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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

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 decommmodification was soon accompanied by the more gender-sensitive counter concept of *defamili(al)isation*, 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 defamiliatisation, 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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