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ABHANDLUNGEN

Ageing and Care Poverty: Theoretical and Empirical Challenges

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Abstract In this article, the authors articulate care poverty as a new theoretical lens through which we might understand the challenges people face as they age and need help and support in their daily lives. They draw on similar theoretical frameworks such as unmet need in formal service provision, and demonstrate how care poverty is a more powerful epistemological and discursive tool than unmet need to analyse the complexity of needs and support that people have as they age, particularly by including the perspectives of those who give as well as those who receive care. The authors then draw on current research around defining and measuring care poverty to articulate a blueprint for further work needed and to demonstrate the clear policy and practice challenges posed by their findings.

Keywords Older people · Informal care · Formal care · Unmet need · Care theory

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Alternde Gesellschaften und ‘Care Poverty’: theoretische und empirische Herausforderungen

Zusammenfassung In diesem Beitrag wird ein evidenzbasierter Ansatz verfolgt, um einen innovativen theoretischen Ansatz zur Untersuchung der Themen Pflege und Altern zu entwickeln. Der Care-Poverty-Ansatz stützt sich auf Theorien aus den Bereichen feministischer Wohlfahrtsstaatsforschung und der Rechte von Menschen mit Behinderung. In dieser neuen theoretischen Perspektive geht es darum, Herausforderungen zu verstehen, mit denen Menschen konfrontiert sind, wenn sie altern sowie Hilfe und Unterstützung im Alltag benötigen. Dies stellt eine deutliche Abkehr von früheren Theorien dar, die sich zu sehr auf empirische Befunde zu ungedecktem Bedarf in der öffentlichen Dienstleistungserbringung stützten und – mit wenigen, bemerkenswerte Ausnahmen – entweder aus der Perspektive von Pflegenden oder von zu Pflegenden formuliert wurden. Indem der Beitrag die Entwicklung dieses neuen theoretischen Ansatzes nachzeichnet, zeigt er, wie „Care Poverty” als Analyseinstrument eingesetzt werde kann, um die Komplexität der Bedürfnisse und der erforderlichen Unterstützungen im Alter zu erfassen. Dies wird insbesondere dadurch erreicht, dass sowohl die Perspektiven der Pflegenden wie auch der Pflegebedürftigen einbezogen werden. Obwohl es sich eher um einen konzeptionellen als um einen empirischen Beitrag handelt, wird abschließend reflektiert, wie der Care-Poverty-Ansatz dazu beitragen kann, die empirischen und politischen Herausforderungen in einer rasch alternden Welt zu bewältigen.

Schlüsselwörter Ältere Menschen · Informelle Pflege · Formelle Pflege · Ungedeckte Bedarfe · Pflege-Theorie

1 Introduction

We live in a rapidly ageing society—today around 10% of the world’s population is over 65 years of age, and it is estimated that this will rise to 16% by 2050. Life expectancy has increased dramatically in developed welfare states; life expectancy in the European Union (EU) is currently 81 years, compared to 71 in 1980, and is predicted to continue rising. In many ways, this is a social policy success; reduced morbidity and mortality and increased well-being due to improvements in public health, reductions in material poverty, and improved support for older people are demonstrable proof that developed health and social care systems actively benefit their ageing citizens (Nelson and Fritzell 2014; Wagner and Brandt 2018). However, EU–wide spending on long-term care for older people has trebled since 2014 and is set to increase further to accompany the growth in the number of older people, at a time when the figures for the working-age population will be reduced (European Commission and Directorate-General for Economic and Financial Affairs 2021).

The care and support of older people is therefore a significant societal and policy concern. However, academic developments in analysing and providing theoretical frameworks to critically engage with this phenomenon have relied overwhelmingly on measures such as state expenditure on services, use of care services, and whether or not these meet the needs of older people (cf. Carrieri et al. 2017; Rodrigues et al. 2018; Vlachantoni 2019). In this article, the authors argue that such approaches are inadequate in explaining the lived experiences of older people who need care and support and their families and carers (including non-kin carers). The underlying reasons for the inadequacy of these approaches are manifold. First of all, such measures have taken an individualist approach, as in the case of unmet needs, to an issue that has its roots in structural inequalities in the distribution of resources. They fail to take into consideration carers (both family and non-kin carers) as well as those receiving care. Finally, they do not sufficiently engage with what is the main objective of long-term care systems (Kröger 2022)—and on what they should be evaluated—which is to meet the support and care needs of the older and disabled population, as well as of informal carers.

The authors make the case instead for a relatively new theoretical approach, known as ‘care poverty’, to older people’s needs for care and support in an ageing society. They first discuss how this theoretical approach has been developed to address the reasons for the inadequacy of the current approaches mentioned above, drawing on health services and gerontological, feminist, and disability rights social theories. They then draw on the limited but growing body of empirical research into care poverty to demonstrate some of its usefulness and limitations, particularly focusing on issues of measurement; the balance of responsibilities between the state, families, and the market to address care poverty; and the need for further research. They conclude by setting out a vision for the further theoretical and empirical development of care poverty. This article synthesises the main tenets of care poverty, which have thus far been presented mostly as part of monographs (cf. Kröger 2022; Kröger et al. 2025a), thus contributing to expanding its readership. This article also surveys most of the empirical studies that have applied the concept up to this day, thus providing an overall picture of the current research that has so far been lacking. Finally, the authors also critically systematise and discuss not only some of the methodological options and measures of care poverty used in the literature but also the remaining unresolved or missing issues surrounding the concept and its measurements and how these may be addressed in the future. These include possibilities to more thoroughly expand the application of the concept to informal carers, for example. In this sense, the authors also provide possible future directions for research.

2 Care Poverty in Theory

In recent decades, the term ‘unmet need’ has been used more regularly in long-term care research to focus attention on whether disabled and older persons are receiving adequate care (Vlachantoni et al. 2011; Peng et al. 2015). However, such a body of research and the concept of unmet needs itself have mostly been used in isolation from research on social inequality and comparative social policy. Care poverty, defined as ‘inadequate coverage of care needs resulting from an interplay between individual and societal factors’ (Kröger et al. 2019), aims to connect earlier research discussions on unmet needs, social inequality, and care policy and offers a framework for understanding the difficulties of disabled and older persons in having their care needs met in a societal and social policy context (Kröger et al. 2025b). In doing so, care poverty moves away from the individualist approach underpinning unmet needs. It takes a more structural approach, focusing on the inequalities of resources (for example, formal and informal care) that enable some people to meet their needs whereas others cannot. In this way, care poverty is more directly linked to social policy. By reconceptualising a lack of sufficient care as ‘care poverty’ (rather than ‘unmet need’, which, as Kelly [2025] and others point out is really just a shorthand term for ‘lack of service provision’ rather than an examination of the nature of that provision and whether it actually meets needs), researchers are empowered to treat this as a political, as well as a private, issue. Poverty is, after all, a social issue that demands action: The right to resources to enable social participation is itself a recognised demand for social citizenship that underpins the ideology of most developed welfare states (Marshall 1992).

Theoretical frameworks to explain and understand ‘care’ have historically been divided into two—sometimes portrayed as antagonistic—overarching developments. First, there is a long history of rights activism around care services that is based on the experiences of those receiving care—most often younger disabled people (Morris 2004), but their points apply equally to people above working age who need care and support. These authors take issue with those who have chiefly defined who receives care as ‘dependent’ on those who provide care (Daly 2002), an ideology that, these authors argue, itself disempowers both carers and those who need care (Shakespeare 2000). Second, drawing on a long history of feminist research, writers such as Knijn and Kremer (1997) have developed an ethical approach to care (Tronto 1998), which highlights the important role that giving care plays in individual and sociopolitical dimensions of gender inequality. They point out that the physical, emotional, and financial burden of providing care falls disproportionately on women, and thus care is both undervalued and a way of trapping women into poverty and disempowerment (Himmelweit 1999). In order to address this, feminists advocate a justice model of care—treating it as a social right but recognising it as an emotional and relational concept (Fine 2005)—a point that is further developed by Weicht (this issue). Kittay (1999) advocates both an acknowledgement of and a political aim to tackle the risk of exploitation to both parties in the caring relationship. Care as a social justice issue also enables a focus on the poverty, social isolation, and exclusion experienced by carers, particularly family carers (Williams 2001). Kröger has pointed out elsewhere (2009) that this ontological and political divide between feminist and disability rights scholars may not be as insurmountable as it appears. In fact, Rummery (2022) has argued that the conceptual lens of care poverty offers a way out of the impasse between feminist and disability rights scholars, namely by making it clear that deprivation of formal care services affects not only those who need care but also informal carers, who in those circumstances are called upon to fill this gap. In this sense, the concept of care poverty goes well beyond considering (lack of) informal care as a cause of care poverty to extending the right to ‘not be in poverty’ to those who provide care.

In its initial formulation, care poverty was developed in order to provide a critical approach to the adequacy of formal and informal care provision and place the focus of care research on those who need care and support (Kröger et al. 2019). While the situation of carers and care workers is often problematic and requires research and policy attention, the primary goal of care policy—that is, to provide care and support that *meets the needs* of older and disabled people (bearing in mind that provision does not necessarily equate to meeting of needs)—has largely remained secondary in research and policy and needs more attention (Kröger 2022). Care poverty places this aim and its evaluation directly at the centre of research and policy discussion. A case in point is the debate around marketisation in the Nordic countries and whether this policy development still delivers the goal of universalism central to welfare provision in those countries (Kröger et al. 2019). Marketisation has been posited as a solution for delivering care through markets rather than families and thus empowering both the purchasers and providers (Watson et al. 2004; Rummery 2011). But markets empower only those with sufficient resources, both in terms of purchasing power and sufficient information, and those who can reasonably withhold their labour and bargain for reasonable wages. Markets are also based on the premise of supply meeting demand at a given price. In assessing whether care systems can meet their universalism creed, an obvious starting point would be to analyse how material and care poverty are linked together. However, Kröger and colleagues (2019) show that care poverty is driven not only by individual needs and (lack of) resources but also by welfare policies and social structures. In other words, material poverty is closely correlated with care poverty only once we consider the mechanisms through which welfare states affect care availability and access.

The social citizenship of older people is protected if they are protected from care poverty—i.e. if their right to self-determination, well-being, and support that enables social participation and prevents social exclusion is protected—just as it is if their right to resources is protected. The social citizenship of carers is also protected if we address care poverty; the right to not be in poverty includes the right to not suffer material deprivation, ill health, or other issues that mitigate against social participation and social citizenship.

As hinted by its name, care poverty is closely linked with the more established concept of material poverty. This goes well beyond the hypothesis that those in material poverty may be at greater risk of facing care poverty—as income is one of the resources that older people may utilise to acquire or reward the care that meets their needs for care and support—to include a number of more conceptual connections. To begin with, both material and care poverty refer to the deprivation of sufficient resources to accomplish one's potential and societal participation (Kröger 2022). Further, parallels can be made with Townsend's call for a focus on the difference between absolute and relative poverty, as well as Sen and Nussbaum's focus on capabilities (what we above refer to as social participation) rather than functionings to replace simplistic material measures of income as indicators of poverty. Kröger (2022) and Puthenparambil et al. (2025) have pointed out that 'unmet need' among older people has often been limited across various welfare states to a narrow definition of need encompassing only 'activities of daily living' (ADLs) such as eating, bathing, and dressing. Although this definition comes close to what could be deemed as an absolute (care) poverty—akin to what in material poverty studies is considered as a subsistence level below which it should not be possible for anyone in a developed welfare state to fall and what Sen would refer to as ‘functionings’—most literature on care poverty (see the following section) has actually used a wider definition of ‘unmet need’ that includes ‘instrumental activities of daily living’ (IADLs). This latter broader definition comes closer to what Sen would refer to as ‘capabilities’ and we refer to above as ‘social participation’, such as self-determination, community engagement, and family relationships. As with material poverty, care poverty expresses not only the absence of *something* that is crucial to human existence but also something that carries with it a moral imperative or weight in such a way that society ought to do something to address that absence or gap (Hill 2022).

3 Care Poverty in Practice: The Empirical Evidence

Depending on the nature of the welfare state in question, most developed welfare states operate on the assumption that when older citizens are living in care poverty, they will receive support to address that poverty from a mix of state, market, and family sources. However, welfare states differ dramatically in where they draw the care poverty line. For example, most welfare states that fall into the Nordic model assume that the state has the primary responsibility for addressing care poverty, drawing only marginally on the family and markets. However, Rostgaard (2025) has demonstrated that even in highly state-focussed welfare states, such as Denmark, family is expected to fill in the gaps of state provision, particularly when older people have complex needs—but as this does not necessarily happen, even older people with high levels of support are left in care poverty. Indeed, Puthenparambil et al. (2025) have found that in another highly state-centred welfare state (Finland), an inverse care law operates whereby those who receive both state and family care are in fact in the highest levels of care poverty, indicating that it is extremely challenging to address care poverty when needs are very complex, even when there are significant levels of support.

Potočnik et al. (2025) show that in Slovenia there is a clear overlap between groups of older people living in material poverty and those living in care poverty: The inability to meet one’s basic needs (functionings) is impaired both by access to material resources and providers of care, and the inability to participate socially (capabilities) is also impaired by having a below-average material income and insufficient networks of formal and family care providers. According to Vlachantoni et al. (2025), this is particularly the case with socio-emotional needs—what feminists would refer to as the ‘emotional labour’ of providing care and the loneliness and lack of social participation caused by fragmented family and friendship support networks. Similarly, the emotional strains and excessive workload placed on care workers can themselves be a source of care poverty by impacting the amount of care that they can provide (Puthenparambil et al. 2025).

The majority of empirical studies on care poverty to date have employed quantitative methods. However, care poverty has also underpinned a number of qualitative studies (Sihto and Van Aerschot 2021; Leiber and Brüker 2025; Potočnik et al. 2025; Paananen et al. 2025). These included, for example, the exploration of (lack of) quality as a source of care poverty and the relationship of care poverty with the relational aspects of care (Sihto and Van Aerschot 2021; Paananen et al. 2025). While the concept of care poverty is inclusive of the needs of informal carers, so far few studies have focused specifically on ‘carer poverty’. Among the exceptions are studies that highlight the consequences of care poverty on informal carers. For example, the socio-emotional needs of those with dementia are particularly hard to address through formal care provision (Aaltonen et al. 2025). This places an extraordinary burden on family carers in every type of welfare state—and family carers—particularly intergenerational carers of older people, who are most often women (Rummery 2022), leading to a gender bias in care poverty similar to that observed in material poverty. The emotional labour of care is not just gendered in the provision of care and support, but it also extends to managing access to formal support on behalf of the older person (Ulmanen 2025). Another qualitative study that applies the lens of care poverty to informal carers in Germany offers clues as to the possible dimensions of care poverty that may affect carers (Leiber and Brüker 2025). These include the need not only for respite care but also for employment, stability, and control of their lives in the face of changing needs of the cared-for person.

Care poverty has also been used comparatively across different long-term care systems, and while the concept initially emerged in Europe, it has been applied to other realities as well (Hu and Chou 2022; Chou et al. 2024, Li and Liu 2024; Panchadhyayi and Saha 2024). For example, Chou et al. (2024) used the concept to compare Taiwan and Finland, showing not only different rates of care poverty among the two countries but also differences across different dimensions of care poverty, specifically those pertaining to personal care and practical and emotional needs. Echoing findings from previous studies (Kröger et al. 2019; Ristolainen et al. 2024), the Finnish care system seems better equipped to protect from personal care poverty, while Taiwan’s family-based model better meets the needs for practical and emotional support. Further underscoring the relevance of public policies, Hu and Chou (2022) show how predisposing factors for care poverty may be dissimilar even among culturally similar countries (China and Taiwan).

4 Care Poverty and the Challenges of Definition and Measurement

In developing the theoretical framework of care poverty, Kröger et al. take a multidimensional perspective of care poverty by distinguishing between practical care (related to IADLs), personal care (related to ADLs), and socio-emotional care (related to loneliness, for example) poverty (Kröger et al. 2019; Kröger 2022). In effect, Kröger’s (2022) multidimensional approach to assessing care poverty does not consider the possibility of substitutability because people are defined as being in care poverty if they lack care in at least one of these dimensions (i.e. practical, personal, or socio-emotional), as lack of care for ADLs cannot be replaced by care received for IADLs, for example. This is echoed by other authors, such as Hill (2022, p. 24), who define this multidimensional measure as the ‘evaluative space’ of care poverty. This distinction is important to capture, as the ability to address care poverty de-

Table 1 Measures or approaches to care poverty and examples

Measure	Definition	Example
One-dimensional	Only one aspect of care poverty or type of need (e.g., ADL limitations or IADL limitations, emotional support) is considered	Rodrigues et al. (2018) (c)
Multidimensional	Distinction is made between different types of care poverty or needs, and the care poverty head counts for each are typically compared	Kröger et al. (2019), Chou et al. (2024)
Third-party observable[a]	The assessment of being in poverty is done by an external person (e.g. researcher, health professional) or in relation to a predefined threshold (e.g. reporting limitations with ADLs and not reporting any care received) that is common for all observations/persons	Vlachantoni et al. (2025)
Self-assessed[a]	The assessment is made by the person who is the subject of the study itself, in relation both to their own needs and the adequacy of the care received	Kröger et al. (2019)
Absolute[b]	Care poverty is defined against a cutoff point (usually defined as having any needs that are left wholly or partially unmet; these can be defined as multidimensional or one-dimensional needs) that is independent of the society under study	Kröger et al. (2019)
Relative[b]	Defined as lacking resources to meet needs that typically would be met for people living in the same society; takes into consideration distribution of needs and resources in a given society	Tenand et al. (2020a[c])

[a] In the unmet needs literature, this is also defined as objective (third-party observable) and subjective (self-assessed)

[b] Definitions provided here follow closely those of the material poverty. Kröger (2022) defines absolute care poverty as receiving no care whatsoever, while relative care poverty is defined as needs that are at least partially met (i.e. some care is received)

[c] As no studies on care poverty currently employ these measures or approaches, the studies provided here as examples do not use the care poverty concept as their framework of analysis and serve merely as examples in terms of methodology

ADL activities of daily living, *IADL* instrumental activities of daily living

pends not only on political will and ideology but also on social context and the availability of resources. While some studies focus only on some dimensions of care poverty, namely those using qualitative methods (cf. Sihto and Van Aerschot 2021; Paananen et al. 2025), the majority of the empirical analysis that relies on quantitative methods have used a multidimensional approach to the measurement of care poverty.

As for the absolute and relative care poverty definitions proposed by Hill (2022) and Kröger (2022), they somewhat depart from those employed in the material poverty literature (Medgyesi et al. 2025). In the latter, absolute poverty is defined against a minimum that is established externally, while relative poverty captures the inability to meet the needs to the same extent that others do in the same societies they live in. In a nonexhaustive review of the literature, Medgyesi et al. (2025) show that most studies on care poverty have used some measure of absolute care poverty as defined by the material poverty literature. In other words, they have not defined care poverty relative to the distribution of needs and resources in a given society, but rather as lacking the care needed to meet needs in a wholesome way.

The idea of 'unmet need', a precursor (albeit, as we have argued, highly limited) to the conceptual framework of care poverty has long held traction in both academia and state measures of care provision. However, these have a hugely variable disciplinary, epistemological, discursive, and ontological history, measuring things as diverse as harm, rights, collective responsibilities, autonomy, choice, empowerment, resource distribution, and others (Hill et al. 2025). There is a sharp distinction between measures of unmet need that rely on self-assessment (largely older people themselves, when called upon to reflect on whether they feel their needs are being met) and those that rely on third-party observable and quantifiable measures (often in health sciences and practitioner-focused disciplines). There are relevant arguments to rely on self-assessment of unmet needs and care poverty. For example, these might better capture quality of care (Levy-Storms et al. 2002), especially as needs may involve an interpretational (Kröger 2022) and a relational component (Rodrigues 2020). These arguments, as well as considerations of feasibility in gathering data or using existing datasets, seem to have found echo in the majority of empirical studies on care poverty (Medgyesi et al. 2025), as self-assessment of unmet needs has been the most used form of measurement. At the same time, however, self-assessment of care poverty, as with unmet needs, presumably has some limitations when carrying out cross-country comparisons. Across different countries these measures are likely to reflect different expectations of what is adequate care, in line with the variability that is observed in relation to how needs are considered by different long-term care systems for eligibility purposes (Brugiavini et al. 2017). Given the importance, policy- and research-wise, of comparative studies on care poverty, this is where the relevance of a relative measure of care poverty is more visible. Kröger (2022) suggests that it is exactly because they capture different expectations across countries that self-reported measures should be considered as a measure of care poverty. An alternative is to use the approach of Tenand et al. (2020a, b) and standardise care use against the use that one would expect to observe among those with similar levels of need for each context. Table 1 provides a summary of the different ways or approaches to measuring care poverty described above.

In order for care poverty to be addressed from a policy and practice perspective, it needs to become measurable at a street level to shape perceptions of need and appropriate responses (Dickson et al. 2022). A lack of a universally accepted definition of ‘need’ hampers its measurement (Medgyesi et al. 2025) unless a measure of relative care poverty is employed. It is also important that measures of care poverty include information on the possible reasons for unmet needs, as not all carry the same weight for policymakers. For example, some unmet needs may reflect different preferences by users or willingness to wait or search for a better option. In a related development, Smith and Connolly (2020) argue for a typology of care needs that considers a time dimension: 1) needed but never demanded care, 2) delayed care, 3) demanded care but received suboptimal care. Beyond measures of care poverty based on a head count ratio, another relevant measure that is so far missing in care poverty studies is intensity of care poverty. The intensity of poverty assesses how far people in poverty are from the poverty threshold. An example of such measure is provided by LaPlante et al. (2004), who quantify the missing number of hours of help associated with unmet care needs for the United States. Because intensity of care poverty measures how much care would be needed to lift people out of care poverty, this would be a tool with a powerful policy guidance impact.

The evidence base we draw on for this article is largely research carried out in developed welfare states in the global North, even if not only in Europe, as seen above. The situation of care poverty in areas of the global South, where material poverty is much higher, requires its own analytical and empirical approaches from scholars working in those regions and one in which an absolute measure of care poverty (understood in a similar way to those defined for material poverty) may prove to be more adequate. Moreover, care poverty is itself a relatively new concept that has only now started to develop some traction amongst empirical data analysts working in academia and state research concerning care. This is therefore an area in which further developments are expected in the near future. Yet another blind spot refers to the measurement of care poverty among informal carers. While most of the concepts and measurement approaches summarised here apply equally to informal carers, there is still limited guidance as to what dimensions of care poverty to consider for that specific group. In this sense, qualitative studies (cf. Leiber and Brüker 2025) could provide a useful contribution to fill this gap.

5 Care Poverty in Policy: Epistemological, Discursive, and Implementation Challenges

We would argue that care poverty provides a powerful epistemological framework through which to examine the issues of ageing, unmet health and social needs, and declining social citizenship and participation. Although it has developed from ideas of unmet need, these perspectives have focused largely on the measurement of service input and provision of family and formal care, and these do not address whether or not the recipients (or indeed the providers) of such services, care, and support actually have their care poverty addressed. Care poverty is a wider framework: It encompasses personal, practical, and socio-emotional elements and the perspectives of those who need and those who give care, the structural and interpersonal elements of care, and its complexity in developed welfare states.

Care poverty provides a political as well as an analytical framework. Those living in relatively wealthy and well-developed welfare states *should not* be living in care poverty, any more than material poverty, homelessness, or other areas of deprivation that can be considered politically inacceptable in rich nations. How care poverty is addressed is an issue for citizens to debate, for parliamentarians to ask for votes on, for policymakers to shape, and for practitioners to measure, define, and address. It is clear from the evidence base that the state cannot meet the socio-emotional aspects of care poverty on its own because care involves relationships as well as technical and practical support. It is also clear from the evidence base that not all older people experience care poverty equally. There is a clear link with material poverty and other social divisions, and overreliance on the family to provide practical/personal as well as social support damages relationships and exacerbates gender inequalities.

Investment in long-term care services for older people is clearly incredibly important, as all the evidence suggests that the care poverty of growing numbers of ageing people with support needs will otherwise place an intolerable burden on family relationships and widen inequality. However, all the evidence suggests that formal care services alone cannot address care poverty or meet the needs of older people for self-determination and social participation. Investment also needs to be made in families, communities, and relationships. In some regards, addressing the current challenges caused by material poverty experienced by families and communities would provide the resources needed to develop and sustain the socio-emotional networks needed to address care poverty amongst older people. If resources are available to both older people and their families to meet their material and care needs, they themselves will develop the capabilities to be fully participating social citizens.

However, current trends in long-term care policy in developed welfare states when viewed through the lens of care poverty give rise to some significant concerns. First, following the 2008 financial crash and even more recently following the COVID-19 pandemic, it is clear that spending on health and long-term care services for older people is receiving sharp attention from policymakers keen to reduce rising costs. This has been accompanied by a shift in epistemological and discursive approaches to the provision of long-term care. For example, the Nordic welfare states were all originally founded on the basis that the family should *not* be the first provider of care and support to older people due to the gender inequality that this leads to, as it is primarily women within the family who take on such work. However, this ‘welfare consensus’ in Nordic states has seen significant challenges through the reduction of services provided at both local and national levels to older people, leading to what Kröger et al. (2019) point out is a rebalancing of the responsibility to provide care to the family, therefore introducing the risk of care poverty as well as risks for family carers that their own material, health, and socio-emotional needs may not be met.

Second, in developed welfare states relying on a more mixed economy of long-term care provision (whereby needs are supposed to be met by a mix of the state, family, and market), the role of the state in directly providing care is being severely curtailed. Individuals and families are increasingly expected to provide for their own care needs, with only residual services provided to address absolute care poverty. This has been accompanied by a shift in all types of states providing long-term care services for older people towards personalisation and individualisation of services. While this has the advantage of placing more control in the hands of older people and their families, rather than the state acting paternalistically on their behalf, there are dangers in this approach, particularly if it is coupled with the cost-reducing measures mentioned above. Rummery et al. (2022) have shown how underinvestment in personalised long-term care leads to an increase rather than a decrease in both absolute and relative care poverty, whereas it takes a relatively small extra investment to lead to much higher social returns for individuals, families, and communities in terms of work, leisure, and social participation, as well as significant health gains for older people and carers.

Finally, whilst disability rights approaches argue for a reduction in the role that family and other unpaid carers play in addressing care poverty, the empirical evidence discussed in this article clearly shows that paid care alone cannot address care poverty. In particular, the socio-emotional elements—what Kröger (2022) refers to as relative care poverty—very often cannot be met through paid care without the risks of exploitation and abuse. This means that in policy terms we need to pay more attention to the role that unpaid care from families and friends plays in addressing care poverty. Clearly, an underfunded system that relies on the exploitation of family carers does not lead to a reduction in care poverty, as the costs are simply shifted elsewhere—to gender inequality, carer poverty, ill health, and relationship strain—and do indeed significantly increase risks and costs to the state (Sherwood-Johnson et al. 2023). However, the evidence discussed in this article overwhelmingly shows that families and communities play a significant role in addressing care poverty—particularly the socio-emotional relative care poverty—in a way that cannot be done by the state or the market. In order to reduce care poverty, investment must be made in developing, supporting, and nurturing socio-emotional relationships between older people and those in their families and communities who provide them with care and support. It should also be remembered that older people are very rarely simply the receivers of care and support; very often they are providing care, support, and voluntary services to their families (for example, in the case of care of adult disabled children, grandchildren, and spouses with care needs) and their communities (it is estimated that over three-quarters of elected local councillors are over the age of 65, and older people provide significant community support in volunteering).

6 Conclusions

In this article the authors proposed a new epistemological and ontological tool to understand the lived experiences of ageing citizens who have personal, practical, and socio-emotional care needs: care poverty. Care poverty is defined as lacking sufficient coverage of care needs as a result of both individual and structural causes. Unlike previous concepts, such as unmet needs, which reflect care inadequacy at the individual level, care poverty is a manifestation of unmet care needs at a societal level. It also provides a theoretical framework to understand not only the individual experiences of ageing citizens but also those of their families and paid and unpaid carers. Moreover, it gives researchers a new epistemological, discursive, and empirical basis for analysing state, market, family, and individual responses to the care needs of ageing citizens, both within and across different national care contexts and different welfare regimes. We argue that it is therefore well suited for comparative research.

In this way, care poverty represents a substantial development in our understanding of care theory. In drawing from disparate and sometimes conflicting social theories regarding care, it synthesises gerontological, health services, feminist, and disability rights theories in a way that usefully moves us on from divisive and sometimes antagonistic debates in social care theory.

The authors provided here a novel synthesis of the defining characteristics of the concept of care poverty, its empirical applications to this date, and the open questions regarding such a still nascent concept, most notably those concerning its measurement. As such, care poverty is not a closed concept but one that is in a process of being constructed, and what the authors have sought to provide here is also a mapping of such possible developments in the future. Despite its youth, the concept has been applied already to a wide range of countries and populations, including those outside of Europe. Although the existing studies cover a wide variety of welfare regimes, it remains the analyses of the minority of the world's population. Most ageing citizens do not live in high-income welfare states—life expectancy is rising fastest in the global South and in middle and low-income nations where care poverty competes for policy attention with arguably more pressing concerns about material poverty, economic inequality, and the morbidity and mortality of populations. Similarly, the concept of care poverty also encompasses informal carers, but few empirical studies presently exist on these, particularly those based on quantitative data. These are yet other possible and welcomed directions of future developments in care poverty.

Finally, the authors have also made here a case for challenging the discourse of care to include aspects of care poverty. As authors such as Bradshaw (1972) and Sen (1983) have postulated in relation to needs in general and material poverty, the inadequacy at the heart of care poverty is one that has an ethical weight that necessitates a societal response. In one of the initial formulations of care poverty, Kröger (2022) sought to draw attention to one of the main goals of long-term care systems: that of meeting the support and care needs of the older and disabled population, as well as informal carers. So long as that goal is not attained and may even be jeopardised by developments such as marketisation, climate change, or growing competition for scarce public resources arising from the need to increase spending elsewhere (e.g. on defence), care poverty also remains an important tool to direct advocacy and policy towards the advancement of the wellbeing of older people and their carers.

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