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Care Under Constraint: Unmet Care Needs Among Older Adults in Romania

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Abstract

Population ageing is a common trend across Europe, yet its social consequences vary significantly between countries. In Romania, older adults face heightened risks of social exclusion and vulnerability, shaped by the legacy of post-communist welfare transformations and large-scale emigration. The shift from a state-socialist model of social protection to a fragmented, residual system has led to a growing reliance on families and informal networks. At the same time, outmigration of the care workforce abroad has generated a domestic care drain. As a result, access to care in later life is characterised by significant inequalities, which depend on family resources, material conditions, and geographic location. Drawing on a 2025 national survey of over 900 persons aged 65 and older, this study examines the relationship between the care needs of older people and the support they receive, with the aim of identifying the most vulnerable groups. Anchored in the care poverty framework, the analysis considers individual characteristics (age, gender, health status, socioeconomic position), family context (living arrangements, presence of migrant children), and structural dimensions (urban-rural divides). Findings reveal that older adults living in rural areas, those residing alone, individuals with migrant close family members, weak social networks, material deprivation, or poor health are more likely to experience care poverty. These results highlight the uneven distribution of care resources and point to the urgent need for targeted policy interventions to mitigate inequalities in later-life care provision.

Keywords

care needs; care poverty; later-life inequalities; Romania

1. Introduction

Increased life expectancy and longevity have led to a steady growth in the share of older people across Europe, with those aged 65 and above accounting for approximately one-fifth of the total population (Eurostat, 2024). In 2024, 20% of Romania's population was over the age of 65. Although demographic ageing is a common European trend, its social consequences are not evenly distributed across the continent.

Following the collapse of the communist regime in 1989, Romania's transition to a market economy was among the most radical in the region, characterised by what Ban (2016) terms "disembedded neoliberalism," a form of market liberalisation marked by minimal social buffers and limited welfare investment. Over the past decades, the development of policy sectors has not followed a single, coherent pattern of change (Rațet al., 2019). The result is a dualised welfare system that offers relatively generous, contribution-based horizontal redistribution for those in stable employment but limited vertical redistribution for precarious workers and individuals with reduced market capacity (Rațet al., 2019), such as older persons. Social services for vulnerable groups, including long-term care for older persons, have largely remained the responsibility of families or have been outsourced to private organisations, often with limited state support (Rațet al., 2019).

In Romania, the obligation of a person's descendants to support their parents when they can no longer support themselves is stipulated in the Family Code; support may be in-kind or financial. State intervention is subsidiary and complementary, stepping in only when neither older adults nor their families can secure adequate housing and care. Consequently, public allowances for old-age care are low and unevenly accessible. As a result, families bear both the labour and a significant share of the financial costs associated with care. The reach of formal services remains limited, particularly in rural areas and for low-income households.

More recent policy documents emphasise the prevention of institutionalisation, the expansion of home care services, and the provision of support for family carers (Romanian Government, 2022). However, implementation has so far been partial. Recent legislative changes signal a cautious shift toward recognising informal care, notably through the introduction of a standard contract for informal carers and the regulation of care allowances (Ministry of Labour and Social Solidarity, 2023). While these measures aim to protect carers from labour-market withdrawal, in the absence of substantial investment in affordable home-based services, they risk formalising family care rather than expanding service coverage.

These institutional arrangements interact with enduring cultural norms that emphasise family responsibility and traditional gender roles in caregiving. Historical analyses show that Romanian family policy has been predominantly child-centred, prioritising demographic objectives over support for carers or the development of comprehensive long-term care systems for dependent adults (Inglot et al., 2022). As a result, care for dependent older persons has remained marginal within the family-policy framework, reinforcing reliance on informal, family-based care. Caregiving is commonly framed as a moral obligation, primarily assumed by women and frequently delivered without specialised training or adequate public support (Rațet & Szikra, 2018).

Taken together, these dynamics point beyond questions of service provision toward the relational foundations of care itself. We argue that care goes beyond a simple service transaction. Instead, it is a relational practice deeply embedded in social relationships. The availability or lack of care during times of

need serves as an indicator of an older person's embeddedness in supportive relationships and, more broadly, of their inclusion within or exclusion from essential social networks (Tronto, 1993). These dynamics are shaped by interconnected structural factors, including class, gender, and where one lives, which affect both the availability of care and the ability to access it. To better understand these inequalities, we employ the conceptual framework of care poverty (Kröger, 2022; Kröger et al., 2019). This concept sees unmet care needs not just as a lack of services, but as a result of broader social vulnerabilities. Care poverty includes both the lack of practical help and the weakening of relationships that usually support caregiving. Therefore, unmet care needs can indicate not only a need for assistance but also exposure to structural disadvantages and limited access to resources.

By foregrounding the interplay between relational care and structural limitations, this research contributes to a more complex understanding of how ageing, inequality, and the moral economies of care intersect in post-socialist contexts. Specifically, the study examines how care relationships are structured for non-institutionalised older adults and the extent to which their support needs are met or remain unmet. Although research on ageing and care has expanded significantly in recent decades, studies focusing on Central and Eastern Europe remain relatively limited, and those specifically addressing Romania are particularly scarce. Using data from a national survey on older persons aged 65 years and over, conducted in 2025, the article addresses two research questions:

> RQ1: How do structural and socio-economic conditions shape the likelihood that older adults experience unmet care needs in Romania?
>
> RQ2: How do relational and familial factors interact with health status in influencing whether older adults' care needs are met or remain unmet?

To analyse these dynamics, the article combines a care configuration perspective with the concept of care poverty, thereby understanding unmet care as both structurally and relationally produced. The next section reviews the relevant literature and develops the theoretical framework, focusing on the intersection between care configurations and care poverty. Six hypotheses are built around the role of individual characteristics (age, gender, health status, socioeconomic position), family context (living arrangements, presence of migrant children), and structural dimensions (urban-rural divides). The third section discusses the data and research methodology. The findings are then presented comparatively across different care outcomes (no need, met need, unmet need). The article concludes by discussing the implications of the findings for social inclusion policies and care provision practices.

2. Literature Review and Theoretical Framework

Drawing on the care configuration model (Daly, 2021; Pfau-Effinger, 2017; Williams, 2018), care practices are situated within a broader sociocultural and institutional context, emphasising how welfare regimes, gender norms, and family structures co-constitute specific constellations of care. In parallel, the concept of care poverty (Kröger, 2022; Kröger et al., 2019) provides an analytical lens through which unmet care (having care needs but not receiving adequate or any support) is interpreted not simply as a service deficit, but as a manifestation of material and relational deprivation under conditions of social vulnerability. By putting these perspectives into dialogue, our contribution challenges the reductionist view of care as a

technical or commodified service, instead advancing care as a socially embedded practice that is both shaped by and constitutive of broader structures of inequality, dependency, and social cohesion.

Starting from the premise that care is a complex social process embedded in the institutional and relational fabric of society (Tronto, 1993, 2013), care can also be understood as a right, a need, and a resource for social inclusion. It is not merely an act of support but a fundamental condition for social participation and dignity in old age. By integrating the care configuration and care poverty frameworks, we aim to explain the overlapping effects of macro-structural forces and micro-level relational dynamics on care. This nuanced analysis transcends the idea that care is an isolated flow of labour and highlights its incorporation within moral economies, welfare systems, and everyday support practices.

Neoliberalism, as described by Harvey (2005), does not function in opposition to local moral values but instead operates through their co-optation and re-signification, particularly by emphasising individual responsibility and familialism's ideals (Nguyen et al., 2017). Care for older people is produced within configurations of actors, resources, norms, and regulations that transcend the boundaries of the state, market, family, and the voluntary sector (Glucksmann & Lyon, 2006). From the perspective of "the total social organisation of labour," these domains are interdependent rather than separate. Care spans public and private divisions, as well as paid and unpaid sectors, and is enacted through ties of varying strength, continuity, and authority (Glucksmann & Lyon, 2006). Configurations are relational and contextual, reflecting who is available to care, under what conditions, with which skills, time, and money, and according to which normative expectations (Daly, 2021; Potter, 2019; Tronto, 2017). Potter (2019) revisits two contrasting models of care allocation: the task-specificity model, which focuses on the alignment between carers' capacities and care tasks, and the hierarchical-compensatory model, which assumes that care needs will be met sequentially by available members of a normative caregiving hierarchy. In this sense, configurations are the mechanisms that generate concrete support structures. The care poverty lens shifts our attention to the outcomes of these mechanisms, conceptualising unmet care needs as a form of deprivation and social exclusion rather than a mere individual shortfall (Kröger, 2022; Kröger et al., 2019). It insists that whether needs are met depends on structural arrangements such as welfare rules, financing, marketisation, and territorial service supply, as well as on gendered and familistic norms that allocate responsibilities.

We use care configurations to explain how support is organised, and care poverty is a diagnosis of failure within that structure. Care configurations specify the mix of actors, resources, and rules through which care is produced, and care poverty indicates when that mix does not suffice, leaving needs unmet. The resources at hand, their quality, and the governing regulations can transform needs into effective support or leave them unmet. The key distinction between the presence or absence of adequate support in the face of care needs becomes central for understanding which older adults are able to maintain their dignity, autonomy, and participation, and which are left with unmet needs, fragmented care, or complete neglect (Potter, 2019). Who is deemed "deserving" of support, and under what conditions, is not value-neutral (Daly, 2021). Care configurations, then, reflect not only resource distributions but also symbolic and normative judgements that include or exclude older adults from meaningful support networks. Drawing on research on poverty and inequality, especially the notion of deprivation as social exclusion, Kröger (2022) argues that inadequate care is comparable to being denied other essential social goods. In this view, care is not just a service or resource but a social right, and its absence constitutes care poverty.

Across Europe, older people have become increasingly likely to live alone in recent decades due to demographic factors (declining fertility has reduced the number of adult children with whom to share a household), economic factors (increased income levels enabled people to afford to live independently), and cultural factors (increased individualism; Dykstra, 2021, p. 206). Women are more likely than men to live alone due to their higher life expectancy and, consequently, their higher risk of becoming widows. Those living alone often turn to individuals outside their household for support when necessary. They are at risk of unmet care needs, especially as they age and their health declines (Calderón-Jaramillo & Zueras, 2023; Dykstra, 2021; Kröger, 2022; Vlachantoni, 2019). Considering the risks mentioned above, we expect that older adults living alone are more likely to experience unmet care needs than those living with a partner or other family members (H1). Building on this, another hypothesis posits that older adults with weaker support networks are more likely to experience unmet care needs than those embedded in stronger social networks (H2).

International and internal migration patterns influence the availability of carers, the conditions they must meet, and the resources they can access. These patterns influence care configurations, which can either prevent or produce care poverty. The out-migration of working-age adult children can increase the financial capacity of non-migrant older parents through remittances (Földes, 2020). This phenomenon can result in family care being replaced by purchased services or informal arrangements, but it can also leave gaps where service markets are weak or eligibility rules are stringent (Kilkey & Merla, 2014). At the same time, transnational and circular mobilities produce complex and diverse care relationships maintained not only through money, but also through visits and mediated communication, with moral expectations of reciprocity negotiated at a distance (Baldassar & Merla, 2014). In this sense, transnational family arrangements can serve as a compensatory measure for weak local support. Literature on transnationalism explains the connections between the family, state, market, and non-profit sector through the "care diamond" and shows how care tasks are concentrated within households (Vianello, 2016). Within these constellations, caregiving responsibilities are maintained by a person who remains in the country of origin, typically a woman from the extended family or an informal network. At the same time, migrant relatives provide financial remittances and coordinate support from afar. For the parents of migrants, however, access to public, commercial, or non-profit services remains intermittent and stratified along social lines, leading to an unequal distribution of care deficits (Vianello, 2016). Discussing care migration, Lutz and Palenga-Möllenbeck (2011) argue that destination countries externalise their social reproduction costs by relying on women from Central and Eastern Europe, whereas countries of origin experience a familial care deficit. Romania is one of the main countries of origin for care workers in Western Europe, resulting in a significant care drain effect. Accordingly, we expect that older people with close family members living abroad are more likely to experience unmet care needs (H3).

In a care configuration, gender, as a key normative determinant, describes who is expected to do what, when, and for whom. Within personal networks of significant others, ties differ by type and frequency, and their formation reflects life-course trajectories shaped by class stratification, gender differences, and generational position (Widmer, 2010; Widmer et al., 2018). Gender role inequalities are especially evident in familialistic regimes characterised by strong family obligation norms and limited formal care provision (Haberkern et al., 2015). Furthermore, gender inequality increases due to high public spending on cash benefits and low professional care (Haberkern et al., 2015). In familialistic settings, gender norms translate into the recurrent assignment of hands-on, time-intensive care to women (especially daughters or daughters-in-law; see Batur

et al., 2024; Raschick & Ingersoll-Dayton, 2004). Studies using SHARE data demonstrate that women are more likely to provide informal care and to do so as sole caregivers, while men tend to share or outsource caregiving responsibilities (Bertogg & Strauss, 2020; Ilinca et al., 2022). Women appear to be more likely to use both formal and informal support, whereas men primarily rely on informal care (Ilinca et al., 2022). In terms of care receipt, women are more likely to experience unmet healthcare needs than men due to economic reasons (Rahman et al., 2022). Building on this literature and given that Romania is characterised by limited formal care services and strong familistic norms, we expect that gender significantly influences access to adequate care, with women being more likely than men to experience unmet care needs (H4).

Research on the association between resource availability and the likelihood of experiencing unmet needs is inconsistent. For example, when controlling for age, health, or living arrangements, variables that described the care recipients' socio-economic status did not significantly account for unmet needs (Dunatchik et al., 2019; Hlebec et al., 2016). Other research shows that unmet healthcare needs are strongly linked to education level, primarily due to cost-related barriers (Rahman et al., 2022). Older adults with higher education levels report substantially lower cost-related unmet needs than those with lower education levels (Rahman et al., 2022). More substantial evidence suggests that the income group is a significant determinant of explaining unmet needs. Older adults without economic privileges are more likely to have unmet care needs than those who are rich, regardless of the reason for the lack of support (Rahman et al., 2022). Based on this evidence, we hypothesise that lower socio-economic status, as reflected in lower education and existing material deprivation, increases the likelihood of experiencing unmet care needs (H5).

Internal mobility and uneven territorial development also negatively affect access to care by placing services and paid carers in cities, creating "care deserts" in rural and peripheral areas, where transport barriers, shortages of skilled personnel, and service deficiencies make it difficult to meet care needs (Brînduşe et al., 2024; Ungureanu et al., 2020; Weinhold & Gurtner, 2014; World Bank, 2022). Higher-income regions tend to offer better-quality care, while increased mobility of patients and workers may exacerbate inequalities and undermine service stability in middle- and low-income areas (Brekke et al., 2016). Based on this, in the Romanian context, we expect that older adults living in rural areas are more likely than those in urban settings to experience unmet care needs (H6).

3. Methodology

3.1. Data

The data used in this study were collected through a nationally representative survey targeting the Romanian population aged 65 and over. The survey was implemented by a professional research company with extensive experience in social science fieldwork in Romania, the Romanian Institute for Evaluation and Strategy (https://ires.ro). The sample consists of individuals selected through a simple random sampling using random digit dialling (RDD). To ensure adequate coverage of the older population, the sample was supplemented with respondents from previous surveys who met the age criteria and had originally been selected through probabilistic methods. Data collection was conducted in January 2025 using computer-assisted telephone interviewing, a method that enhances the standardisation and reliability of responses.

The questionnaire was designed to capture multiple dimensions of older adults' lives and care arrangements, including self-reported physical health, emotional well-being, financial needs, sociodemographic characteristics, family migration (particularly the emigration of adult children), help received and provided, living arrangements, and attitudes towards long-term care and support. The questionnaire included "tried-and-tested" survey questions from existing recognised surveys measuring relevant concepts, such as the Survey on Health, Ageing and Retirement in Europe, the Generations and Gender Survey, and the Population Policy Acceptance Study, brought together to capture issues at the intersection of ageing, care, migration, intergenerational responsibility, and commodification.

All procedures complied with applicable national and European data protection requirements. Informed consent was obtained from all participants, personal data were pseudonymised prior to analysis, and data were stored securely for research purposes only. As the data were collected through a telephone survey, participation was necessarily limited to older persons able to engage independently in a phone interview. This implies that individuals with very severe impairments, such as advanced dementia or serious hearing problems, are likely underrepresented, and that observed levels of care needs and unmet care needs should be interpreted as conservative estimates. At the same time, the survey is well-suited to capturing the situations of older adults living in private households—who constitute most of the older population in Romania—and for whom care arrangements are most strongly shaped by family resources, social networks, and local service availability. In this sense, the data are appropriate for analysing how relational and structural factors intersect to produce unmet care needs outside institutional settings, which is the primary focus of this study.

Table 1 presents the composition of the analytical sample, consisting of 918 individuals. Unweighted frequencies reflect the observed sample distribution, while weighted percentages reflect the estimated population distribution after post-stratification weighting applied on age, sex, urban-rural residence, regional distribution, and education level. The most notable difference is in the education level. Likely due to the recruitment method, the analytical sample overrepresents highly educated individuals relative to the general old age Romanian population, which is characterised by comparatively low educational attainment.

Table 1. Sample composition.

Variable		N (unweighted)	% (weighted)
Gender	Man	408	39.9
	Woman	510	60.1
Education level	Low education	108	46.4
	Medium education	549	41.9
	High education	261	11.6
Age	65–74 years	673	61.6
	75+ years	245	38.4
Living arrangement	Living with spouse only	403	39.7
	Living alone	288	36.3
	Other living arrangement	227	24.0
Residence	Urban residence	543	53.9
	Rural residence	375	46.1

Table 1. (Cont.) Sample composition.

Variable		N (unweighted)	% (weighted)
Support network	Good support network	779	81.0
	Weak support network	139	19.0
Material deprivation	No material deprivation	668	65.1
	Material deprivation	250	34.9
Migration of family members	No migrant family member	624	62.4
	Migrant family member	294	37.6
Self-perceived health status	Good health	792	78.3
	Bad health	126	21.7

3.2. Method

The survey did not register detailed activities of daily living (ADL) but asked about any long-term illness or condition that might create difficulties in performing daily activities. We consider respondents with severe difficulties to have needs for care that are more intensive, similar to ADL (e.g., eating, bathing, walking). We are interested in seeing the match between the care needs and the support received and, consequently, the dependent variable accounts for three possible situations: no need for care (either no long-term illness or no limitation in performing daily activities), need for care and support received, and need for care but no support received.

In measuring unmet care needs, we adopt an absolute approach, as introduced by Vlachantoni (2019), which refers to individuals with a clear and identifiable need for care who do not receive any support. The downfall of this approach is that it portrays those who receive care as receiving the support they need, without accounting for the quality or adequacy of that care, thereby underestimating the prevalence of unmet care needs. Our focus will consequently be on the most vulnerable groups, those who are entirely excluded from care systems, whether formal or informal (Vlachantoni, 2019).

Several groups of explanatory factors are included in the analysis. One set consists of relational and familial factors, referring to support network opportunities and constraints: living arrangements, the existence of migrant family members, and the reported strength of the support network. We grouped living arrangements in three categories: living alone, living with a spouse only, and other configurations. The strength of the support network is dichotomous, measuring whether the respondent confirmed having enough people around them whom they could ask for help in any situation.

A second group of variables refers to structural and socio-economic conditions, such as rural or urban residence, material deprivation, and education level. For material deprivation, we followed the Eurostat methodology: A person is considered to experience household-level material deprivation if they lack at least three of the following items: capacity to face unexpected expenses, capacity to afford paying for one week of annual holiday away from home, capacity to be confronted with payment arrears (on mortgage or rental payments, utility bills, hire purchase instalments or other loan payments), capacity to afford a meal with meat, chicken, fish or a vegetarian equivalent every second day, ability to keep home adequately warm, access to a car/van for personal use, and ability to replace worn-out furniture. Education was grouped into

three levels: low (elementary), medium (secondary), and high (tertiary). The control variable age is grouped into two categories: 65–74 years and 75 and above. Self-perceived health status is grouped into two categories: poor health (those who rate it as bad or very bad) and not poor health (those who rate it as neither good nor bad).

Using multinomial logistic regression, we comparatively investigate the characteristics of older people associated with each of the three instances of the need-support combination: no need for care, needs with support, and needs without support. Our focus will be on the most vulnerable category of those with care needs but lacking support.

4. Descriptive Results

We consider reporting severe difficulties in performing daily activities to be equivalent to the need for personal care. By the same logic, we considered reporting at least moderate difficulties as being similar to having needs for practical help around the household, like the instrumental ADL (e.g., cleaning, cooking, shopping). The overall degree of perceived difficulties in daily activities is 22% for severe difficulties and 53% for at least moderate difficulties. However, the extent of difficulties varies by different characteristics. Individuals with self-perceived bad health show the highest degree of limitations in performing daily activities. Women, persons aged 75 and above, those with the least education, individuals living alone, those experiencing household-level material deprivation, those with a close family member who is a migrant, those with a weak support network, or those residing in rural settlements exhibit greater dependence on support (Figure 1).

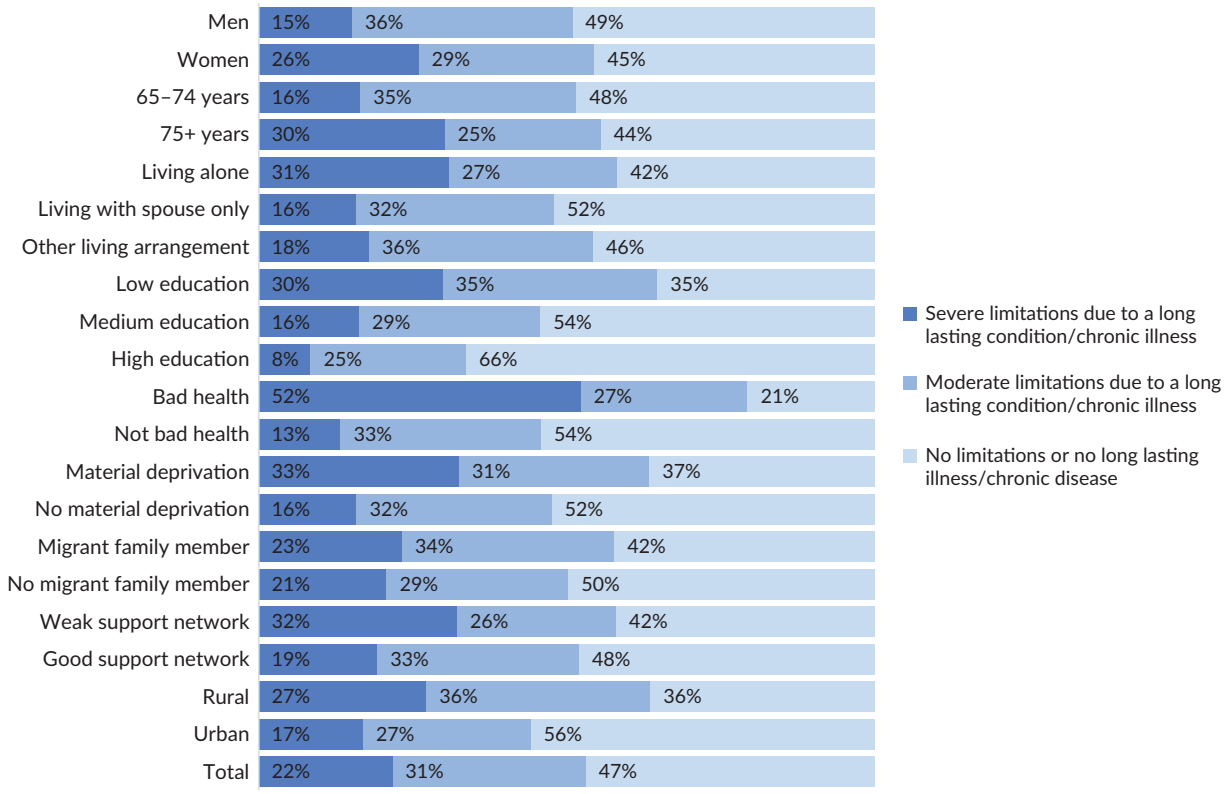

Figure 1. Distribution of respondents by the degree of limitations in daily activities and different characteristics. Note: The figure shows weighted percentages. Source: Authors' analysis based on primary data.

Further analysis reveals that those with severe limitations in daily activities (considered as having needs for personal care) disproportionately confront a lack of support (Figure 2). The overall level of care received, as a percentage of individuals in need who receive help, is only 19%. Only for the oldest, in poor health, those with family members in their proximity (not living alone or not having close migrant family members), or living in urban settlements, does the level of help and care they receive exceed 20%.

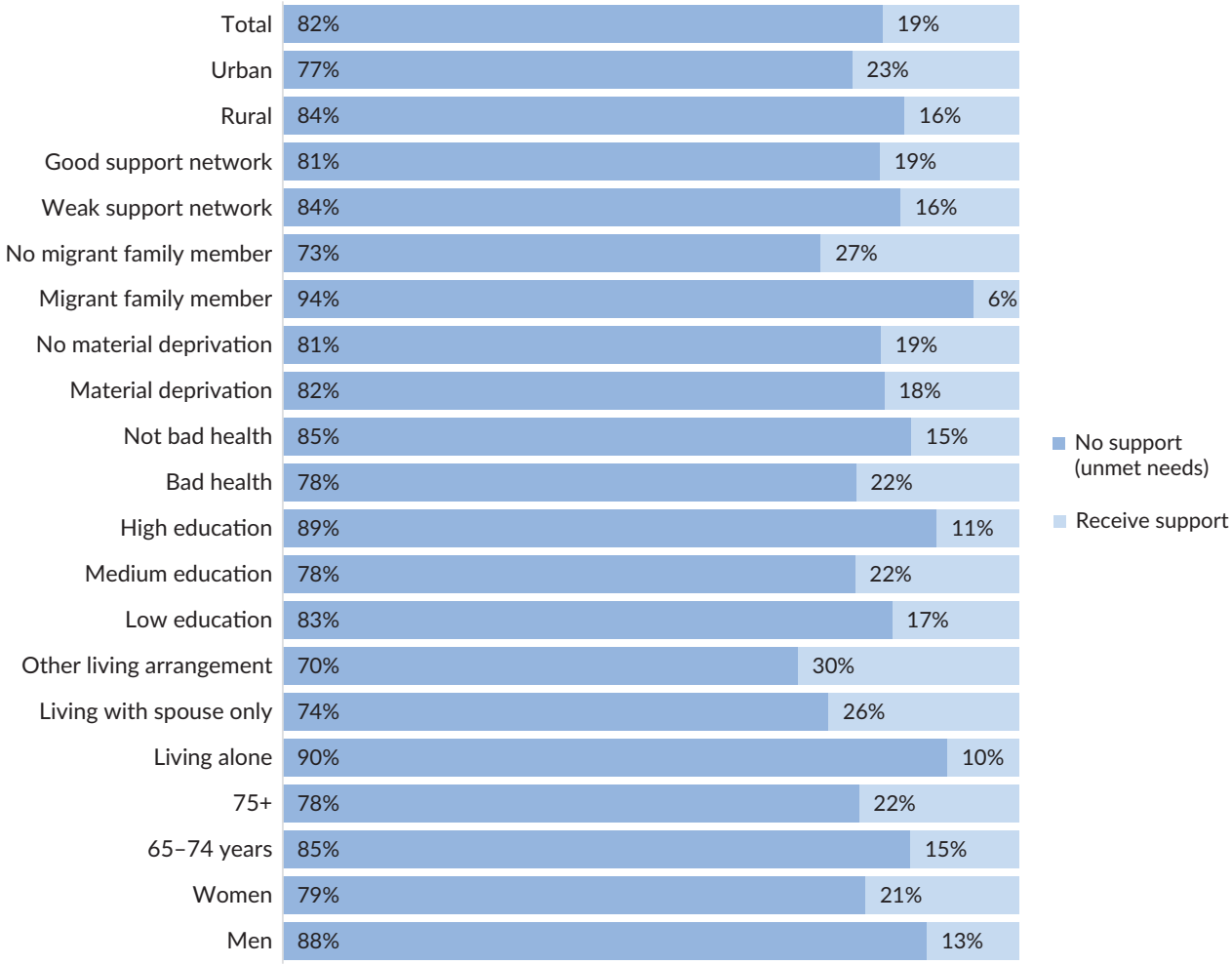

Figure 2. Respondents with severe limitations in daily activities, organized by support received and different characteristics. Note: The figure shows weighted percentages. Source: Authors' analysis based on primary data.

By considering the presence or absence of personal care needs alongside the availability or lack of support and care, we gain an in-depth understanding of older individuals. We use this approach in our multivariate analysis to compare the characteristics of respondents associated with each outcome and to profile the most vulnerable group of persons with unmet care needs. Figure 3 illustrates that within the entire sample, the most vulnerable individuals—characterised by unmet care needs—are women, the oldest, those living alone, individuals with low educational attainment, those in poor health, those facing material deprivation, individuals with a migrant family member, those with a weak support network, and residents of rural areas.

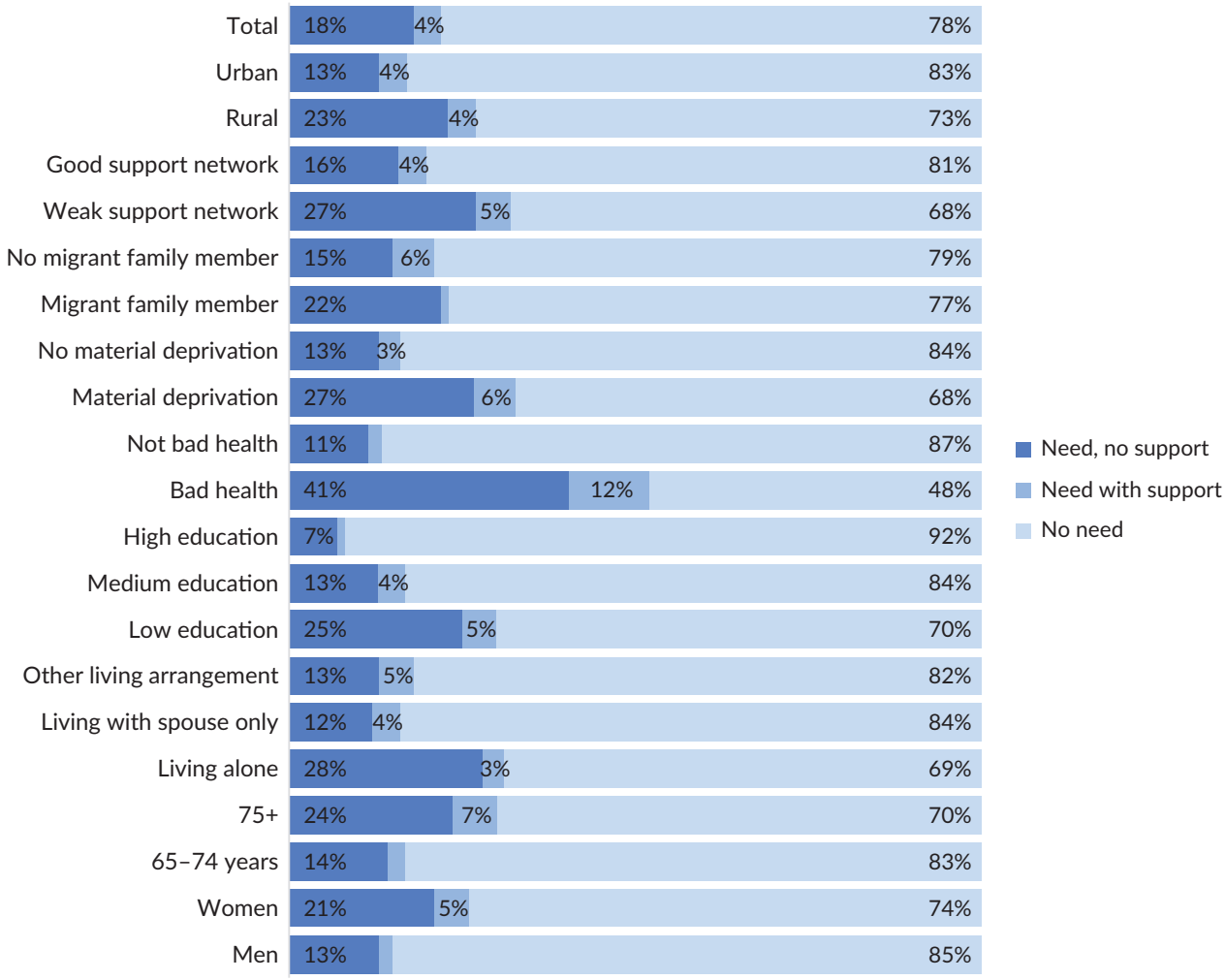

Figure 3. Distribution of respondents by personal care needs, support received, and various individual and structural characteristics. Note: The figure shows weighted percentages. Source: Authors' analysis based on primary data.

5. Multivariate Analysis

We performed a multinomial logistic regression to explore the factors associated with care needs and the likelihood of receiving support. These results are interpreted as associational rather than causal effects. The results of the model are presented in Table 2, which reports the average marginal effects (AMEs) for each outcome across categories of the independent variables. Since all independent variables are categorical, these marginal effects represent the difference in predicted probability between each category and the reference category, averaged across all observations. The dependent variable captures the relationship between the existence of personal care needs and the availability of support. It distinguishes between three possible outcomes: (a) no need for (personal) care, referring to individuals with no severe limitations in daily activities; (b) need with support, representing individuals reporting severe limitations in daily activities who receive support; and (c) need without support, referring to individuals experiencing severe limitations and unmet care needs.

Among all predictors included in the model, self-reported health shows the strongest associations with care needs. Poor health is significantly associated with a higher likelihood of reporting a need for care, whether met or unmet, compared to good health (AME = 0.218 [0.147, 0.288] and AME = 0.113 [0.060, 0.167], respectively). The higher predicted probabilities of unmet care needs among individuals with difficult health conditions highlight a critical gap between the recognition of care needs and the availability of effective support systems. Since health status operates as the strongest and most predictable determinant of care needs, this result also validates the internal consistency of our model.

Table 2. Results of multinomial logistic regression (marginal effects): Personal care needs vs. care received.

Variable	No need			Need, support			Need, no support		
	AME	90% CI		AME	90% CI		AME	90% CI	
		LL	UL		LL	UL		LL	UL
Man	0.023	−0.016	0.061	−0.001	−0.019	0.017	−0.021	−0.058	0.015
Woman (ref)									
Low education	−0.065	−0.130	0.001	0.022	−0.005	0.050	0.042	−0.020	0.105
Medium education	−0.047*	−0.091	−0.003	0.02*	0.003	0.037	0.027	−0.016	0.070
Higher education (ref)									
65–74 years (ref)									
75+ years	−0.01*	−0.031	0.052	0.011	−0.031	0.008	−0.001	−0.039	0.040
Living with spouse only (ref)									
Living alone	−0.041	−0.085	0.003	−0.007	−0.027	0.012	0.048*	0.006	0.091
Other living arrangements	−0.016	−0.062	0.029	0.001	−0.022	0.024	0.015	−0.028	0.059
Urban residence (ref)									
Rural residence	−0.031	−0.069	0.007	−0.017	−0.034	0.000	0.048**	0.011	0.085
Good support network (ref)									
Weak support network	−0.069**	−0.123	−0.015	0.015	−0.010	0.039	0.054*	0.002	0.106
No material deprivation (ref)									
Material deprivation	−0.043*	−0.086	0.000	0.001	−0.017	0.019	0.042*	0.001	0.083
No migrant family member (ref)									
Migrant family member	−0.036	−0.075	0.004	−0.009	−0.026	0.008	0.045*	0.007	0.083
Good health (ref)									
Bad health	−0.331***	−0.409	−0.253	0.113***	0.060	0.167	0.218***	0.147	0.288

Note: * $p < 0.1$, ** $p < 0.05$, *** $p < 0.01$; AME = average marginal effects, LL = lower limit, UL = upper limit. Source: Authors' own survey data; analysis by the authors.

Living arrangements and the migration of family members are relevant factors in predicting unmet needs. Living alone is associated with a 4.8 percentage-point higher predicted probability of reporting unmet needs (AME = 0.048 [0.006, 0.091]) compared with persons living with a spouse only, while having a migrant family member is associated with a 4.5 percentage-point higher predicted probability of unmet needs (AME = 0.045 [0.007, 0.083]). Although both effects are marginally significant, our regression model thus provides evidence for hypotheses H1 and H3. Moreover, the weak support networks category is associated with a higher predicted probability of unmet needs, supporting H2 (AME = 0.054 [0.002, 0.106]), and with a lower probability of remaining in the no-need group (AME = −0.069 [−0.123, −0.015]). The association between living alone, weak support networks, and migrant family members, on the one hand, and higher probabilities of unmet care needs, on the other, reflects limited access to care rather than the absence of family solidarity.

Gender shows no statistically significant effect on unmet care needs in any of the three outcome categories (Table 2), suggesting that, in the Romanian context, men and women do not differ significantly in their likelihood of experiencing unmet needs. This leads to the rejection of H4. This absence of gender effect might suggest that broader structural and economic inequalities absorb gender differences, consistent with prior research indicating that gender disparities in unmet needs become pronounced when financial limitations are the principal obstacle to obtaining support (Rahman et al., 2022).

Structural and socio-economic factors, such as material conditions, type of residence, and level of education, are stronger predictors of both care needs and access to care (Table 2). Older adults experiencing material deprivation show a predicted probability of unmet care needs that is 4.2 percentage points higher (AME = 0.042 [0.001, 0.083]) than that of those without severe financial difficulties, confirming H5. Material deprivation and medium education are also associated with a lower probability of reporting no need (AME = −0.043 [−0.086, 0.000] and AME = −0.047 [−0.091, −0.003], respectively), suggesting that socio-economic advantage reduces not only exposure to unmet needs but also the risk of developing functional limitations that require support. Similarly, older adults residing in rural areas show a predicted probability of unmet needs that is 4.8 percentage points higher (AME = 0.048 [0.011, 0.085]) than that of those residing in urban areas, confirming H6 about territorial and socioeconomic differences in access to care.

6. Discussions

This study examined the relationship between the care needs of older people and the support they receive, aiming to identify how structural, relational, and individual factors contribute to care poverty. We addressed this issue using data from a recent nationally representative survey of persons aged 65+. Using a multinomial logistic regression model, we examined three care outcomes—no need, met need, and unmet need—and tested six hypotheses derived from an integrated care configuration and care poverty framework.

Our findings are consistent with other research, which shows that the link between specific characteristics of individuals and unmet needs for care transcends country-specific policy contexts (Vlachantoni, 2019). Our results emphasise, however, the specificities of familialistic regimes that, heavily relying on close family members, encompass the greatest volume of unmet needs (Kröger, 2022). For the specific case of Romania, the migration of family members and living in rural areas are additional vulnerabilities that reflect both

fragile care configurations and systemic exclusions that result in care poverty. These findings show that unmet care needs do not result solely from individual frailty but from patterned exclusions tied to both care availability and social embeddedness (Kröger et al., 2019; Tronto, 1993).

A key finding was that poor health increases the probability of experiencing care poverty. As Kröger (2022) argues, such an effect is expected but not self-evident. Health status certainly affects the level of care needed, but it doesn't always determine the extent of unmet needs, particularly when individuals who require assistance can receive it. The occurrence of unmet needs in people with health problems isn't unavoidable; it indicates a failure in how care is organised, whether it's provided by family or through formal systems (Kröger, 2022). This breakdown is especially clear in Romania, where formal long-term care services are limited and families are expected to provide care. In this context, the availability of economic and material resources influences the ability to adequately meet health-related care needs. In line with this interpretation, our results show that education level is not a significant predictor of unmet care needs, whereas material deprivation emerges as a robust predictor. Kröger's (2022) interpretation, which links care poverty more closely to material and economic constraints than to educational differences, aligns with these findings.

Gender and age were not statistically significant predictors of unmet care needs. Our findings may indicate the extent to which gendered expectations are ingrained in household care relations. Women may seem imperceptible in models that insufficiently describe intra-household negotiations and ethical responsibilities (Tronto, 1993; Widmer et al., 2018). Our descriptive analyses nevertheless indicate that women and the oldest-old exhibit higher levels of unmet care needs. However, multivariate analyses demonstrate that living alone, more common among the oldest-old females, is a significant predictor. This means that in our analysis, the observed gender and age disparities function indirectly through living arrangements rather than as independent factors.

Living alone is associated with weak or fragmented care configurations, characterised by the absence of coresident carers and, therefore, reliance on alternative care networks such as non-coresident adult children, neighbours, relatives, or formal services. These networks may be inconsistent or unable to adequately respond to intensive care duties. In Romania's familialistic-by-default regime, living alone constitutes a structural disadvantage because personal care infrastructure requires physical proximity to family members. This reliance on family-based care is reflected in our results. We showed that the migration of close relatives increases the risk of unmet personal care needs among older adults. The migration of children, especially daughters, may disrupt the traditional care configuration and leave older adults without their primary carers. Because personal care is provided on a co-presence basis, high rates of emigration and limited public care provision put many older adults at risk of being excluded from both family and formal care. These findings align with literature on care drain, in which the out-migration of potential carers, especially women, creates local care deficits that are difficult to compensate through either remittances or fragmented informal networks (Földes, 2020; Lutz & Palenga-Möllenbeck, 2011).

When access to formal services is limited and institutional care is not preferred, the availability of an informal support network remains crucial. We have shown that a weak support network increases the probability of unmet care needs. In a familialistic regime such as Romania, non-coresident family members, neighbours, and friends compensate for the absence of a coresident carer. The increased likelihood of unmet

personal care needs among older people living alone and those with migrant family members can be interpreted as the outcome of intersecting relational vulnerabilities and structural disadvantages. Our integrated framework argues that the inability to meet needs is not an individual failure. Getting needs met depends on social relationships, is shaped by social structures, and is often ignored by care systems that expect informal, gendered, and live-in carers to be available. The study shows that these groups are especially vulnerable to care poverty due to micro-level caregiving failures and macro-level exclusions, necessitating both relational and policy interventions. Just as income poverty triggers targeted redistribution and housing deprivation activates housing policy, care poverty should activate responses across the long-term care, social services, and public health domains.

One limitation of our study arises from the quantitative approach we used. Our sample omits the most vulnerable older people, including those with dementia, significant frailty, or those who are institutionalised. This omission reflects a broader gap in care research, where the perspectives and experiences of the most dependent older adults remain systematically underrepresented (Vlachantoni et al., 2011). Future studies should prioritise the inclusion of these groups, as their experiences of unmet need are likely more acute and may follow different patterns than those captured here.

7. Conclusion

Our findings bring together and build on earlier evidence about unmet care needs, showing how different care outcomes are linked to various structural, relational, and individual factors. While previous studies emphasised similar predictors of unmet needs, our results integrate these factors into a comparative framework that simultaneously distinguishes among older people without care needs, those with met needs, and those lacking support for their needs. Older persons without care needs represent a privileged group. They are in good health, have higher education, are not materially deprived, and enjoy being part of broader social networks. Despite the unknown adequacy of the care they receive, older adults experiencing their needs being met typically have poor health and are less educated. Finally, the most disadvantaged category is the older adults with unmet care needs. Specifically, this category captures multiple vulnerabilities at the individual level (poor health, material deprivation), the relational level (living alone, transnational family dispersion, and weak social networks), and the structural level (rural residence). These findings stress that layered vulnerabilities are clearly linked to care outcomes.

Theoretically, the study contributes by combining the care configuration approach with the concept of care poverty, thereby offering a novel analytical framework for understanding social inclusion in later life. This dual lens allows for a relational and structurally embedded perspective on care, focused on both personal networks and broader institutional constraints. Romania is presented as a critical case for examining broader regional trends, such as reliance on familial care and the limited reach of formal welfare systems. The insights developed here resonate with patterns observed across Central and Eastern Europe while also informing global debates on ageing, vulnerability, and inclusive care policies.

Addressing care poverty in the Romanian context requires policy responses that must move toward integrated social and territorial approaches, tackling both care and inequality. Investment in care infrastructure in disadvantaged and rural areas is a necessary starting point, while community-based models that build relational capital—including neighbourhood care networks, volunteer visiting schemes, and peer

support for isolated older adults—may be relevant policy responses. Subsidised formal care and means-tested home help programmes should be developed to complement or replace family care, treating material deprivation as a barrier to accessing care rather than as a separate welfare concern.

To conclude, this study advances existing research on unmet care needs by empirically mapping a full spectrum of care outcomes—no need, met need, and unmet need—within a single multinomial framework. Our results show that unmet need emerges from the convergence of individual frailty, material deprivation, fragile social networks, and rural disadvantage, thereby extending earlier evidence to include spatial and relational dimensions. As a policy implication, care poverty is not a peripheral welfare concern but a structural dimension of social inequality that governments should measure, monitor, and reduce.

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Conflict of Interests

The authors declare no conflict of interests.

Data Availability

The data is not available for public use.

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