c]	Choi et al. (2015)			SIG/NS	SIG/NS		
Relative[c]	Choi et al. (2015)			SIG	SIG		
Relative	Kuiper et al. (2015)	SIG					
Relative	Petitte et al. (2015)		SIG				
Relative	Crewdson (2016)	SIG	SIG	SIG			
Absolute	Valtorta et al. (2016)		SIG				
Relative	Valtorta et al. (2016)		SIG				
Absolute	Courtin and Knapp (2017)		SIG	SIG/NS		SIG/NS	SIG

(*continued*)

Table 6.4 (continued)

Measurement of care poverty	Study	Cognitive function (poorer)	Physical health (poorer, more problems)	Depression (more)	Emotional well-being (weaker)	Mortality (higher)	Health care use (more)	Residential care placements (more)
Relative	Courtin and Knapp (2017)		SIG	SIG		SIG/NS	SIG/NS	
Absolute	Evans et al. (2019)	SIG						
Total[b]		**SIG**	**SIG**	**SIG**	**SIG**	**SIG**	**SIG**	**(SIG)**

SIG: Significant association; NS: No significant association

[a] Based on studies of loneliness and social isolation

[b] SIG: Most analyses show a significant association. SIG/NS: Around half of the analyses show a significant association. NS: Most analyses show no significant association

[c] The review speaks of 'objective social isolation' and 'subjective social isolation'. Here, the first term is understood to mean absolute socio-emotional care poverty, while the latter term refers to relative socio-emotional care poverty

factors weakens the statistical connection (Boss et al., 2015). In general, however, the evidence for loneliness as a major predictor of cognitive decline is strong.

Also more generally, health outcomes have been a major area for loneliness research. In Courtin and Knapp's (2017) scoping review, all but 2 of 128 articles found that isolation or loneliness had a detrimental effect on health of older people. Luanaigh and Lawlor (2008) conclude that loneliness has a significant impact on, for example, higher blood pressure and immune stress responses. Coronary heart disease is among the most studied consequences of loneliness and social isolation. Valtorta et al.'s (2016) review concludes that deficiencies in social relationships are associated with an increased risk of developing coronary heart disease and stroke; meta-analyses by Steptoe and Kivimäki (2013) showed a 1.5-fold risk of coronary heart disease among adults experiencing social isolation. According to Mushtaq et al.'s (2014) review, loneliness leads not only to heart disease but also to a long list of other health problems including diabetes, rheumatoid arthritis, lupus, hypertension, and cancer. A review by Petitte et al. (2015) concludes that loneliness is a significant biopsychosocial stressor prevalent in adults with heart disease, hypertension, stroke, and lung disease. Though the mechanisms through which loneliness and social isolation affect physical health are still mostly unknown, there is a large and almost unanimous evidence base showing that deprivation of social and emotional needs leads to multiple serious health outcomes.

Depression

The connections of depression not just to loneliness but also to unmet personal and practical care needs have been subject to research (Table 6.1). For instance, Allen and Mor (1997) observed higher levels of depression (MHI-5 score) among respondents who had unmet needs. For both personal and practical care needs, the difference between groups with met and unmet needs was statistically significant.

In Spain, Otero et al. (2003) found an association between unmet needs and symptoms of depression (using the CES-D scale). However, their analyses showed that only some unmet IADL-based needs ('monthly needs', in the authors' terms) increased the odds of depression in a significant way (OR = 1.98). The odds of depression were also slightly higher (OR = 1.38) for other unmet IADL needs ('weekly needs'), but the result lacked statistical strength. In the case of unmet ADL needs ('daily needs'), it was actually people with unmet needs who had lower odds for depression (OR = 0.39). The authors discussed the unexpected latter finding by suggesting that the receipt of personal care from relatives could lead to depression. This referred to a situation in Spain in the 1990s where formal personal care was available only very rarely and informal care was the absolute mainstream for personal care. Another Spanish study from the same period found a similar result: depression was significantly lower among those with unmet personal care needs (Tomás Aznar et al., 2002).

The relationship between personal or practical care poverty and depression does not seem to be straightforward in all contexts. This is echoed in an American study that showed no significant correlation between depression and whether or not the personal care needs of older people are met (Sands et al., 2006). In China, unmet needs proved to have a significant and growing impact on depressive symptoms (using the CES-D scale) among older people in rural areas but not in urban centres (Hu & Wang, 2019).

As depression is a mental condition, its connections with social isolation and loneliness—and thus socio-emotional care poverty—have been widely examined. As such studies are numerous, it is not possible to describe the results of individual publications. Instead, this section is based on review articles and meta-analyses that summarise the findings of individual studies on the topic (Table 6.4). These sources show a close relation between depression and loneliness as well as between loneliness and social isolation. Almost without exception, the reviews and meta-analyses show a significant association between depressive symptoms and either an absolute lack or personal deprivation of social connections (Ouimet et al., 2001; Luanaigh & Lawlor, 2008; Hawkley & Cacioppo, 2010; Mushtaq et al., 2014; Choi et al., 2015; Crewdson, 2016). Hence, depression is related to both absolute and relative socio-emotional care poverty. A lone review by Courtin and Knapp (2017) raises some question marks as some of the studies included in their review failed to identify an association between depression and social isolation. But overall, it seems clear that socio-emotional care poverty is a risk factor for depression.

Emotional Well-Being

Examinations of the negative consequences of unmet care needs have also included difficulties in emotional well-being aside from depression (Table 6.1). On the one hand and as in the case of depression, there is an extensive literature on the connections between emotional well-being and loneliness. On the other hand, however, only few studies examine emotional difficulties resulting from unmet personal or practical care needs, and the studies that exist do not distinguish between personal and practical care needs, which limits the usefulness of their results.

Two of the latter studies mentioned above come from Canada (Table 6.1). Lévesque et al. (2004) report that people with an unmet ADL or IADL need have a significantly increased likelihood of experiencing psychological distress and feeling a lack of control. This study examined unmet psychosocial needs, too, which also proved to be associated with emotional well-being. Likewise, results from Turcotte (2014) show that stress levels are significantly higher and sleep problems are more common among those with unmet personal and practical care needs. The results remained unchanged regardless of whether the absolute or relative approach was used to measure unmet needs.

In the United Kingdom, Dunatchik et al. (2016) found no clear link between unmet needs and emotional well-being. But in the United States, Gibson and Verma (2006) observed a statistically significant increase in the share of those who said they are dissatisfied in life in general (41% among people with unmet needs vs. 23% among people whose needs were met) and that their condition prevented them from ‘reaching their full abilities as a person’ (87% vs. 67%). When asked about having control over their lives, those with unmet needs were significantly more likely to state that they had lost control over how they spend money (43% vs. 19%), who provides services to them (32% vs. 14%), when and what they eat (31% vs. 12%), or when and where they are able to go out (45%

vs. 31%). Another American study analysed connections between unmet care needs and the emotional well-being of family carers (Li et al., 2005). The results showed that informal caregivers who reported unmet needs were more likely to experience emotional strain.

Four different research reviews focus on the connections between emotional well-being and loneliness and social isolation (Table 6.4). Along with Luanaigh and Lawlor (2008), Hawkley and Cacioppo (2010) identify a significant association between loneliness and sleep problems. Choi et al. (2015) reviewed the consequences of 'subjective social isolation' (i.e., loneliness) and 'objective social isolation', finding both associated with sleep disturbance of older adults. For their part, Mushtaq et al. (2014) highlighted how loneliness is a risk factor for suicidal ideation, parasuicide, alcoholism, or acute and chronic stress. Overall, the evidence shows that personal, practical, and socio-emotional care poverty are each linked to emotional problems.

Mortality

Death is the ultimate possible negative outcome of unmet care needs. The connection between loneliness and mortality is already studied rather widely, but there is surprisingly little research into the relationship between mortality and unmet personal or practical care needs. Only three such studies were located, two from the United States and one from China (Table 6.1).

Gaugler et al.'s (2005) 18-month follow-up study showed unmet needs (reported by family carers) as a significant predictor of mortality for older people with dementia (OR = 1.17). For their part, He et al. (2015) received partly contradictory results: unmet personal care needs were associated with an increased risk of mortality within one year for Medicare enrolees with one (HR = 1.96) or two ADL limitations (HR = 1.37), but not with three or more ADL limitations.

In China, Zhen et al. (2015) analysed whether unmet personal care needs influence the risk of mortality within three years for very old people (the mean age of the sample was 94.5 years). The results showed that older adults with unmet needs had an approximately 10% increased mortality risk, but unmet needs predicted mortality only in urban areas. Gender was also influential, with old urban women at particular risk of increased mortality due to unmet needs.

A number of studies have analysed connections between mortality and loneliness/social isolation (Table 6.4). In a rather early review of loneliness literature, Routasalo and Pitkälä (2003) concluded that the evidence is strong for both social isolation and loneliness predicting increased mortality. This conclusion was affirmed by later reviews. According to Hawkley and Cacioppo (2010), a growing body of longitudinal research indicates that loneliness indeed predicts increased mortality. In their meta-analytic review, Holt-Lunstad et al. (2015) observed that loneliness and social isolation increase the likelihood of mortality by a respective 26% and 29%. They conclude that the risk associated with social isolation and loneliness is comparable to other well-established risk factors for mortality (e.g., physical inactivity, obesity, and substance abuse). A review by Courtin and Knapp (2017) is the only one here that reported more mixed results; the authors noted that most of the studies they reviewed found that social isolation is not an independent mortality risk factor in old age, but loneliness does predict mortality. Still, there is a general consensus among researchers that loneliness and social isolation are both connected with increased mortality.

Use of Health Care

Aside from consequences for the well-being and health of older people, researchers have also examined whether unmet care needs affect the use of health care or residential social care by older people. Outcomes for the care system have thus also been analysed in addition to outcomes for people in need of care.

Once again, Allen and Mor (1997) were the first to study the issue (Table 6.1). Their analyses identified a doubling in the likelihood of physician visits, emergency room visits, and hospitalisations among those with unmet ADL needs. However, there was no indication of a relationship between unmet IADL-based needs and health care use indicators.

This means the study connected personal care poverty, but not practical care poverty, to the increased use of health care.

Sands et al. (2006) also observed that older people without any support for their personal care needs, that is, those in absolute personal care poverty, are at an increased risk for hospital admissions. Though the difference in likelihood (OR = 1.26) was not as large as in Allen and Mor's (1997) study, it still was statistically significant. Another 12-month follow-up study showed that insufficient help for ADL needs increased the likelihood of hospitalisations by 14% (Xu et al., 2012). The same research group also observed that once older people have returned home from a recent hospitalisation, unmet personal care needs are associated with an increased probability of readmission (DePalma et al., 2013).

Furthermore, a Canadian study showed that significantly more older people with unmet personal and practical care needs visit emergency departments compared to those whose needs are met (Lévesque et al., 2004: 25.2% vs. 11.8%). Hospital admissions, too, were slightly more common among those with unmet needs (7.4% vs. 5.8%)—but this difference was not statistically significant.

Among people with unmet needs, Gibson and Verma (2006) observed statistically significant increases in the share of those saying they had put off seeking needed health care due to cost (47% vs. 28%) or they were dissatisfied with health services (26% vs. 18%). In other words, almost half of those with unmet needs delayed seeking necessary health care because they could not afford it. These results offer another perspective on the relationship between care poverty and the use of health care. While other studies connect care poverty to the increased use of health care, Gibson and Verma (2006) suggest that people with unmet needs face extra barriers in their use of health care when compared to others with care needs.

In research reviews on the consequences of loneliness and social isolation, the use of health care is rarely covered (Table 6.4). As an exception, however, Routasalo and Pitkälä's (2003) review concluded 20 years ago that increased health care use is associated with and predicted by loneliness. A more recent review by Courtin and Knapp (2017) found only three studies focused on the health care use of lonely or socially isolated older people. One of these studied dental care. Of the remaining two, one showed that social isolation predicts re-hospitalisations. The other analysed whether loneliness predicts the number of preventive home care visits, finding dissimilar results for women and men.

Use of Residential Care

An issue rather similar to the use of health care—hospital admissions, in particular—is whether older people in care poverty are more likely to be admitted to residential long-term care. For the long-term care system, this is a major question as untimely residential care placements mean a failure of home care and bring about considerable extra costs. Unfortunately, only two studies were found to have examined this issue (Table 6.1).

The first study reports that the unmet ADL needs of people with dementia were, in an 18-month follow-up, found to be a significant predictor (OR = 1.26) of nursing home placements (Gaugler et al., 2005). The second study reports that, during a six-month period, over one-quarter (28%) of people with unmet needs were temporarily admitted to a nursing home; among those without unmet needs, the number of admissions was significantly lower (14%) (Sands et al., 2006). Also, the number of days spent in a nursing home was significantly higher among those with unmet needs.

Concerning socio-emotional care poverty, there seems to be very little research on the use of residential care. Only one of the research reviews used here mentions the connection between loneliness and the use of institutional care (Table 6.4). According to Routasalo and Pitkälä (2003), loneliness predicts nursing home admissions among older people.

Conclusions

The beginning of this chapter asked the question of whether care poverty has negative consequences for older people and society at large. Does it really matter? The answer is a firm 'yes'. According to a growing body of research evidence, unmet care needs have many kinds of unwelcome consequences for older people's health and well-being (Table 6.5). They further lead to an increased use of social and health care. These outcomes impact not only many different areas of an older person's life, but also its end—that is, mortality. Although the number of studies on these consequences is less than the number of those analysing the rates and factors of care poverty, this body of research has recently grown and produced consistent results.

However, these studies are distributed quite unevenly across the different domains of care poverty. Due to the loneliness boom in gerontology over the last few decades, the consequences of socio-emotional care poverty are most widely studied. Studies on the consequences of unmet personal care needs are much rarer, and research into the consequences of unmet practical care needs barely exists at all. The emphasis of this research has also varied across different domains for care poverty: studies of unmet (I/)ADL needs concentrate especially on adverse consequences, while the loneliness research stream focuses primarily on psychological, physical, and cognitive consequences.

However, several consequences have been examined across different domains. Personal as well as personal-practical care poverty brings adverse consequences. In terms of depression, the evidence shows that personal care poverty and socio-emotional care poverty are clear predictors. At the same time, the results are less uniform for practical (and personal-practical) care poverty. In terms of emotional well-being, the evidence is univocal: unmet needs predict emotional difficulties regardless of care poverty domain. Increased mortality is unambiguously predicted by socio-emotional care poverty. In a few studies, it is also connected with personal care poverty. Health care use is undoubtedly increased by personal, personal-practical, and socio-emotional care poverty. Finally, the use of long-term residential care is demonstrably more frequent among those with unmet personal care needs. Unmet social and emotional needs may likewise have a similar impact.

Despite gaps in the research indicated by the empty cells in Table 6.5 and although the evidence is not fully unanimous in all cases, there is generally enough evidence to confirm that all domains of care poverty

Table 6.5 Consequences of care poverty

	Adverse consequences	Cognitive decline	Physical health problems	Depression	Emotional well-being	Mortality	Use of health care	Use of residential care
Personal care poverty	SIG			SIG		SIG/NS	SIG	SIG
Practical care poverty	(SIG)			SIG/NS			(NS)	
Personal-practical care poverty	SIG			(SIG/NS)	SIG		SIG	
Socio-emotional care poverty		SIG	SIG	SIG	SIG	SIG	SIG	(SIG)
Total	**SIG**	**SIG**	**SIG**	**SIG/NS**	**SIG**	**SIG/NS**	**SIG/NS**	**SIG**

SIG: Most studies show a significant association. SIG/NS: Around half of the studies a show significant association. NS: Most studies show no significant association

( ) This issue is reported by only one study reviewed here have negative consequences for older people's health and well-being. Some consequences are less critical, but many of them are serious. They jeopardise the human dignity and longevity of the people who suffer them. Moreover, the negative consequences are not restricted to the individual level as they also affect the social and health care system. Care poverty leads to an increased use of health care and residential care, and thus to unnecessarily growing expenditures within these services.

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7

Social Inequalities and Care Poverty

Care poverty has serious consequences that threaten the health and well-being of older people, bringing about unnecessary and untimely admissions to hospitals or long-term residential care. This imposes major economic and human costs on the older population, their families, and society at large. As with the prevalence of care poverty, its consequences are not distributed equally across all older people. Instead, they are concentrated within certain population groups, reflecting and reproducing existing social inequalities. Care poverty is thoroughly embedded in its social and structural contexts—and thus in the inequalities prevalent in those contexts.

A key rationale for introducing the concept of care poverty to this book is the disregard that gerontological research into unmet needs has shown for social inequalities. Income level, education, age, gender, and ethnicity are regularly included as background factors in these studies, and their statistical associations with the prevalence of unmet needs are analysed and routinely reported. But the findings of those studies have not been collected together or discussed in the light of research on social inequalities.

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This chapter aims to open such a discussion by summarising available knowledge of the connections between care poverty and key dimensions of social inequalities. It begins with a discussion of income inequalities and educational disparities before moving on to gender inequalities and ethnic and regional disparities. The chapter concludes by considering whether care poverty can be seen as a dimension of inequality in its own right.

Income Inequalities and Care Poverty

It would not be surprising if income level were connected to access to care and support. Care is a very labour-intensive activity based most often on one-to-one interactions. Though salary levels in care work are generally low, care services are still expensive to purchase—especially if the user is left to cover the costs alone, without public subvention. Even when public funding is available to share the costs, user co-payments can still be high. This is particularly true for residential care, but also for home care (Huber et al., 2009; Rodrigues & Schmidt, 2010).

Before the introduction of the Long-Term Care Insurance (LTCI) programme in 2000 in Japan, for example, only very high-income individuals and families were able to bear the costs of intensive home care (Izuhara, 2003, pp. 403–404). The new programme considerably expanded the size of the group of older persons who could afford these services. Still, Izuhara (2003, p. 408) concludes that the LTCI scheme tends to benefit middle- to high-income households, putting pressure on lower-income households.

Different long-term care systems clearly create dissimilar conditions for how older people from different income groups can access assistance and support. The design of co-payments for formal care also has a major effect on the financial burden of different income groups (Wouterse et al., 2021)—and thus on the affordability of these services.

Researchers have started to examine whether income inequalities affect access to care for older people. Rodrigues and Schmidt (2010) analysed the use of home care services in the 65+ age group for different income groups in nine European countries, observing substantial variations. In

Germany, Austria, and Italy, the quintile with the highest incomes was shown to use home care considerably more often than the lowest quintile. However, the situation was the opposite in Sweden, Denmark, France, and the Netherlands. In Spain and Belgium, both income groups used home care in an equal manner. Albertini and Pavolini (2017) also compared the situation in Germany, Italy, Denmark, and France, finding very similar results. Older people with low incomes seem thus to be disadvantaged in terms of their access to formal home care, especially in countries that are based on cash-for-care allowances often used to pay for informal or migrant carers. The situation seems less problematic in nations where the focus is instead on professional care service provision as it 'allows for de facto targeting of low-income groups or of those more in need of care' (Rodrigues & Schmidt, 2010, p. 14).

Broese van Groenou et al. (2006) observed a socio-economic gradient in the use of formal care in the Netherlands, Belgium, the United Kingdom, and Italy. In all of these countries, it was older people in low-level socio-economic groups who used formal long-term care most often. In the case of informal care, lower socio-economic groups received noticeably more help from informal sources. The authors explain the higher use of formal and informal care among older people in lower-level socio-economic groups by their relatively poor health and lack of social and material resources.

Health inequalities further weaken the position of older people with low incomes. As the research on health disparities has clearly shown, there is a distinctive socio-economic gradient in health status (e.g., Siegrist & Marmot, 2006). Health inequalities do not vanish with ageing, either. They remain in effect even though higher mortality means that a disproportionate number of those from lower-income groups never even reach old age (e.g., Bosworth, 2018; Enroth et al., 2019). Poor health and subsequently greater care needs are a typical characteristic of low-income older people (Broese van Groenou et al., 2006). This means these groups not only have fewer financial resources to pay for care but also have more care needs to start with.

Hence, there are multiple reasons to expect a close association between income inequalities and care poverty. But does the literature actually confirm such a connection? There is ample research on the topic as almost all studies of unmet long-term care needs include income levels in their analyses. The results, however, are less clear than what might be anticipated (Tables 5.1–5.7). While a straightforward connection between income level and the prevalence of unmet needs could be expected, the results vary across countries and care poverty domains. They also depend on whether the studies used the absolute or relative approach to measurement.

Much of the ambivalence concerns personal care poverty. In the case of absolute personal care poverty, four of the five reviewed studies failed to find a significant association between income level and unmet needs (Table 5.1). These studies came from the United States, the United Kingdom, India, and Malaysia. The evidence here is thus based on individual studies from four different countries. Firm conclusions might better be avoided, especially as Ashokkumar et al. (2012) did not run a multivariate analysis, the sample of LaPlante et al. (2004) consisted mostly of people younger than 65, and Zhu and Österle (2017) still found a significant association in China.

In the case of relative personal care poverty, a slight majority of studies identified income as accounting for unmet needs (Table 5.2). From Spain, both studies agree on this connection. From China, only the study by Gu and Vlosky (2008) did not confirm it. On the other hand, Desai et al. (2001) were the only ones who found a significant association between income level and unmet needs in the United States—but then, theirs was the sole American study that used a sample consisting exclusively of older people. In our lone study from Finland, people with low incomes were no more likely to have their personal care needs uncovered. When trying to understand these partly contradictory findings, it is necessary to take into account care policy as a mediating factor between income levels and care poverty. In Spain (in the 1990s) and China, formal care used to be very limited. In the United States and Finland, the respective Medicaid programme and the Nordic welfare model made formal care available to many older people with low incomes.

In terms of practical care poverty, the evidence is limited but unanimous nonetheless: for all three studies, people with low incomes were more likely to have their needs unmet (Table 5.3). Still, the studies come from different decades and different countries. As assistance with household tasks and other practical care needs is rarely provided publicly but instead usually purchased out of pocket, it is hardly surprising that older people with higher incomes are less likely to experience practical care poverty.

Among those studies that used the absolute measurement approach but failed to distinguish between unmet personal and practical care needs, regression analyses from the United States, Slovenia, and China did not identify income level as a predictor of unmet needs. In contrast, a study from France and Ireland showed a significant association (Table 5.4). But for studies using the relative approach, only one American study did not confirm the association; other analyses show it to be significant (Table 5.5). These findings are difficult to interpret because the studies mix together two very different domains for care needs. Informal care probably plays a major role here, providing much practical help and—especially in countries with limited formal care provisions—also personal care.

Socio-emotional care poverty, measured here by loneliness, shows consistent results. However, only two out of the four international studies reviewed included income level in their independent variables (Table 5.6). Both studies confirmed that loneliness is significantly associated with low income levels in Europe. However, the studies did not provide results at the level of individual countries.

The influence of income level is observed not only for the rates of care poverty, but also for its consequences. In the United States, Desai et al. (2001) report that an annual income under $20,000 almost triples the likelihood of adverse consequences among those with unmet needs. The importance of low incomes to adverse outcomes is further confirmed by Freedman and Spillman (2014). As well, Allen et al. (2014) noticed that such consequences were more common among 'dual eligibles' than other Medicare users; having passed the strict Medicaid means test, the first group has lower incomes than the second group. A study from China observed that low economic status is a risk factor for mortality among those with unmet care needs (Zhen et al., 2015). The current evidence thus suggests that, even though a low level of income does not always predict care poverty, financial hardship is associated with the emergence of negative consequences among those who are in care poverty.

Overall, it seems that studies using the absolute approach only rarely show income level as a significant factor of unmet needs. In contrast, this is more common among studies using the relative measurement approach. Evidence concerning personal care poverty is partly contradictory because a low income level seems to be a risk factor for unmet personal care needs in some, but not in all, countries. At the same time, low income is more systematically associated with practical care poverty, and the same goes for socio-emotional care poverty. The total picture is not as clear-cut as what might be expected: a low income level is not always, in every domain and all contexts, connected with care poverty. There seem to be other factors involved, including the care policy model. But then, this conclusion supports one of the key arguments of this book: care poverty is not only about poverty and a lack of material resources. Instead, it is a much more complicated phenomenon.

Educational Inequalities and Care Poverty

Health research has discerned that indicators of socio-economic status are not interchangeable as they each yield distinct results. Different indicators are understood to capture different aspects of overall health risk (Duncan et al., 2002). Research into care poverty, too, requires more than one socio-economic indicator.

Within the context of care poverty, educational level can be considered a relevant socio-economic indicator. In order to receive public formal care, the older person (or their family) must know about available services and benefits, their eligibility criteria, and how to apply for them. Applying for services includes filling out forms, which are nowadays increasingly found online, and interacting with social or health care professionals. Purchasing for-profit care services can also be a complex process involving many of the same elements. All of this requires access to information and skills acquired from education. Albertini and Pavolini (2017, p. 511) conclude that a higher educational level can be expected to lead to a greater chance of accessing public care as the procedures for accessing formal care are nowadays complex—particularly when it comes to needs- or means-testing.

It is rather surprising, then, that studies of unmet needs do not show education level playing an actual role in care poverty. For the analyses of absolute personal care poverty, Zhu and Österle (2017) are the lone study to recognise educational level as a significant factor (Table 5.1). In the case of relative personal care poverty, Desai et al. (2001) in the United States and Rogero-García and Ahmed-Mohamed (2014) in Spain reported a correlation between educational level and unmet needs (Table 5.2). However, Liu et al. (2012) from Taiwan were the only ones who identified a significant association in their regression analysis.

In the case of practical care poverty, only Otero et al. (2003) in Spain found evidence of low levels of education being related to inadequate coverage for some—but even here, not all—IADL needs (Table 5.3). Other studies did not recognise a significant association. Among those studies that combine personal and practical care needs, Gibson and Verma (2006) in the United States and Rogero-García and Ahmed-Mohamed (2011) in Spain both noticed a correlation between unmet need and education levels. Still, this connection was confirmed only by a regression analysis from China (Tables 5.4 and 5.5).

In terms of socio-emotional care poverty, three out of the four comparative loneliness studies under review included educational level among their independent variables (Table 5.6). One showed loneliness to be inversely related to educational level, while another failed to find such an association. The ambivalence of European-level findings as a whole is made understandable by the third study, which showed a low educational level being associated with loneliness in four countries (France, Germany, Israel, and Spain) but not in seven (Austria, Belgium, Denmark, Greece, Italy, the Netherlands, or Sweden). Hence, national contexts were proven to affect the connection.

In general, most evidence fails to prove that a low level of education can predict care poverty. This is surprising because a high level of education might be expected to confer advantages in access to care. Still, it should be recalled that care poverty is not just about formal care. In principle, it is always possible that informal care is compensating for the lack or inadequacy of formal care. For example, there is evidence that older people with a low level of education in Sweden use informal care to fill the gap between their care needs and available formal services (Szebehely

& Trydegård, 2012). Further research is needed to determine whether this is true on a larger scale and across countries. Educational inequalities exist in care, but when looking at care poverty, their explanatory power appears more limited than expected.

Gender Inequalities and Care Poverty

Despite societal movement towards more gender equality, women are still disadvantaged in current societies in many ways. They earn lower salaries than men and experience career breaks due to childbirth and childcare. They struggle with glass ceilings, gender stereotypes, and gender-segregated labour markets (e.g., Scott et al., 2012; Daly, 2020). Within families, women still perform the overwhelming part of housework and caring. In the words of Fiona Williams (2021, p. 42), 'women's inequalities, at work and in the household, relate to the (unpaid) care domestic responsibilities they carry'. Feminist scholarship shows that gender inequalities permeate societies and manifest themselves in multiple ways in both the private and the public sphere.

Care is one of the most thoroughly gendered social phenomena (Leira & Saraceno, 2002). Care work is performed overwhelmingly by women in both the informal and formal sectors. It is middle-aged women, in particular, whose opportunities to fully participate in the labour market are contingent to their informal care responsibilities and whether formal long-term care services are available to share their care work (Kröger & Yeandle, 2013). At the same time, due to the fact that men have a shorter lifespan, the majority of people in need of formal care in old age are women (EIGE, 2019). Daly and Rake (2003, pp. 68–69) summarise the situation by stating that '[c]are is thus heavily implicated in gender inequality and patterns of individual and family well-being, just as variations in welfare state policy are systematically associated with variations in the situation of women and men'. So, care is fundamentally gendered but is care poverty a gender-specific issue, as well? In other words, are women more likely to have unmet care needs?

For personal care poverty, regressions show a significant association between gender and unmet personal care needs in Spain and Malaysia.

However, analyses from the United States and Finland fail to confirm this (Tables 5.1 and 5.2). Another Spanish study failed to confirm the association, as well. In the United Kingdom, Brimblecombe et al. (2017) and Dunatchik et al. (2016) did not identify gender as a predictor of unmet needs. In contrast, Vlachantoni (2019) did—but in her study, it was actually men who were more likely to have unmet needs. In China, Gu and Vlosky (2008) did not report gender as a factor for unmet needs. Yet for the same country, results from Peng et al. (2015) and Zhu (2015) show the opposite—but only in a rural context. For cities, there were no statistical differences between men and women; in the countryside, gender differences existed with men in both studies more likely to have unmet needs. Using self-reporting to measure unmet needs, Peng et al. (2015) suggest that rural women may have lower expectations than men—which could explain why men are more often unsatisfied with the support they receive. But in general, gender typically fails to predict personal care poverty. When it does, it could be that men are more prone to have unmet needs.

For practical care poverty, the evidence is scarce. Only one of the five studies under review identifies gender as a significant factor of unmet needs (Table 5.3). Analyses from the United States, Spain, and Finland all found gender to be non-significant. Only British research by Vlachantoni (2019) reports a significant association between gender and unmet practical care needs. But once again, regressions show older men facing a heightened risk—not older women.

Studies that fail to distinguish personal from practical care needs and employ the absolute approach to measurement report similar kinds of results (Table 5.4). Only two studies (from France/Ireland and China) identify gender as a significant factor. As before, it is men who were more likely to have unmet care needs. Other studies from the United States, India, the United Kingdom, Sweden, and Slovenia all failed to identify gender as statistically significant.

When studies use the relative approach to measure unmet personal-practical care needs, there is more evidence of an association (Table 5.5). Lima and Allen (2001) in the United States, Lévesque et al. (2004) in Canada, Rogero-García and Ahmed-Mohamed (2011) in Spain, and Wilkinson-Meyers et al. (2014) in New Zealand all found regression results showing women as significantly more likely to have unmet care needs. On the other hand, analyses from Gibson and Verma (2006) and Schure et al. (2015) in the United States, Busque and Légaré (2012) in Canada, and Davin et al. (2006) in France did not show a significant relation. In this case, none of the studies showed men as more at risk than women. Overall, for the first time, a slight majority of analyses identified gender as a significant factor of care poverty.

Finally, when it comes to socio-emotional care poverty, only two out of the four comparative studies under review analysed the connection between gender and loneliness (Table 5.6). A study of 14 countries by Fokkema et al. (2012) identified gender as a significant factor of loneliness, while results from Sundström et al. (2009) were more mixed. The latter study reported women as more likely to experience loneliness in three countries (France, Greece, and Spain) but not in eight countries (Austria, Belgium, Denmark, Germany, Israel, Italy, the Netherlands, and Sweden).

When it comes to whether gender affects the consequences of care poverty, the evidence remains very thin. In one American study on adverse outcomes, gender did not have a significant impact (Desai et al., 2001). Instead, Zhen et al. (2015) observed that women in Chinese cities have a heightened mortality risk due to unmet needs.

Gender inequalities are widespread in society, disadvantaging women in many ways. Care, in particular, is a thoroughly gendered field. At the same time, studies of unmet needs do not show women being systematically overrepresented among the population of older people living in care poverty. There are even studies that show men as more likely to have unmet needs. This is surprising and unexpected. However, the results seem to depend at least partly on national context. On the one hand, most Spanish studies show older women as more likely to have unmet needs; single studies from Malaysia and New Zealand found a similar result. On the other hand, most American studies do not show gender as a factor of unmet needs; single studies from Finland, India, Slovenia, and Sweden point to a similar situation. Canada has mixed results. Studies from the United Kingdom, China, France, and Ireland show men at greater risk for care poverty, although not all studies from these countries find a statistically significant association between gender and unmet needs.

As care poverty depends on both informal and formal care, gender differences can mean inequalities in access to either or both of these sources of care. Accordingly, lack of a gender difference can mean either equality in access to both or that another source is compensating for an unequal lack of access to a particular source of care. The available empirical evidence does not make it possible to draw firmer conclusions on the issue. Many questions are still left unanswered, so there is a clear need for more thorough research on the connections between care poverty and gender.

Racial and Ethnic Inequalities and Care Poverty

Another source of major social inequality is ethnicity. For many migrant and ethnic minority groups, discrimination, social disadvantage, and racism are regular experiences (e.g., Alexander & Byrne, 2020). Ethnic residential segregation has been a key part of the development of social inequality (Nazroo & Williams, 2006). In Europe and North America, non-white groups are regularly disadvantaged by differences between the opportunities available to ethnic majority and minority populations. Disparities between ethnic majority and minority groups also exist in regions such as Asia and Africa.

There is firm evidence also for persistent health inequalities grounded in ethnicity, showing clear morbidity and mortality differences across ethnic groups (Nazroo & Williams, 2006; Ingleby, 2012). Experiencing racial harassment and discrimination is observed to contribute to ethnic inequalities in health; health inequalities are also connected to the overall low socio-economic position of many minority groups (Nazroo & Williams, 2006). In Britain, however, older people from ethnic minorities report poorer health status even after controlling for social and economic disadvantages (Evandrou et al., 2016). Similar observations have been made in the Netherlands, Denmark, and Sweden (Lorant & Dauvrin, 2012).

Ethnicity matters not only for health status, but also in access to health care. In the United States, more than half of the country's uninsured citizens are from ethnic and racial minorities even though these groups make only one-third of the total population (Lancet, 2011). In Britain, research shows that ethnic inequalities in experiences with health care are substantial: despite the universal nature of the National Health Service (NHS), ethnic minority people are, for example, more likely to be dissatisfied with the health care they receive, to wait longer for an appointment, and to face language barriers during the consultation (Chouhan & Nazroo, 2020). The total picture is complex, however, as there are many variations across specific ethnic groups and health conditions as well as across countries.

Concerning unmet health care needs, Wu et al. (2005) did not find them to be linked with immigrant status in Canada, but in the United States, there is considerable evidence for ethnic disparities in the use of health care. African Americans and Latinos, in particular, use health services at lower rates when compared to white Americans (Ashton et al., 2003). One American study observed that 25–31% of respondents from different ethnic minority groups had experienced discrimination in health care and that this experience was associated with a more than two-fold likelihood of having unmet health care needs (Benjamins & Whitman, 2014).

Unmet health care needs thus have an ethnic gradient, but what about unmet long-term care needs? Are there ethnic or racial inequalities in care poverty? Once again, the issue is studied predominantly in the United States, and once more, the results are mixed. On the one hand, several American studies have found no significant association. But on the other hand, a number of American studies have identified ethnicity as a factor of unmet care needs. Kennedy (2001) observed that the odds of unmet needs among Hispanics were 50% higher and among blacks 90% higher than among whites. Newcomer et al. (2005) reported whites as 33% less likely than other racial groups to have unmet care needs. Lima and Allen's (2001) multinomial regressions show blacks and Hispanics as 38% more likely to have inadequate help than whites. But at the same time, studies such as Allen and Mor (1997) and LaPlante et al. (2004) found no apparent link between ethnicity and unmet care needs. In terms of the consequences of care poverty, Desai et al. (2001) did not identify ethnicity as a predictor of adverse outcomes. In contrast, Freedman and Spillman (2014) identified non-white groups of older people as significantly more likely to experience adverse consequences.

Studies from other countries on ethnic inequalities in the context of unmet needs are rare. In China, Gu and Vlosky (2008) report the majority Han population as significantly (32%) less likely to have unmet needs than non-Han groups. However, Zhu (2015) did not find such a difference. In Malaysia, Momtaz et al. (2012) identified unmet needs as more common among Malay than non-Malay populations, but their regression analysis did not confirm the finding. In New Zealand, Wilkinson-Meyers et al. (2014) could not identify a significant difference in unmet care needs between Māori and non-Māori groups. Self-reporting in Britain showed that 45% of white and 65% of black and other ethnic minority older people had unmet needs, but the difference remained statistically insignificant (Brimblecombe et al., 2017).

Thus the evidence from the United States remains ambiguous, and the results from other countries are too patchy and contradictory to draw any conclusions. There is no consensus in the literature on whether ethnicity and unmet needs are significantly related or whether ethnicity predicts adverse consequences among people with unmet needs. The number of American studies that failed to identify racial or ethnic disparities in unmet needs is surprising. The Medicaid programme could be an intermediate variable that explains the surprisingly weak link between ethnicity and care poverty in the United States. As non-white groups are overrepresented among those who fill the strict Medicaid eligibility criteria, the programme serves racial minorities, in particular, obviously reducing their care poverty.

At the same time, several studies still do show a significant gradient in care poverty: whites are more unlikely to have unmet needs or their negative consequences than blacks and Hispanics. A recent study by Berridge and Mor (2018) discusses these contradictions. In their unadjusted models, older black adults were more likely than whites to experience an adverse consequence of unmet need. However, this difference disappeared in adjusted models. They came to the interesting conclusion that while there are apparent absolute racial inequalities in unmet needs and their consequences, controlling other variables (such as health and functional status, living arrangement, and marital status) 'adjusts away' the effect of race, per se.

Regional Inequalities and Care Poverty

Regional inequalities influence people's lives, as well. Living conditions differ across geographical areas and so does the availability of public and private services (Cörvers & Mayhew, 2021). Formal long-term care services are no exception to this rule as they are less available in rural areas, even though several welfare states have tried to even out regional differences through central grant systems or other measures (e.g., Kröger, 2011; Henning-Smith et al., 2019). Yet large variations in service provisions remain, and rural residents face several barriers to accessing formal care, linked to, for example, transportation, workforce shortages, and financial constraints (Henning-Smith, 2021). Coburn (2002, p. 67) concludes that 'despite a greater need, rural elders are less likely to have their health and long-term care needs met because of problems in the availability of health and social services and the obstacles to delivering services in rural areas, including low population densities, limited transportation, and longer travel distances'.

At the same time, informal support networks are often thought to be tighter in the rural environment, as it is not rare to have family members living in the same village or town. Accordingly, a study from Sweden reports that rural older people were almost three times more likely to receive informal care than people living in urban environments (Nordberg, 2007). However, Glasgow (2000) states that although older people in American rural settings are more likely to have a spouse and more children, urban older people are more likely to co-reside with or have adult children living by. A study from rural Belgium also found that informal care depends on spatial context and cannot be guaranteed everywhere (Volckaert et al., 2020).

Regional variations in the availability of care are not only about the rural-urban divide but also about differences between different regional units—between municipalities, counties, regions, provinces, and states (e.g., Hébert et al., 2019; Duell et al., 2020). Liu et al. (2012, p. 164) listed the backgrounds for these variations:

> Local diversities are manifested in long-term care policies in general and in home care provisions in particular, thanks to differences among areas' political cultures, demographic make-ups, care resources, efficiencies in civil services, grants from the central government, budgets, and amount of welfare handouts.

The specific characteristics of regional units, which includes their economic, political, and population structures, thus contribute to the emergence of regional differences. Overall, the more administrative and political autonomy that subnational units have, the greater the difference one might expect across their service provisions (Kröger, 1997, 2011). The opposite also holds true: the more centralised that policy-making and implementation are in a country, the more uniformity across regions one might expect to find in its care service system.

What does the available evidence say about regional inequalities in care poverty? Not very much, as this has clearly not been a key focus of unmet need research (Tables 5.1–5.7). Single studies from France and New Zealand failed to demonstrate a significant rural-urban difference, while studies from Slovenia and Taiwan observed unmet needs as more prevalent in rural areas. In China, Gu and Vlosky (2008) reported that living in an urban area reduces the likelihood of unmet needs by 23%. In contrast, Gibson and Verma (2006) in the United States and Rogero-García and Ahmed-Mohamed (2011) in Spain found a higher probability of unmet needs in urban over rural areas.

In Finland, our study compared unmet care needs in two cities and found no significant differences in their care poverty rates (Kröger et al., 2019). As both of these cities also have large rural areas, we further analysed whether the prevalence of unmet needs differs in centres and other areas of these cities. For practical care poverty, no regional differences were found. But for personal care poverty, living outside the city centre increased the care poverty risk by 89%. This was understood to primarily result from the greater availability of formal care services in city centres.

In terms of the negative consequences of unmet needs, an American analysis found practically no differences between rural and urban areas (Henning-Smith et al., 2019). For their part, Hu and Wang (2019) reported unmet needs as connected to a significant increase in the risk for depression in rural, but not urban, areas of China. Yet Zhen et al. (2015) observed that for China, unmet needs brought a significant increase in mortality only in urban areas.

Aside from urban-rural comparisons, some research looks at unmet care needs in different parts of the country. Gibson and Verma (2006) discerned a higher prevalence of unmet needs in eastern and southern parts of the United States than in the Midwest. As well, Davey et al. (2013) found that older people were less likely to report an unmet need when they lived in states where a higher proportion of older adults lived in institutional care (many of which were located in the Midwest). These two studies are thus largely consistent with each other.

Gu and Vlosky (2008) found that living in any area of China other than in the north considerably increased the risk of unmet needs (by 62–71%). Busque and Légaré (2012) observed regional variations in Canada, with Quebec and British Columbia showing a significantly higher prevalence of unmet needs than Ontario, the Atlantic provinces, or the Prairie Provinces. When discussing these differences, they refer to home care expenditures clearly below the general Canadian level in the former two provinces. Liu et al. (2012) explained the differences they uncovered in unmet care needs across 23 Taiwanese counties and municipalities in the same way: in certain areas, higher social welfare expenditures (among other area-level factors) led to lower levels of unmet needs.

The body of unmet need literature does not offer fully consistent results on regional inequalities in care poverty. However, one issue seems to be clear: there are major differences in care poverty rates across different areas, at least in geographically large countries such as the United States, Canada, and China. Typically, researchers interpret these variations as the outcome of dissimilar resources for formal care services. The evidence also demonstrates some inequalities between rural and urban areas. But no matter whether it is rural areas (as in Slovenia and Taiwan) or urban centres (as in Spain and the United States) that are disadvantaged, this seems to depend on the nation and sometimes on the exact issue being studied.

Conclusions

When it comes to links between care poverty and different kinds of social inequalities, findings from available literature are partly inconsistent. Although care is a gendered activity to its core, women do not appear to be at a systematically higher risk for care poverty than men. Yet the clear majority of older people in care poverty are nonetheless female, due to their larger share of the oldest age groups.

Indicators of socio-economic status give dissimilar results, as educational background seldom predicts unmet needs while income level proves to be a significant factor more often. However, the evidence is also mixed concerning the significance of income levels; results seem to depend on the care poverty domain, the country, and the methods used to measure unmet needs.

Some studies report racial and ethnic inequalities in unmet needs, while others fail to find a statistically significant association. But when significance is found, it is almost always ethnic minority groups who are disadvantaged in comparison to the majority. Rural areas seem to be at specific risk for care poverty, though some studies show urban centres as having even higher rates. Large countries, at least, also show major variations across different areas. Higher rates of care poverty typically occur in economically weaker areas with limited provisions for formal care.

There are distinct knowledge gaps regarding how different dimensions of social inequalities are connected to care poverty. The evidence generally suggests that low incomes, ethnic disparities, and regional differences in particular increase the risk of care poverty in many countries. But at the same time, there are clearly other factors at play. So far, interactions between these different forces are not well understood. It seems important to learn why gender and educational level do not generally predict care poverty in statistical analyses. The available evidence does not allow for a full comparison of the three care poverty domains, either. The results point to certain directions, such as by suggesting that income level is closely connected to practical care poverty and that the impact of gender on personal care poverty is context dependent, but these issues require systematic analysis. Relationships between social inequalities and informal and formal care are another issue requiring further examination: how do social inequalities affect access to formal care and informal care—and under which conditions does the formal-informal interplay lead to care poverty?

The final question regarding social inequalities and care poverty is whether care poverty could and should be seen as a dimension of inequality in itself. Though poverty can sometimes predict care poverty, this is not always the case. There are many other factors that also affect the prevalence of unmet needs. Moreover, none of these factors fully explain the phenomenon of inadequate care. Other dimensions of social inequality affect care poverty, but this does not mean that care poverty can be reduced back to those dimensions. Whether or not individual care needs are met is a social issue in its own right. When some people receive adequate care while others do not, a new type of inequality emerges. This book thus understands care poverty as a dimension of inequality on its own.

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8

Long-Term Care Systems and Care Poverty

Care poverty is embedded in multiple social inequalities, but also forms an essential dimension of inequality on its own. Furthermore, it poses a serious threat to the well-being and health of older people—and in grave situations, even to their life. According to *Oxford English Dictionary*, the welfare system is 'a system whereby the state undertakes to protect the health and well-being of its citizens, especially those in financial or social need' (Lexico, 2021). Care poverty is exactly the kind of issue that a welfare state is expected to address. But do real-life welfare states manage to lift their older citizens out of care poverty and protect their health and well-being? Are their policies equipped to tackle unmet care needs and eradicate inequalities in access to adequate care? When compared to each other, how do different care regimes perform in this respect? Which policy models work best against care poverty?

This chapter collects available evidence for the relations between care poverty and long-term care systems in different countries for the purpose of discussing how different policies work to reduce care poverty among the older population. The chapter opens with presenting findings from the few existing international comparisons on unmet needs, showing first the results of differences between European care regimes. Next, it

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discusses lessons for social policy gleaned from the few available two-country studies on unmet needs. We then return once more to the local and national studies presented in Chaps. 4, 5, and 6: what can we learn from their key findings about the impact of different care policy designs on care poverty?

Care Poverty and European Long-Term Care Regimes

The lack of comparable data on unmet long-term care needs has largely hampered the development of comparative research on the issue. Consequently, international literature remains very scarce. Still, the 2010s saw the publication of the first larger international studies on unmet care needs.

Bień et al. (2013) were among the first to analyse unmet needs comparatively. They used questionnaire survey data collected from family carers of people aged 65+ for the EUROFAMCARE project. The proxy-respondent data came from six European countries: Germany, Greece, Italy, Poland, Sweden, and the United Kingdom. As the dataset does not include questions on ADLs or IADLs, respondents were asked about eight different areas of need—the contents of which were illustrated by examples. Four out of these eight areas were included in the analysis:

- ‘Health needs’ (e.g., assistance with medication, rehabilitation)
- ‘Physical/personal needs’ (e.g., washing, dressing, eating)
- ‘Mobility needs’ (e.g., moving around in- or outside the house, transportation)
- ‘Domestic needs’ (e.g., housework)

‘Physical/personal needs’ cover ADLs, while ‘domestic needs’ include IADLs. ‘Mobility needs’ refers to IADLs and some ADLs, and and ‘health needs’ to IADLs as well as some other needs. Unmet ‘physical/personal needs' thus reflect personal care poverty, while the three other areas are at least partly about practical care poverty.

The results show variations in the four areas between the six countries (Fig. 8.1). The findings are surprisingly consistent across the different areas of needs. For all four areas, Greece has the highest prevalence of unmet needs followed by Italy. The next three countries (the United Kingdom, Germany, and Poland) are not much different from each other, although when all the four areas are counted together, Poland clearly has more older people who are deprived of several kinds of help. Sweden has the lowest levels of personal and practical care poverty in all four areas.

These findings mostly follow the usual understandings of care regimes, wherein formal care provisions are seen as stronger in Northern and Western Europe than in Southern and Eastern Europe (e.g., Bettio & Plantenga, 2004; Lightman, 2020). But it is not self-evident that care poverty rates should follow the availability of formal care. This is because for care poverty, informal care also plays a decisive role. The results of this study nevertheless suggest that informal care in Greece and Italy does not manage to complement the paucity of formal care. Northern welfare states Sweden and the United Kingdom seem to succeed better in cutting

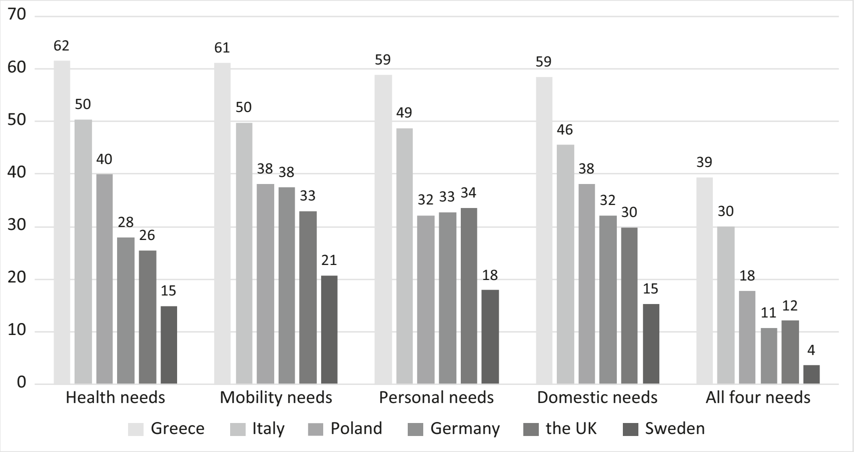

Fig. 8.1 Prevalence of proxy-reported unmet care needs in six European countries. (Source: Bień et al., 2013)

down personal and practical care poverty. The authors of the study conclude that expanding formal social care might be the most effective strategy to reduce unmet needs.

Next, Vilaplana Prieto and Jiménez-Martín (2015) analysed unmet care needs with Eurobarometer 67.3 data from 18 countries. As with EUROFAMCARE, this dataset focuses on informal carers (or more accurately, on the level of interest within the adult population in becoming an informal carer). Here, the data consist of proxy-respondent understandings of the unmet needs of older people. These were measured in a very particular way by asking whether the respondent knew anyone in need of long-term care whose experience with care services was fairly bad or very bad, whose access to care services was fairly or very difficult, or who found care services not very affordable or not at all affordable. Thus the focus falls on the availability and quality of formal care rather than on unmet care needs in the usual broad sense. But as international studies of unmet needs are so rare, the results from this study are included here.

Vilaplana Prieto and Jiménez-Martín (2015) report their findings separately in terms of three reasons for unmet formal care needs (poor quality, poor accessibility, and poor affordability). However, they also provide a figure that represents all respondents who mentioned at least one of these three issues (Fig. 8.2). Affordability and accessibility prove to be the main problems, while quality issues were mentioned less often. Out of the 18 countries, the total prevalence of unmet formal care needs is the highest in the Czech Republic (79%), Hungary (75%), Slovakia (75%), and Italy (74%). It is the lowest in Sweden (34%), Denmark (35%), and Luxembourg (39%).

The authors grouped the countries into four clusters: the 'standard model' (Austria, Belgium, the Czech Republic, Finland, France, Germany, Italy, and the United Kingdom), the 'Nordic model' (Denmark, the Netherlands, and Sweden), the 'family model' (Spain and Ireland), and the 'transition model' (Hungary, Poland, Slovenia, and Slovakia). This grouping is exceptional as it does not follow usual care regime clusters. The first group includes nations from the north and the south as well as the east and west of Europe. Many countries are not placed in their usual clusters: for example, the Czech Republic is not in the 'transition model',

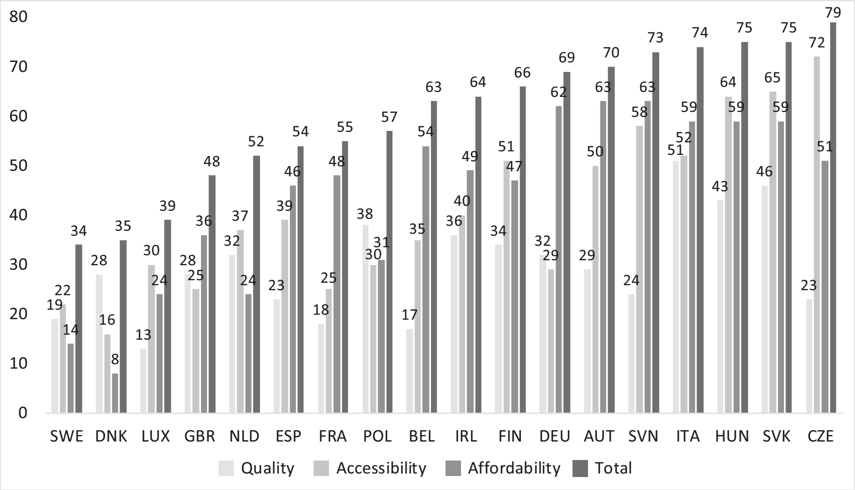

Fig. 8.2 Prevalence of proxy-reported unmet formal care needs in 18 European countries. (Source: Vilaplana Prieto & Jiménez-Martín, 2015)

Finland is not in the 'Nordic model', and Italy is not in the 'family model'. Luxembourg was not included in any model.

When comparing these four country groups, the authors report the 'transition model' (70%) as having the highest total prevalence of unmet needs. This is followed by the heterogeneous 'standard model' (66%), the small 'family model' (59%), and finally the 'Nordic model' (40%). The analysis thus supports the results from Bień et al. (2013) in that the volume of unmet needs is the greatest in Central Eastern Europe and the smallest in Northern Europe. This, however, is not a surprise as the study focuses only on the lack of adequate formal care and does not take informal care into account. The study is also based on a very specific kind of proxy-reporting, which could explain the very high reported levels of unmet needs.

The same year two other comparative studies were also published in a book comprising chapters analysing SHARE data. SHARE does not have a question about the adequacy of care, so the two chapters used the absolute approach. People were defined as having unmet needs when they reported receiving no formal or informal care while having I/ADL-based care needs. The chapter by Laferrère and Van den Bosch (2015) does not report the national prevalence of unmet needs but instead compares the prevalence across three different care regimes: Northern Europe (Denmark, the Netherlands, and Sweden); Central Europe (Austria, Belgium, France, and Germany); and Southern and Eastern Europe (Spain, Estonia, Italy, Slovenia, and Switzerland).

For the group with the greatest care needs, those with several ADL and IADL limitations, unmet needs were the most common in Southern and Eastern Europe (around 15%, compared to around 10% elsewhere). For the second group with only one IADL limitation, the situation was the opposite: unmet needs were rarer in Southern and Eastern Europe (around 35%) than elsewhere (around 50%). The findings show that the extent of need could be an important mediating factor in measuring care poverty, at least in the case of absolute care poverty. Informal care, which is the basis of support in Southern and Eastern Europe, may more easily suffice to cover less severe (practical care) needs. Formal care, which is more available in Northern and Central Europe, seems necessary to get people with extensive needs out of (personal) care poverty.

The other chapter from the same volume used a slightly different definition for care needs, covering people who had at least two I/ADL limitations (Srakar et al., 2015). The study analysed data from 15 countries to show that the prevalence of unmet needs, measured again with the absolute approach, was the highest in Eastern Europe (especially Estonia and Slovenia) and the Mediterranean region (especially Israel and Italy), and lower elsewhere (especially in the Netherlands, Austria, Sweden, and Denmark). However, it is not clear from the publication whether the prevalence of unmet needs was determined from only those respondents with care needs or from all respondents. The very low reported prevalence figures (all under 5%) suggest the latter—which would mean that they do not actually indicate the level of care poverty.

International comparisons of unmet needs have been hindered by the absence of quality international datasets. The datasets used in the aforementioned studies are either based on proxy-reporting (Eurobarometer, EUROFAMCARE) or lack a question on unmet needs (SHARE). The situation may be improving, however. EHIS (European Health Interview Survey) is a new European survey conducted among the population aged

15+ in all EU member states as well as Norway and Iceland. This survey includes specific questions on unmet care needs: it asks about 12 different I/ADLs and, above all, whether people need more help for these activities. The survey thus employs the relative approach to measuring unmet needs.

Comparative results from the second wave of EHIS, which ran between 2013 and 2015, were published by Eurofound (2020) to show levels of unmet care needs in the EU27 countries and the United Kingdom. The findings are reported separately for 'lack of assistance with personal care' and 'lack of assistance with household activities', thus measuring personal and practical care poverty. The reported figures are extremely high overall, the reason for which is unclear. The results show Bulgaria as having the highest prevalence of both kinds of unmet needs, followed by Malta and Romania (in terms of personal care) and by Romania, Finland, and Luxembourg (in terms of household assistance). Still, there is a major problem with these figures: they were counted from all respondents aged 65+, not from only those with care needs. Hence, the results do not indicate care poverty rates.

It however is possible to download country-level data from the Eurostat website and count national care poverty rates by excluding respondents without care needs from the calculation. The results from such recalculation are rather surprising (Fig. 8.3): it is now Luxembourg together with Bulgaria that has the highest level of unmet personal care needs, both showing an extremely high rate of personal care poverty (91%). They are followed by Finland (75%), Malta (73%), and Germany (73%). At the other end of the continuum are Estonia (19%), the Netherlands (23%), and Latvia (37%). For practical care poverty, the recalculation does not much alter the countries with the highest figures (Bulgaria 87%, Finland 78%, and Luxembourg 72%) nor the nations with the lowest rates of care poverty (the Netherlands 25%, Latvia 26%, Estonia 30%, and the United Kingdom 30%).

But there is still one more problem with the data. Eurostat has marked figures from Denmark, Germany, France, Luxembourg, and Finland (for both personal and practical care) in addition to Austria (for personal care) as having only low reliability, probably due to a small number of respondents in the relevant categories. The survey covers the whole population

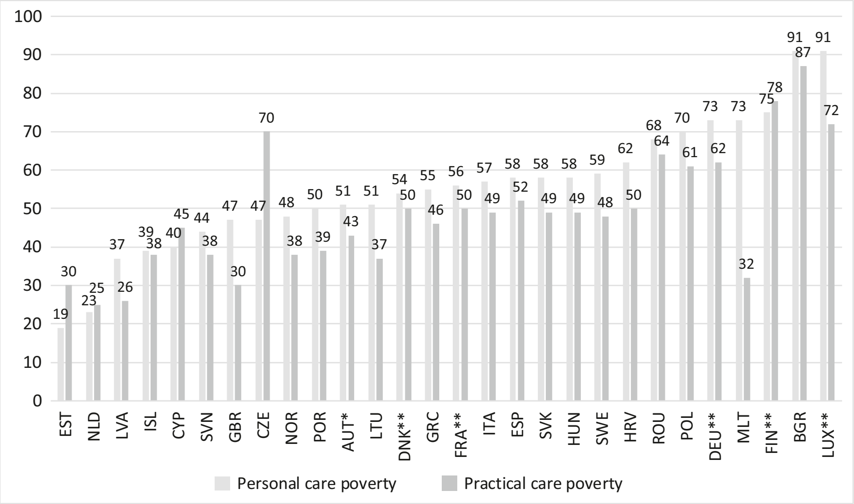

Fig. 8.3 Personal and practical care poverty rates in EU27 countries and the United Kingdom. (* Low reliability for personal care poverty rate; ** Low reliability for personal and practical care poverty rates. Source: EHIS 2014 dataset [Eurostat, 2019a, 2019b])

aged 15+, so the number of respondents aged 65+ with care needs can be expected to be limited in several countries. From Belgium and Ireland, figures are not available at all. When these countries are removed from the list, personal care poverty is the most common in Bulgaria, Malta, and Poland. Practical care poverty would be the most common in Bulgaria, Czechia, and Romania. The countries at the other end of the line would remain unchanged. But as the number of older respondents with unmet needs is probably limited for all countries, caution is needed when interpreting these results.

It nonetheless seems that countries from Eastern Europe, in particular, display high levels of care poverty in the EHIS (with the exception of Slovenia and the Baltic states). Nordic countries do not show up so well as usual; only Iceland is among the least problematic countries. In contrast, Southern European nations do somewhat better than in most care policy comparisons. Countries from Western and Central Europe are scattered around the list. Rates of personal and practical care poverty in a country seem consistently close to each other, save for in Malta and the United Kingdom, where practical care poverty rates are distinctively lower than personal care poverty rates, and in Czechia, where the situation is the opposite.

On the whole, comparative evidence on unmet long-term care needs is still very weak. The few existing studies suggest high rates of care poverty especially in Eastern and Southern European countries. They thus reflect the level of development of formal long-term care systems and follow the typical categorisations of care regimes. The evidence regarding Southern Europe is less consistent, though. Nordic countries (except Finland), the Netherlands, and the Baltic countries are reported to have the lowest rates of care poverty, but different studies generate somewhat dissimilar results. We are still waiting for reliable international datasets that have large enough samples of older respondents with care needs in order to really know whether or not the level of care poverty follows the usual categorisations of long-term care systems.

Care Poverty and Long-Term Care Systems in Two-Country Studies

In addition to the aforementioned European studies, there are a few comparative studies of another sort that analyse unmet care needs in a pair of countries. Davey and Patsios (1999) were the first to conduct such a two-country study, comparing the situation in the United Kingdom and the United States. Using the absolute approach and combining personal and practical care, they uncovered a high prevalence of unmet needs in both countries: 44% in the United Kingdom and 53% in the United States. Access to both formal and informal care was more common in Britain, and the authors emphasised that while Britain had a community care system at the time of study, no national long-term care system for community-based services existed in the United States.

Shea et al. (2003) examined the United States in relation to Sweden. Even though the US prevalence of unmet needs reported in this study was considerably lower than the one shown by Davey and Patsios (1999), the contrast between the two countries proved very strong: the absolute personal care poverty rate was 22% in the United States, but as little as 1% in Sweden. The study discerned dramatic differences in the patterns of assistance across the two countries, especially when it came to ADL needs: only few people in Sweden failed to receive help for personal care needs, while in the United States a substantial proportion of people with ADL limitations received no formal or informal support. Older people in Sweden were much more likely to receive some formal help. The authors concluded that without a well-coordinated system of long-term care, the United States was failing to meet the personal care needs of its residents.

Gannon and Davin (2010) also used the absolute approach to compare unmet needs across France and Ireland, combining personal and practical care domains in the analysis. Data from SHARE showed high figures for both countries, but unmet needs proved somewhat more common in Ireland than in France (63% vs. 51%). Slightly more older people received informal care in Ireland (23% vs. 17%), but the share of those who received formal home care was more than double in France (24% vs. 9%). The paper states that in Ireland, formal care is provided on an ad hoc basis, while in France the system is more structured.

Finally, a recent two-country study from Austria and Slovenia (Kadi et al., 2021) differs from other comparative analyses in that it is not based on a questionnaire survey, but on qualitative interviews of care dyads—that is, older people and their informal carers. Kadi et al. (2021) define unmet needs through approachability, acceptability, and availability in addition to the accommodation, affordability, and appropriateness of formal care services. Their focus thus clearly falls on evaluating access to adequate formal care, although informal care was also discussed in the dyad interviews. The study used the relative approach as it examined people's perceptions of unmet needs. Instead of identifying major differences between the two countries, the results showed that both systems are based on familialism that has led to gaps in formal care provisions. In both countries, social and emotional needs of older people typically go unaddressed. Unmet needs were also linked to how the delivery of formal care was organised, which could involve uncomfortable timing or high staff turnover among other issues.

So, what do these two-country studies tell us about the relation between care poverty and long-term care systems? Once again, some caution is needed when interpreting the results as most studies are based on a secondary analysis of datasets that are not fully comparable. In any case, the last mentioned study compares countries with rather similar care systems, and its results show no major differences in care poverty across the pair. In contrast, the first three studies compare countries with different care regimes. Each shows a higher rate of care poverty for the country that has less extensive and less systematic formal care provisions. The datasets still leave a lot of room for improvement as the surveys were not originally collected for a comparative analysis of unmet needs. Nevertheless, these findings support the importance of formal home care in reducing care poverty.

Care Poverty and the Design of Long-Term Care Policies

While comparative knowledge of care poverty remains limited, existing local and national studies offer findings that may help with starting to build an understanding of the relationships between care poverty and the design of long-term care policy. Due to their methodological diversity, as we learned in Chap. 4, these studies do not provide us with firm comparable knowledge of the level of care poverty in different countries. Nonetheless, they can help outline some connections between policy design and the unmet care needs of older people.

The United States has produced the largest body of literature on unmet care needs, and it is American studies, in particular, that have addressed the role of long-term care policies. These studies regularly deal with one or both of the two main federal social policy programmes relevant to long-term care: (1) Medicare, which covers the whole older population but, as a health insurance programme, does not provide much social care; and (2) Medicaid, which provides social care (institutional as well as home-based care) but is based on means-testing and covers only low-income older people (e.g., Komisar et al., 2005; Allen et al., 2014).

Although these two are federal programmes, the states have a considerable amount of discretion in implementation regarding eligibility and the scope of benefits.

By the mid-1980s, the US General Accounting Office had already analysed how these two policy programmes were managing to address unmet care needs. Its report highlighted how Medicare was not intended to cover the personal care needs of community-dwelling older people, and while Medicaid worked better in this respect, it was not widely available (GAO, 1986). The report also provided a list of policy options to deal with the future home care needs of the growing older population. While further encouraging private long-term care insurance and family care through tax incentives, the main suggestions focused on expanding the home care coverage of Medicare and the availability of Medicaid—two policy recommendations that have since been repeated a number of times in American studies of unmet needs.

The landmark study from Allen and Mor (1997) occurred at a time when 'managed care', a controversial policy model aiming to reduce health care costs, was becoming widely implemented in Medicaid and Medicare. Some elements of managed care (e.g., consumer involvement) were supported by the authors, as these were seen appropriate for decreasing unmet need. But as resources for both Medicare and Medicaid were also being cut under managed care, they estimated that the policy model would likely lead to an escalation of unmet need.

Muramatsu and Campbell (2002) brought a comparative approach to American research on long-term care needs by analysing the situation across US states. Combining macro-level data on home care service expenditures and micro-level data on the receipt of informal and formal care, they observed—not very surprisingly—that in states with the highest home care expenditures, the share of older people receiving formal care was the highest (especially among those with the greatest personal care need). More interestingly, they found that the likelihood of receiving no informal or formal care—that is, the rate of absolute care poverty—in these same states was the lowest (14% vs. 27% in states with the lowest expenditures). The study concludes that a higher level of state commitment to home- and community-based services not only leads to greater provision of formal care, but also strengthens the existing informal care system. Strengthening informal as well as formal care can certainly be expected to reduce care poverty.

A few years later, Komisar et al. (2005) continued the comparative line of unmet need research by analysing the situation of 'dual eligibles', that is, of older people eligible for support from both Medicaid and Medicare, across six states. Their findings show that the greater the use of formal home care in a state, the lower the likelihood of unmet personal care needs. The receipt of formal care, primarily from Medicaid, was found to substantially reduce the level of unmet need. Moreover, the impact was the largest among those with the greatest needs. The authors end up calling for a change in federal policy either by creating a universal federally defined benefit through Medicare or by establishing greater uniformity across states for Medicaid through increased federal funding and standardisation.

Kemper et al. (2008) also compared US states based on their Medicaid home care spending to analyse whether such spending affects the probability of not receiving help with an ADL limitation—that is, absolute personal care poverty. They found the likelihood of not receiving personal care 10 percentage points lower in states at the top quartile of Medicaid home care spending per capita. In particular, the share of low-income older people with personal care needs not receiving help was significantly lower in states that spent the most on Medicaid home care. As such a difference was not observed in higher-income groups excluded from Medicaid, the researchers concluded that Medicaid reduces the proportion of older people who are not getting help despite their ADL limitations—that is, the proportion of people in absolute personal care poverty. Thus, they recommended expanding Medicaid home care.

Li (2006) also shows the key role of Medicaid in cutting down care poverty in the United States; her study found that enrolment in Medicaid reduced the likelihood of unmet needs by 70%. At the same time, Li emphasises that Medicaid programmes are generally underused, which reduces their impact. Accordingly, she recommends that older people in low-income neighbourhoods should be encouraged to participate in Medicaid.

Besides Medicaid and Medicare, the United States has a number of local and state-level long-term care policies (many of which use Medicaid or Medicare funding, nonetheless). These include intervention programmes that expressly target older people who lack adequate support. PACE (Program of All-inclusive Care for the Elderly) is one of the oldest. Started in San Francisco in the 1970s, it has since spread to most American states (Gonzalez, 2017). PACE is a comprehensive medical and social service programme that provides a package of individually tailored services including, for example, day centres, home care, and medical care. Its services are available to older people who are certified as needing care at the level of a nursing home but want to stay in their homes. Sands et al. (2006) evaluated the impact of the programme on the consequences of unmet personal care needs, especially hospital admissions. They found that 7–12 weeks after enrolment in the programme, hospital admissions fell considerably for those who earlier had no formal or informal care. At least in this respect, PACE proved effective at decreasing the negative consequences of personal care poverty.

Another way that Medicaid can be implemented is through the Cash and Counseling option, wherein Medicaid-eligible participants or their families are paid a monthly cash allowance rather than providing formal home care services. With this allowance, users can hire personal care attendants (i.e., personal assistants). Among younger disabled people, experiences with this model are very positive, as their unmet needs are reduced and user satisfaction is improved (Harry et al., 2016). Among older people, the results are more ambivalent. A study (Brown et al., 2007) observed that in one state, unmet needs were significantly lower among Cash and Counseling users in terms of both personal and practical care. But in another state, they were lower only for practical care. In a third state, no statistical difference was found between users of participant-directed and more traditional services. Likewise, a three-year follow-up on the model found a significant impact on the reduction of nursing home admissions in only one of the three states (Dale & Brown, 2006). These results thus seem to echo research from other countries showing that individual budgets and personal assistance usually work well with younger disabled people, but there may be more complications in getting them to serve older people (e.g., Leece & Bornat, 2006; Glasby & Littlechild, 2016; Kelly, 2020).

In Canada, Dubuc et al. (2011) evaluated an intervention programme called PRISMA (Program of Research to Integrate Services for the Maintenance of Autonomy). In the PRISMA model, an integrated service delivery network is embedded within the health and social care system using all of the public, private, and voluntary health or social service organisations involved in caring for older people within a given area. The model was implemented in three zones in Quebec, while three other zones served as control areas. In a three-year follow-up, it was found that unmet ADL needs were significantly less common in the experimental areas than in the control zones (31% vs. 47%). The same was true for unmet IADL needs (5% vs. 12%). The authors say that the level of empowerment among service users was higher in the programme zones and that the control zones may have had more accessibility problems. Overall, the study concludes that the service integration model appears to be effective at meeting the care needs of older adults—especially those with high needs.

Also in a six-year follow-up study in Sweden, the coordination of formal and informal care was highlighted as a key reason why rates of unmet need remained low for older adults despite a decline in the provision levels of formal home care (Savla et al., 2008). Shea et al. (2003), too, emphasise that the Swedish care system is well coordinated, targeting assistance carefully to those with personal care needs and leaving almost no one without support. This is unlike the American system, which, the authors say, largely targets those with a short-term post-acute need and fails to meet the long-term needs of its residents.

Conclusions

The local and national studies reviewed above are limited in number, and almost all come from the United States. Their analyses are fragmented, and thus, only some preliminary conclusions can be drawn. Still, one thing is very clear: the Medicaid programme has obviously played a major role in cutting down care poverty in the United States. Several studies show that more Medicaid spending leads to lower levels of unmet care needs and that Medicaid enrolees have a lower risk of care poverty than other older people with care needs. In the absence of a universal long-term care system that would provide home care to all who need it, Medicaid has been efficient at reducing unmet needs in the United States. This is because it is targeted precisely at those groups at the highest risk for care poverty: low-income older people with extensive care needs who typically come from deprived areas and racial and ethnic minorities. Specific interventions that use Medicaid resources to develop more comprehensive and integrated service packages, such as PACE, have further strengthened the care poverty mitigation effect. These American studies prove that targeted programmes such as Medicaid can have a major impact on care poverty.

At the same time, Medicaid has its limitations. It covers only a portion of older people with care needs. Even within this limited target group, not everyone is enrolled in the programme. Medicaid is also repeatedly subject to budget cuts, which has almost certainly weakened its impact. Differences between US states also remain large, reducing the potential for Medicaid to tackle unmet care needs across the country. As only the low-income minority is included in the programme, older people who fail the income test will continue to be at major risk of care poverty. This is the dilemma of all means-tested social policies: they may be efficient in their target group, but only in that group. Their impact ends where their eligibility ends.

Due to the limited quality and comparability of their data, the two-country and comparative studies reviewed here should be treated with caution. They nonetheless suggest that access to formal care is key: care poverty rates seem the lowest in countries with the most extensive and systematic provisions for formal care. In Europe, the highest rates of care poverty are found in Eastern Europe, where most countries have not yet managed to build strong care provisions, especially for home-based non-institutional care. Southern European countries, which are often understood to count on family care instead of formal provisions, do slightly better in these comparisons than they normally do, which raises a question about the impact of familialistic policies on care poverty. It may be outdated, however, to cluster all countries from the south of Europe as ‘the family care regime’; Spain, for example, has aimed to develop its formal care system in the twenty-first century.

While the data are far from excellent, European comparisons provide preliminary support for the strength of universal formal care systems in reducing care poverty. This makes sense as only universal systems strive to cover the needs of all older people. More evidence is needed before final conclusions can be drawn and firm policy recommendations are provided. But based on the current state of knowledge, the creation of a well-resourced, universal long-term care system seems to be the most effective policy choice when aiming to eradicate care poverty. However, if the welfare state context and political realities do not allow for the creation of such a system, a well-targeted national programme that provides formal care to those with the greatest personal care needs and the lowest incomes appears to be a good second choice: it will not fully annihilate care poverty, but it can still succeed at substantially alleviating unmet needs.

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Conclusions

Population ageing is taking place all over the world and leading everywhere to an increase of care needs. One of the great challenges for humankind in the twenty-first century is finding ways to deal with this development. Countries face this challenge from very different starting points. Some have developed sets of care policies, while others have very limited support structures. Some nations put their trust in informal care. Others have a legacy of institutional care, but very limited home-based care services. There is variation even among those countries where publicly funded home care is available: some welfare states provide both personal and practical care, while others offer help in only one of these two domains. Socio-emotional support is most often left to informal networks. Whatever the starting point, care needs are growing across the globe, and it is not self-evident in any country that this increase will be met adequately. Care poverty is a real risk everywhere already, and it will be even more so in the future.

In order to build policies and practices that are able to counteract the growing risks of unmet care needs, it is first necessary to understand the phenomenon thoroughly. Currently, knowledge of unmet care needs is fragmented, and the accumulation of understanding has been slow. This

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is partly due to the amount of variation in the definitions and methods used for research on unmet care needs and partly due to the separation of this literature from that on social inequalities and social policy. That is why this book has aimed to gather together existing knowledge on the issue, building bridges between different strands of research literature.

Besides describing the state of the art, this book has also suggested a new conceptual framework. It has introduced the concept of care poverty that applies approaches from poverty research, drawing attention to the characterisation of unmet care needs as deprivation and inequality. The book suggests that the notion of care poverty could introduce a more societal approach and thus help research focus its attention on social inequalities, long-term care policies, and their manifold connections with the lack of adequate care.

In existing research, the prevalence of unmet needs—that is, care poverty rates—is the issue that has received the most attention. Yet despite the growing volume of literature, the picture remains blurry as it has been difficult to summarise findings from different studies due to a multiplicity of definitions and operationalisations of unmet needs. Often, datasets used for study are local or regional, not nationally representative. Reliable international datasets simply do not exist. Longitudinal data are rare, as well. All of this makes it very difficult for analyses to grasp the connections between care poverty and societal or policy changes.

To help deal with the fragmentation of research, the book introduced a specific framework consisting of three care poverty domains and two measurement approaches. So far, research has concentrated on the domains of personal and practical care poverty. These have proven to be very different and rather independent from each other. Their rates are often dissimilar, with the first being more dominant in some countries and the second in others. Research into socio-emotional care poverty is still largely missing despite its importance, which is why loneliness studies have been used here as a sort of proxy for analysis of the lack of social and emotional support.

In this book, the two measurement methods widely used in unmet needs studies are called 'the absolute approach' and 'the relative approach' and the issues they measure are called absolute and relative care poverty. While the notions of absolute and relative care poverty follow the concepts of absolute poverty and relative poverty, their meaning is not entirely analogous. Absolute care poverty stands for the complete absence of any informal or formal support for long-term care needs. It thus recalls absolute poverty, which is usually defined as the severe deprivation of basic needs such as food and shelter (UN, 1996).

Relative care poverty is not based on comparing the level of need satisfaction in a certain group to the whole population, so it differs from the approach of relative poverty. When it comes to care, such a comparison would be irrelevant: while everyone needs food and shelter, not all in the population have care needs. Care poverty should be analysed among those who have care needs, not among the total population. Relative care poverty nonetheless takes people's expectations and normative social environments into consideration. Measurements following the relative approach are based on self-reports from older people (or the views of proxy respondents) that depend on local and national norms and values, reflecting conceptions about what is generally understood as the inadequate coverage of care needs in specific cultural contexts.

The care poverty framework proved especially helpful in reviewing the findings of earlier studies on the factors of unmet needs. Different domains of care poverty were found to have somewhat different predictors, although some factors were significant in all domains. Living alone is one such superfactor, together with health status and the number of functional limitations. Income level, too, is a significant factor in most domains—especially when measured with the relative approach. Perhaps surprisingly, gender, ethnicity, and education level proved to predict care poverty only rarely, once other variables were controlled.

Earlier studies showed that unmet needs have a number of negative consequences for older people. Adverse consequences follow especially from personal care poverty and, as the meaning of the term entails, cause the well-being of older people to deteriorate in a serious manner. A lack of assistance with basic personal care tasks such as bathing and toileting makes life substandard and undignified. Depression and other problems with emotional well-being are also among the consequences of inadequate care. Some studies even indicate an augmented mortality rate. Furthermore, the evidence shows that care poverty often leads to disproportionate use of health care and residential social care, creating unnecessary costs for social and health care systems.

The book argues that care poverty is a dimension of social inequality per se. The existence of care poverty creates a contrast between those who receive adequate care for their needs and those who are left without such support. Care is a basic human need. It is a necessary component of well-being and human dignity, so deprivation of such support indicates a major social inequality. The lack of adequate care does not merely reflect other dimensions of inequality such as poverty, gender inequality, or ethnic inequality. Instead, care poverty is a social phenomenon and a type of inequality in itself.

Although it is necessary to understand care poverty as an issue in its own right, lack of adequate support is certainly connected to other social inequalities. Intersectional analysis shows that different dimensions of inequality are interlinked, often amplifying each other's negative impacts (Williams, 2021). Income inequalities, especially, are often closely related to care poverty. This is not surprising as economic resources greatly enhance the capacity to purchase for-profit care and pay user fees for public care services. At the same time, poverty alone does not necessarily lead to care poverty. This is both because informal care resources can compensate for the lack of formal care and because care policies can bring new opportunities to people in low-income groups.

Due to language and attitudinal barriers, racial and ethnic minorities have additional difficulties in accessing formal care. These could include when information about services is available only in the majority language, or when minority groups are uncritically thought 'to look after their own' and prefer informal care to formal services (e.g., Ahmed & Jones, 2008). However, the unmet needs literature suggests that it is possible to reduce ethnic inequalities in care poverty through universal or targeted social policies. Universal programmes cover everyone, and as low-income and minority ethnic groups often overlap, targeted support for minorities or low-income population may also have a sizeable positive impact.

The empirical finding that gender is not a factor of care poverty was unexpected. Based on the wealth of feminist literature on care, we know that care is a thoroughly gendered social issue and that women are largely overrepresented among informal carers, formal care workers, and migrant care workers. As well, they form the clear majority of the very old population and, thus, of care users. But still, gender does not feature in the reviewed studies as a predictor of unmet long-term care needs.

Like we saw in Chap. 7, statistical methods can sometimes 'adjust away' the importance of a major factor. Statistics show that older people at particular risk of care poverty live alone, have low incomes, experience poor health, and have several functional limitations. But they do not highlight the fact that these people are overwhelmingly women. It is women who more often live alone in their old age, have low pension incomes due to disturbed careers, and have poorer health and functional capability due to their longer life expectancy. For example, our Finnish DACO (Daily Life and Care in Old Age) survey dataset from 2020 shows gender as nonsignificant for care poverty; at the same time, the same dataset shows that 78% of all older people in care poverty are women. Care poverty is thus a gender issue that impacts women in particular.

Social inequalities and care poverty are closely interrelated overall, placing those with limited social and economic resources at particular risk for care poverty. A recent qualitative study from Finland shows how care poverty is often intertwined with deep social disadvantage and social inequalities, sometimes resulting from life-long marginality (Sihto & Van Aerschot, 2021). At the same time, care poverty is not simply a reflection of poverty or other inequalities. It is a specific dimension of social inequality in itself, dividing people into haves and have-nots, those with and those without adequate support for their care needs.

Lessons for Care Policies

A key argument of this book has been that it is necessary to understand the lack of adequate care within its societal and policy contexts rather than as resulting from certain characteristics of older individuals. Care needs and ways to meet them are societally structured. So, too, is care poverty. Long-term care policies are a central element of these structural conditions. Policies can have a major role in alleviating care poverty, but they may also exacerbate the problem if they are not carefully planned and implemented.

Unfortunately, the knowledge base for drawing policy lessons is still rather weak. Some, but not many, studies of unmet care needs discuss the policy implications of their findings. Consequently, drawing firm policy conclusions and formulating specific policy recommendations is not yet possible. Comparative policy analyses and longitudinal studies—which both are essential for understanding the impact of social or policy changes and different policy models for care poverty—are particularly in short supply.

However, some preliminary conclusions can still be drawn. First, Europe-wide studies of unmet needs show that care poverty is most pervasive in a number of Eastern European countries. Though the reliability of the datasets still leaves room for improvement, demanding caution when interpreting results, this finding is not unexpected. Formal home care as well as support for informal carers are both limited in these nations. If care is unavailable from either formal or informal sources, widespread care poverty is the logical result. However, not all countries in the region are in the same situation; nations such as Slovenia and the Baltic states indicate noticeably more positive results.

Northern Europe, especially Scandinavia and the Netherlands, does well in the first comparative studies. Sweden, for example, displays very low levels of care poverty. These countries are known for their developed formal care provisions. The current state of the art suggests that universal care systems that also offer home-based services and target them to older people with the highest needs are the most efficient policy choice for eradicating care poverty. On the other hand, evidence on Medicaid from the United States demonstrates that a means-tested long-term care system can also substantially mitigate care poverty—though it will not be able to eliminate all unmet care needs.

Southern Europe is generally known as a family care regime, which is characterised by a lack of extensive formal care provisions and an expected abundance of informal care (e.g., Simoni & Trifiletti, 2004). While EUROFAMCARE and Eurobarometer data show high rates of care poverty for Italy and Greece, the EHIS dataset does not locate the highest rates of care poverty in Southern Europe (save for Malta). Live-in migrant care and perhaps also family care are more available in these countries than in many parts of Eastern Europe. Some Southern European countries also provide cash-for-care schemes that help finance migrant and informal care (Bettio et al., 2006; Da Roit, 2007; Da Roit & Le Bihan, 2011).

In general, familialistic social policies are connected to a traditional gender division of labour and a strong male-breadwinner ideology, contributing to low levels of female employment (e.g., Esping-Andersen, 1999; Leitner, 2014). The first EHIS findings raise the question of whether familialism could possibly work better at decreasing care poverty than in reaching gender equality targets. However, comparative evidence is both contradictory at the moment and only preliminary. Consequently, conclusions can be drawn only when more knowledge is available. Familialism comes in many shapes and forms, so further research on care poverty will also have to distinguish between, for example, familialism by default, prescribed familialism, and supported familialism (Saraceno, 2016).

The COVID-19 pandemic brought the problems of long-term care to light and public debate. The pandemic hit older people hard, and care homes, in particular, saw a massive amount of deaths—many of these due to inefficient responses to the pandemic (e.g., Thompson et al., 2020; Alacevich et al., 2021; Morciano et al., 2021). In addition to pandemic-specific problems such as the lack of personal protective equipment, several long-standing issues characterise current care provisions in many countries. These include insufficient staffing levels, substandard working conditions, problems with staff recruitment and retention, and deficient opportunities for older people to exercise influence and choice over their care arrangements (e.g., SOU, 2020; Wee & Yap, 2020; Werner et al., 2020). All these issues are relevant to care poverty, amplifying its risks.

The pandemic made clear that lack of adequate care—that is, care poverty—is a serious problem in many residential care settings. Research on unmet needs in residential care is nevertheless still limited, and that is why this book has focused on care poverty in home-based settings. During the COVID-19 pandemic, home care was overshadowed by the attention paid to care home deaths. However, issues such as inadequate staffing, insufficient quality, and limited access have characterised also home care provisions for a long time in many countries; these problems were then accentuated under the exceptionally demanding conditions of the pandemic (e.g., Sterling et al., 2020). Infections and deaths have taken place not just in residential settings, but also in home care. Many of the long-term deficiencies of home care systems derive from inadequate resourcing, which elevates the obvious policy conclusion: in many countries, substantial investments are needed in home care (e.g., Grabowski, 2021). Strengthening the capacity of home care to meet the needs of older people has been an urgent challenge during the pandemic. It will remain a key issue in the post-pandemic world.

Lessons for Research

Recent years have seen a development in social policy research where researchers are increasingly directing attention to not only the inputs and outputs of policies, but also their outcomes. This book aims to support this trend by highlighting care poverty as a critical outcome indicator of care policies. The book has made an inventory of the current state of knowledge on unmet long-term care needs and suggested a new conceptual framework for this research. A key argument has been that we must understand the lack of adequate care not only as a problem at the individual level, but also as a social issue—the roots of which are embedded in the structures of society.

Keming Yang's (2019) recent book on loneliness is centred around a similar main argument. While literature on loneliness has grown substantially in recent decades, it almost always, according to Yang, depicts loneliness as an individual psychological problem rather than a societal issue. The mission of Yang's book is to show that loneliness is indeed a social issue. In a very similar way, the main goal of this book is to argue that unmet care needs should be understood as a societal and social policy issue. While the objectives of these two books are almost identical, Yang succeeds more in presenting evidence for his argument. In his book, he shows that loneliness varies between cultures and societies, social classes, and ethnic groups. Major societal events, such as mass immigrations, large-scale social conflicts, and economic crises, prove to increase loneliness.

Unfortunately, this book has not been able to validate its argument the same way. While Yang had access to reliable international longitudinal data on loneliness, such sources are not available on care poverty. In order to analyse the impact of different policy models on care poverty, high-quality international data are needed. And in order to analyse the impact of societal disruptions and policy changes, time series data are needed. A critical challenge for the research community is thus to build reliable international datasets that can be used for comparative and longitudinal analysis of unmet care needs. This requires surveys that include specific questions on the adequacy of care, that are repeated regularly, and that collect large enough samples of older people with care needs.

Having specific questions on the in/adequacy of care means following 'the relative approach' in measuring care poverty. The benefits of this approach outweigh those of 'the absolute approach'. While the absolute approach might at first seem more objective, as it is not based on older people's self-evaluations of the adequacy of their care, it is actually also based on self-reports. It is still the older respondents who need to report whether they received informal or formal care. As it is far from self-evident what actually constitutes informal care (and sometimes even formal care), the subjective interpretative element is present in 'absolute' measurements. Above all, the absolute approach seriously underestimates the spread of care poverty because it assumes everyone who receives any support from either formal or informal sources has their care needs met. This is a groundless assumption.

It is questionable whether absolute care poverty actually represents a more serious situation than relative care poverty. Using SHARE data and thus the absolute approach, Laferrère and Van der Bosch (2015, p. 340) observed that 'the prevalence of unmet need falls with the [rising] level of need'. In other words, the absolute care poverty rate was not highest among people with the most needs; instead, it was highest among those whose needs were less extensive. As well, LaPlante et al. (2004, p. S101) argued that those who receive no help at all despite having care needs—that is, those who are in absolute care poverty—have only a low level of needs in that they mostly need help with IADLs only. Adverse consequences, as well, have been identified as less likely among those who do not receive any help than among those who receive at least some assistance (Freedman & Spillman, 2014).

The term 'absolute' signifies a severe deprivation. But the aforementioned findings suggest that the needs of people in absolute care poverty are less extensive than those in relative care poverty. Even if their needs remain fully unmet, their situation is probably less severe than those who receive some (but not adequate) support for their high needs. Relative care poverty thus probably denotes a more serious deprivation than absolute care poverty. This perception is supported by the observation that adverse consequences seem to occur more typically among those in relative care poverty than those in absolute care poverty. The evidence is still too limited to give a final answer to the question of which type of care poverty represents a more serious deprivation. Nevertheless, ambiguities around the nature of absolute care poverty are another reason to avoid the use of the absolute measurement approach.

While the studies mentioned above pay attention to the extent of needs, this is exceptional. In most studies on unmet needs, variations in the level of people's needs are not taken into account. Studies regularly measure the number of functional limitations but not their scope. However, how much and how often help is needed is of crucial importance in daily life and can also be expected to have a connection with the risk of care poverty. Research on this topic is nevertheless still very thin. In future research, especially when collecting larger international datasets, researchers should take variation in the extent of care needs into account, besides directing attention to differences between different care poverty domains and measurement approaches.

Conclusion

Like food, water, and shelter, care is a basic human need. No human being can survive without it. Everyone is fully dependent on care at the beginning of their lives. Most of us will also need it at the end of our lives. Leaving a person without necessary care means leaving a human being without human dignity, inflicting physical, mental, and social suffering on them. As we saw in Chap. 1, care poverty can even have fatal consequences.

Currently, no nation appears to be free of care poverty. This casts a deep shadow over even the most advanced welfare states, making care poverty a global plight. It is not possible to abolish all misery from the world, but leaving vulnerable older people without the care that they need raises serious questions about the legitimacy of the social order. In democratic societies, in particular, governments are expected to help people meet their basic needs and to protect their human rights. To rephrase Nelson Mandela's words on poverty from Chap. 2, it could be said that overcoming care poverty is both an act of justice and the protection of a fundamental human right to dignity and a decent life. Care poverty is not natural but man-made. It can thus be overcome and eradicated by the actions of human beings.

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