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**Chapter 12**

# Towards the caring or the uncaring state? A social policy perspective on long-term care trends

**Teppo Kröger**

## <1> Introduction

From a social policy perspective, the key question concerning long-term care is the division of responsibilities between the state and the family. Whether the public sector takes a major role in responding to older and disabled people's care needs or whether it tries to avoid such a role and delegate this responsibility to the family is of decisive importance and it also has manifold consequences for our societies and their social structures. In traditional societies older and disabled people were supported most often by their families, regularly by their female members such as wives, daughters, daughters-in-law and sisters, usually unpaid and without any public support. This is still the situation in certain countries and it has significant impacts for gender relations of a society, restricting women's roles and their economic and social independence, and at the same time it leaves older and disabled people to depend on the goodwill and capacity of their family members. Furthermore, not all people with care needs have a family and even if they do have one, not all families are economically or otherwise able to help and provide care for their older and disabled members. Providing family care, especially its intensive forms, limits the lives of caregivers in many ways and often real-life family relations are not harmonious enough to make family care a realistic option.

The situation of those children, older and disabled people who did not have a family to provide care was in many societies the starting point for the development of poor relief and social welfare. In its early phase, people with care needs were placed in private households but the 19th century saw the building of a network of welfare

institutions. In the 20th century most institutions specialized, some in providing care for older people, some for children, others becoming disability institutions. In the latter part of the 20th century, institutional care came under heavy criticism as the deinstitutionalization movement brought into daylight the serious neglect and abuses that had taken place in institutions. Around the same time, services were developed also to support people with care needs at their homes, providing help for their everyday activities. Since the 1980s, concerning older people, this development has been captured and promoted by the concept of ageing-in-place.

During the post-WWII growth of welfare states, public responsibilities for long-term care expanded rapidly in several countries. The state started to take responsibility not anymore only of older people without a family or of people in poverty but also of other older people with care needs. Even when there was a family available, family members were not anymore expected to provide care alone, without any public support. Both residential and home care increased to cover a growing part of the older population. Families did still carry a large part of care responsibilities but the state enhanced its role considerably.

However, this development was not even: not all countries built public provisions in the same way in the post-war period. Furthermore, even in those countries that were building their long-term care systems, it became obvious during the last decades of the 20th century that the growth of formal care is not necessarily everlasting: in pioneer countries like Sweden beds in institutional care became reduced and, as the growth of home care was not enough to compensate for the loss of residential provision, discussion on ‘refamilisation’ of long-term care started. The balance between formal care and informal care, that is, between the responsibilities carried by the state and the family, had become under renegotiation and recalibration.

What has recently happened to this balance, the division of care responsibilities between the public sector and families? Are welfare states currently increasing or decreasing their roles in long-term care for older people? For social policy research on long-term care, this is a basic fundamental question. In particular, it is necessary to focus attention on temporal trends as, due to path dependencies, care systems are like large ships, they do not change their course easily or overnight. However, when they

do turn into a new direction, this may have radical consequences in the long term. It is thus necessary to observe both the consistencies and the inconsistencies in the developments of long-term care and also to compare the trends of different countries with each other.

**<1> Aims, data and key concepts of the chapter**

In order to exemplify and highlight the importance of research on long-term care trends, this chapter takes a look on long-term care statistics of the Organisation for Economic Co-Operation and Development (OECD) and outlines key developments in its member countries in the provision of residential and home care before the outbreak of the COVID-19 pandemic. The pandemic brought exceptional circumstances and placed long-term care under huge pressure as it was its users who were the primary risk group for severe illness and death. Care homes were hit hard by the pandemic and home care and its users also suffered widely. The pandemic created a turning point for long-term care in many countries but at the moment it is still too early to analyse it, at least based on international long-term care statistics. These are published years after and it is not yet possible to see where care systems are heading after the pandemic. Instead, it is now an appropriate time to analyse pre-pandemic trends. These are important to understand because they still create the basis upon which long-term care policies of the late 2020s, the 2030s and the 2040s will be created. When planning long-term care for the post-pandemic, still rapidly ageing world, it is thus necessary to go back to the pre-pandemic period and take a look on what was going on in the care systems of different countries.

In a number of countries the first decade of the 21st century was characterised by progress in long-term care. Spain legislated in 2006 a major reform, laying the foundation for the building of a universal long-term care system. Japan was a pathbreaker in Asia in creating in 2000 universal care provisions based on a long-term care insurance model, followed in 2008 by South Korea. At the same time, however, a number of countries were affected by austerity policies that tried to cap the growth of care expenditures, leading to stricter targeting of services and to narrowing down their contents and availability (e.g. Kröger and Leinonen, 2012).

The global financial crisis of 2008 largely ended the positive developments and brought global austerity, bringing a major disruption to the progress of the whole social care sector (see, Martinelli et al., 2017). For several years, the budgets of the public sector were under major constraint, leading to cuts of services and weakening the implementation of ongoing reforms. The 2010s still started for the public sector under the cloud of the financial crisis but rather soon this cloud started to dissipate. Austerity policies however tend to linger longer than actual economic crises and thus it can be expected that long-term care policies, too, were still in the 2010s affected by the financial crisis in many countries.

The OECD is one of the international organisations that have paid effort to provide reliable comparative data on long-term care and this chapter will use its data in examining the 2010s' developments of long-term care systems. As comparable international data on informal care are unfortunately not available, the focus will here be on formal care, especially on its most usual forms, that is, residential care and home care services. Particular attention is given to trends, that is, directions of change, which are measured by trend values. These are counted by dividing period end values (2019) of long-term care service provision indicators by baseline (2010) values and multiplying the results with 100. Trend value 100 thus stands for the baseline situation and period end values under 100 mean a downward direction and values over 100 an upward direction in service provision.

Unfortunately, reliable time-series data are not available from not all OECD countries. Several member countries like the United States and the United Kingdom can therefore not be included in the analysis. From some countries comparable data were not available from the baseline year 2010 – in these cases information was collected from a year as close to 2010 as possible. In order to catch the situation before the breakout of the pandemic, 2019 figures were used as the end point data.

Long-term care trends are here discussed particularly in the light of two opposite concepts, 'the caring state' and 'the uncaring state'. Three decades ago Leira (1992, p. 21) divided the concept of the welfare state to two parts, to 'an economic provider state' and 'a caring state', claiming also that the universalist approach is stronger in

the first than in the latter part. As a key characteristic of the 'caring state', she saw a belief in state responsibility to 'provide for the vital needs of persons who for various reasons are incapable of caring for themselves' (ibid, p. 19). Daly (1998) has also written about 'the cash redistributive state' and 'the caring state' as the two main components of welfare states. Later, the term has become used by a number other researchers. Vabø and Szebehely (2012) have connected the term with service universalism, especially in long-term care in the Nordic countries. Van Kersbergen and Woldendorp (2014), on the other hand, have used the term in a different, critical meaning, to stand for 'the passive, benefit-oriented' Dutch welfare state that was in the 1990s transformed into a more active system.

In this chapter, however, the concept of 'the caring state' refers to a large public responsibility for care, in this case for long-term care for older people. Extensive provisions of home care and residential care are thus seen as its key benchmarks. Its counter-concept is 'the uncaring state', which is characterized by limited or non-existing public care provisions. This latter term has been used earlier to stand for lacking welfare provisions in different contexts, for example for First Nations children in Canada (Barker et al., 2014) or for abortion seekers in Peru (Duffy et al., 2022). In their field work among older people in Serbia, Thelen et al. (2014, p. 107) encountered an uncaring state 'as there were no locally available services'. Here, in a similar vein, 'the uncaring state' stands for a public sector that is unwilling to take on responsibilities for the care of its older population. These two concepts thus indicate the extent and change of public vis-à-vis family responsibilities for care.

Next the developments of the 2010s in long-term care in OECD countries are examined. This empirical section of the chapter will be followed by a discussion concerning research on long-term care trends in general.

## <1> The 2010s in long-term care: trends in residential and home care

The total coverage rates of long-term care, that is, the combined rates of residential and home care among the population aged 80 or over show that the 2010s were characterised by an increase of long-term care services in OECD countries (Table 1).

On average, the total coverage increased by 11% (trend value 111). If we look at the absolute number of users, the change is even more significant: in 2019 there were on average 40% (trend value 140) more long-term care users in the OECD countries than in 2010.

However, the figures for residential care remained considerably more stable: the average trend indicator changed only from 100 (2010) to 103 (2019) and if we look at the average coverage rate, that actually decreased slightly from 11.5% to 11.2%. However, the average absolute number of residential care users did still increase by 30% (trend value 130). Due to the ongoing ageing of the population, long-term care systems need constantly to provide more and more services, just to keep the coverage rate unchanged as it is counted based on a continuously increasing number of people in the 80+ age group. Thus, absolutely speaking, beds is residential care in the OECD area did increase during the second decade of the new millennium. On the other hand, this increase remained only at the level of population ageing, that is, the average coverage rate did not raise but remained rather unaffected.

At the same time, the average figures disguise large variations between individual countries. The extreme examples are on the one hand Denmark and Israel and on the other hand South Korea and Lithuania. While in Israel the coverage rate of residential care fell by 27% and in Denmark by 23% (trend values 73 and 77), in Korea it raised by 23% and in Lithuania by as much as 60% (trend values 123 and 160). In Denmark and Israel even the absolute number of residential care users decreased (trend values 90 and 93), while in Korea and Lithuania it more than doubled (trend values 233 and 203), which is a remarkable change in just one decade.

Table 1. Coverage of long-term care services among the 80+ population in OECD member countries, 2010–2019

| Country | Residential care 2010 (% of 80+) | Residential care 2019 (% of 80+) | Residential care trend (2010=100, % of 80+) | Residential care trend (2010=100, no of 80+ users) | Home care 2010 (% of 80+) | Home care 2019 (% of 80+) | Home care trend (2010=100, % of 80+) | Home care trend (2010=100, no of 80+ users) | Total trend (2010=100, % of 80+) | Total trend (2010=100, no of 80+ users) |
|---|---|---|---|---|---|---|---|---|---|---|
| Australia | 20.7 | 18.5 | 89 | 111 | 16.3 | 20.6 | 126 | 156 | 106 | 131 |
| Czech Republic | 7.2 | 8.7 | 121 | 141 | 29.7 | 26.5 | 89 | 104 | 95 | 111 |
| Denmark | 13.7 | 10.6 | 77 | 90 | 41.3 | 29.7 | 72 | 84 | 73 | 85 |
| Estonia | 8.3[1] | 9.8 | 118 | 141 | 14.2 | 11.5 | 81 | 111 | 95 | 123 |
| Finland | 13.2 | 12.1 | 92 | 112 | 26.7[2] | 26.3 | 99 | 101 | 96 | 104 |
| Germany | 11.4 | 10.4 | 91 | 119 | 18.4 | 30.8 | 167 | 216 | 138 | 179 |
| Hungary | 6.8 | 7.6 | 112 | 123 | 11.1 | 14.0 | 126 | 139 | 121 | 133 |
| Israel | 6.0 | 4.4 | 73 | 93 | 43.6 | 52.3 | 120 | 153 | 114 | 145 |
| Korea | 7.1 | 8.7 | 123 | 233 | 13.3 | 19.0 | 143 | 274 | 136 | 260 |
| Lithuania | 11.9 | 19.0 | 160 | 203 | 60.3 | 59.4 | 99 | 124 | 109 | 137 |
| Luxembourg | 16.5 | 16.0 | 97 | 130 | 16.9 | 16.4 | 97 | 129 | 97 | 129 |
| Netherlands | 14.0[3] | 12.3 | 88 | 96 | 23.3[3] | 20.2 | 87 | 94 | 87 | 95 |
| New Zealand | 15.3 | 14.1 | 92 | 110 | 26.7[1] | 23.7 | 89 | 101 | 90 | 104 |
| Norway | 14.5 | 12.4 | 86 | 88 | 27.7 | 27.5 | 99 | 102 | 95 | 97 |
| Portugal | 1.7 | 2.5 | 147 | 199 | 0.4 | 1.4 | 350 | 432 | 186 | 246 |
| Slovenia | 13.7[4] | 12.3 | 90 | 117 | 16.4[4] | 19.1 | 116 | 152 | 104 | 136 |
| Spain | 4.2 | 5.6 | 133 | 171 | 12.3 | 21.8 | 177 | 226 | 166 | 212 |
| Sweden | 14.8 | 12.2 | 82 | 87 | 28.5 | 29.5 | 104 | 109 | 96 | 102 |
| Switzerland | 17.7 | 15.7 | 89 | 106 | 31.0 | 37.5 | 121 | 144 | 109 | 131 |
| Total | 11.5 | 11.2 | 103 | 130 | 24.1 | 25.6 | 124 | 155 | 111 | 140 |

Source: OECD 2022: Health: Long-Term Care Resources and Utilisation: Long-term care recipients https://stats.oecd.org/ Retrieved 28 December 2022.

[1] Figure for 2013, due to unavailability of comparable data for 2010

[2] Figure for 2016, due to unavailability of comparable data for 2010

[3] Figure for 2015, due to unavailability of comparable data for 2010

[4] Figure for 2011, due to unavailability of comparable data for 2010

Home care shows a more consistent growth trend across the countries. On average, its coverage rates increased by 24% during the 2010s (trend value 124) and if we look at the absolute number of home care users, it increased by 55% (trend value 155). However, also in this case, individual OECD countries have followed somewhat different paths. Denmark is again an extreme case, having cut down its coverage rate by as much as 28% (trend value 72). Its opposite country case is Portugal that has more than tripled its home care coverage during the 2010s (trend value 350). Looking at absolute numbers, the radicality of change in Portugal becomes even more highlighted: the number of home care users has more than quadrupled there (trend value 432). Also Germany, Korea and Spain have more than doubled the absolute

number of their home care users in a decade (trend values 216, 274 and 226). At the same time, in Denmark and the Netherlands even the absolute number of users has decreased (trend values 84 and 94). There are several other countries, as well, where the numbers of users have not increased practically at all, including Finland, New Zealand and Norway (trend values 101–102), and that have experienced at least slight decreases in their coverage rates (trend values 89–99).

## <1> Trends towards what? A categorisation of long-term care trends

Overall, based on coverage rates, the general trend for residential care looks thus rather stable, while home care shows an upward development, but these overall results conceal major differences between the trends of individual countries. How could these trends be categorized? And how are the developments in the two fields of home care and residential care related with each other? Denmark has had a downward trend in both residential and home care but does this go also for some other countries? And have those countries that have increased their home care been increasing also the coverage of residential care?

In a scatterplot where trend values for residential care and home care make the x and y dimensions, OECD countries are scattered around the ascending linear regression line (Figure 1). There are some countries that are scattered rather far away from the regression line, especially Portugal, due to its remarkable expansion trend of home care, and Lithuania, due to a very high trend value for the residential care. At the same time, several countries are placed close to the regression line and in many of them the trends of home care and residential care are clearly linked with each other.

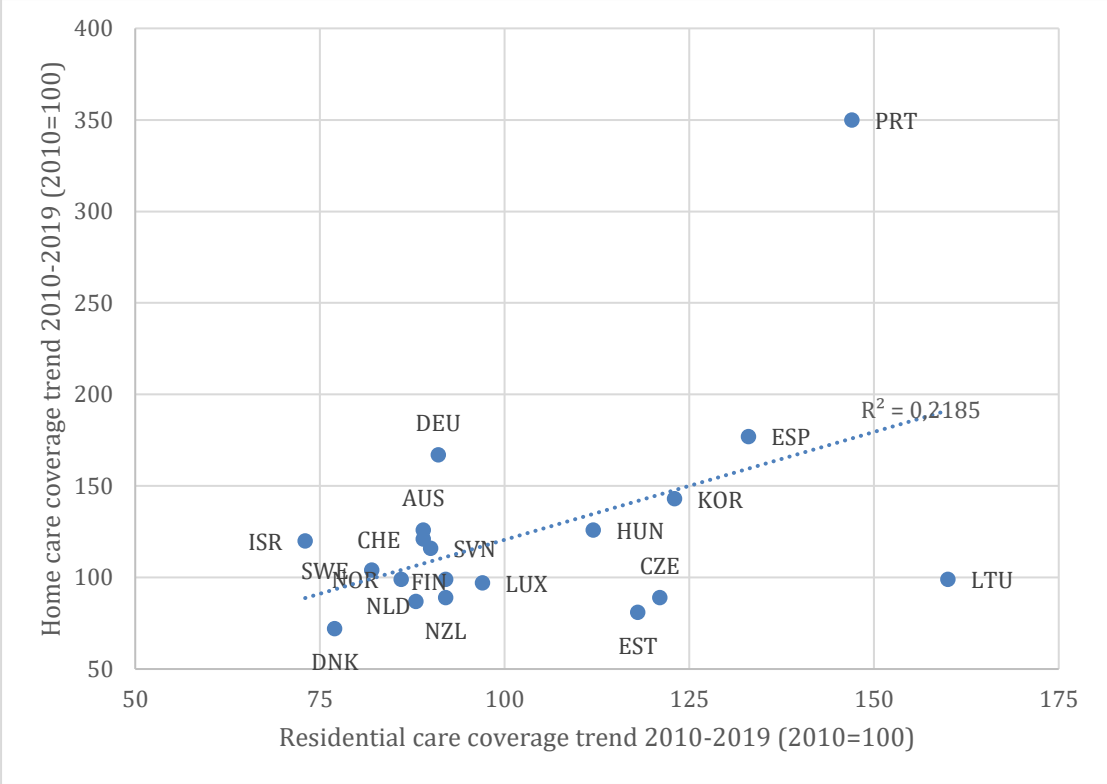


Figure 1. Trends of coverage of residential and home care among 80+ population in OECD member countries, 2010–2020

Source: Table 1

A straightforward way to categorise the long-term care trends of different countries is to look at whether their residential and home care provisions have been increasing or decreasing. From a policy perspective, coverage rates are more relevant to use for this purpose than absolute numbers of service users due to the ongoing ageing of the population: the key question is the share of the older population that are receiving vs not receiving publicly funded services, not the absolute amount of service users. When the trends of residential and home care are combined, four different categories of long-term care trends emerge (Table 2).

The category that shows an increase for both home care and residential care can be said showing a trend ‘towards the caring state’, that is, towards larger state responsibility for care in both service fields. Correspondingly, the category, where both trends go downwards, can be named ‘towards the uncaring state’, moving towards decreased public responsibility for care. In addition to these two categories, there are also two more alternatives where one service field is growing but the other

one is diminishing. The category where home care coverage is increasing but residential care coverage is decreasing is called here ‘towards ageing in place’ as it clearly follows the ageing-in-place idea. Finally, the fourth category, where the situation is the opposite and home care is decreasing while residential care is on the increase, is named here as a trend ‘towards ageing in institutions’.

Table 2. A categorisation of long-term care trends

| | Decreasing residential care coverage | Increasing residential care coverage |
|---|---|---|
| Decreasing home care coverage | Towards the uncaring state | Towards ageing in institutions |
| Increasing home care coverage | Towards ageing in place | Towards the caring state |

Based on the OECD data presented above, the 19 countries can now be placed in these four categories. The ‘towards the caring state’ category includes the nations of Hungary, South Korea, Portugal and Spain, while the opposite ‘towards the uncaring state’ country group consists of Denmark, Finland, Luxembourg, the Netherlands, New Zealand and Norway. Australia, Germany, Israel, Slovenia, Sweden and Switzerland are heading ‘towards ageing in place’, while Czechia, Estonia and Lithuania have moved ‘towards ageing in institutions’.

This grouping of countries brings several surprises. First of all, the ‘towards the uncaring state’ category includes three Nordic countries together with the Netherlands, New Zealand and Luxembourg – countries that have earlier been seen as pioneers of long-term care. At the same time, the progressive trend of ‘towards the caring state’ is observed in Hungary, Portugal, Spain and Korea, none of which has been known as a country investing heavily in care for older people. The ‘towards ageing in place’ category is more expected, including countries like Germany and Sweden that are known for their long-term care provisions. Finally, it is slightly surprising that there are some countries where residential care is increasing and home care coverage is decreasing.

It is necessary to remember here that these categories are based on trends, that is, directions of change, not on the level of care provision. We are here focusing on the direction of developments during a decade, unlike most country comparions that look at the situation at a certain time. Furthermore, as explained above, a decreasing coverage rate of home care or residential care does not mean that the absolute number of users would necessarily be in decline, due to the rapid growth of the 80+ age group. As well, in some cases a decreasing coverage rate stood in practice for a trend value of 99, that is, only 1% decrease of the coverage rate. Finally, it may also be that the data from all countries are not fully reliable or comparable with other countries. Collecting fully comparable data from a large number of countries on the ever-changing forms of home care and residential care, often with unclear boundaries between social care and health care, is a complicated task.

**<1> The starting and end points of long-term care trends**

The main attention of this chapter is on trends, as said above, but in order to understand the trends, it is still useful to know their starting and end points. Besides knowing the steepness of the curves, learning where they start from and end at can increase our understanding of them.

When comparing the 2010 starting points and 2019 end points of the four country groups, many differences come up (Table 3). In residential care, countries of the 'towards the uncaring state' and 'towards in ageing in place' categories started from a much higher average coverage rate (14.1–14.5) than those in the two other categories (5.0–7.8/9.1). In home care, however, also the 'towards ageing in institutions' category displays a high starting point (22.0/25.7–34.7) and only the 'towards the caring state' country group started from a low level (9.3). Counting residential and home care together shows that the last-mentioned category had in 2010 a considerably lower total long-term care coverage rate (14.3) than the three other categories (29.8/39.8–41.6/43.8).

Table 3. Average coverage of residential and home care within the four long-term care trend categories, % of 80+ population, 2010 and 2019

| | Coverage of residential care, 2010 | Coverage of residential care, 2019 | Coverage of home care, 2010 | Coverage of home care, 2019 | Total coverage, 2010 | Total coverage, 2019 |
|---|---|---|---|---|---|---|
| Towards the uncaring state | 14.5 | 12.9 | 27.1 | 24.0 | 41.6 | 36.9 |
| Towards ageing in institutions | 9.1 (7.8)* | 12.5 (9.3)* | 34.7 (22.0)* | 32.5 (19.0)* | 43.8 (29.8)* | 45.0 (28.3)* |
| Towards ageing in place | 14.1 | 12.3 | 25.7 | 31.6 | 39.8 | 43.9 |
| Towards the caring state | 5.0 | 6.1 | 9.3 | 14.1 | 14.3 | 20.2 |
| Total | 11.5 | 11.2 | 24.1 | 25.6 | 35.6 | 36.8 |

Source: Table 1
* Without Lithuania. Lithuania has very high values for home care (2010: 60.3, 2019: 59.4) and rather high numbers also for residential care (2010: 11.9, 2019: 19.0), which may indicate that its figures are not fully comparable with those of other countries. That is why alternative average figures are here counted for this country group without the values of Lithuania.

This general situation did not experience a major change during the 2010s: also at the end of the decade the average total coverage rate was substantitially lower (20.2) in the ‘towards the caring state’ category than in the three other country groups (28.3/36.9–43.9/45.0). In residential care, the differences between the countries diminished as the ‘towards ageing in institutions’ category (9.3/12.5) came closer to the ‘towards the uncaring state’ (12.9) and ‘towards ageing in place’ (12.3) country groups. Also the ‘towards the caring state’ group (6.1) moved somewhat closer to the other categories. In home care, the order between the ‘towards ageing in place’ and ‘towards the uncaring state’ categories changed as the former passed the latter in coverage rates. Countries in the ‘towards the caring state’ made a leap forward as their average home care coverage rate increased by almost 5 percentage points (to

14.1), coming closer to that of Czechia and Estonia (19.0) of the ‘towards ageing in institutions’ group.

Overall, it becomes clear that the ‘towards the caring state’ category has full reason for adopting its trend as these countries started the 2010s from a low level concerning both residential and home care. They still have way to go before they can actually be called caring states but they clearly have made a decision to turn their policies towards a long-term care system where the state carries a larger part of the responsibility than previously. Whereas, by contrast, in countries belonging to the ‘towards the uncaring state’ policy trends show downwards, towards decreasing public responsibility for long-term care. These countries started in 2010 from rather high provision levels but by the end of the decade they have become left behind, particularly in the development of home care. In home care, the peak position has been taken over by the ‘toward ageing in place’ group (as Lithuanian home care numbers seem not comparable to other countries and, without them, the home care coverage rate for the ‘towards ageing in institutions’ category remains lower). These two categories – ‘towards the uncaring state’ and ‘towards ageing in place’ – begun their 2010s from very similar positions and both have since reduced the provision of residential care. However, their ways have parted during the 2010s: while the former has cut down also its home care provision, the latter group has invested more in it. Concerning countries in the ‘towards ageing in institutions’ category, it is clear that the coverage rate of their residential was not on an adequate level in 2010, which explains their efforts to increase their residential provisions. What remains more a mystery is why they at the same time cut down their home care provisions which, at least when compared to the two leading country groups, seem also to need strengthening.

## <1> Discussion

The above, rather straightforward examination of changes in the coverage of residential and home care in OECD countries during the 2010s shows substantial differences in the long-term care trends between individual countries and between the four country groups. Understanding these differences and particularly the trend of

one's own country in comparison to other countries is vital for policy-making: without knowledge of the past trajectory and its national specifities, planning the nation's future trajectory for long-term care is on a weak foundation. International organisations are also in need of comparative knowledge on long-term trends to guide their actions and recommendations to their member countries. It is clear, for example, that policy recommendations for countries belonging in the 'towards the caring state' category need to be rather different from those given to 'towards the uncaring state' countries as the first group is increasing public responsibility for care while the latter is cutting it down, though starting from a considerably higher level.

This chapter started by argueing that, from the perspective of social policy, the division of care responsbilities between the state and the family is a key question. However, strictly speaking, the data used above cover actually only a half of this question. OECD datasets provide information on formal care, that is, on public provisions, but they do not offer data on the extent of care responsibilities carried by families. Thus we can only indirectly assume that an increase in public activity reduces the responsibilities of the family and vice versa. These conclusions would be on a stronger ground if comparative time-series data would be available also on informal family care. Comparative research and datasets should not anymore focus solely on formal care as it is already well-known that informal care is the actual mainstream of care and that in the everyday life of older and disabled people, informal and formal care are thoroughly intertwined. Some research projects and networks like the Survey of Health, Ageing and Retirement in Europe (SHARE) aim to provide international data also on family care but these datasets are not yet on the same level as statistics for formal care.

Besides strengthening comparative longitudinal work on informal care, it is necessary for the future research agenda of long-term care to address another major gap of comparative knowledge and data. Current statistics focus on provisions of care services but we have very limited knowledge on whether these provisions are adequate, enough or fitting with the care needs of older and disabled people. If they are not, long-term care fails in its basic mission to cover the care needs of the population. Looking for an answer to this question, research on 'unmet long-term care needs' has been growing gradually during recent decades, but in many countries this

research is still in its infancy (Kröger 2022). Furthermore, there are practically no reliable international datasets that could be used to analyse the issue. Longitudinal comparative data are in particularly burning demand. In order to strengthen this research strand and to connect it better with social policy research, the concept of 'care poverty' has recently been suggested as a starting point, conceptualising inadequate care as a specific dimension of social inequality and deprivation (ibid). In social policy research, the questions of 'who gets what' and 'how are benefits and services distributed between different population groups' and 'who is left without support' are central and these questions are necessary to be highlighted in future long-term care research, as well. In order to assess the outcomes of changes of long-term care policies on unmet care needs, it is not enough to have individual separate studies from a few countries on this issue – systematic collection of reliable and comparable international data is required also on this topic.

In summary, the long-term care model of a nation, that is, the ways how the care needs of its population are addressed, can be argued to consist of three elements: care needs covered by formal care, care needs covered by informal care and care needs that are left uncovered. In order to properly understand care systems in their totality, we need knowledge on each of these three. At the moment, international longitudinal data is available on the first one but not much on the second and practically not at all on the third element. This needs to be changed if nations and the international community are to face the rapid ageing of the population and the connected substantial increase of care needs with long-term care policies that are not based on groundless assumptions but on knowledge.