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Care poverty: unmet care needs in Turkiye

Aysun Danayiyen

Department of Health Management, Faculty of Health Sciences, İstanbul Sabahattin Zaim University, İstanbul, Turkiye

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ABSTRACT

Aims: This study examines care poverty among older adults in Turkiye by analyzing socio-demographic and health-related factors that contribute to unmet care needs in basic and instrumental activities of daily living (ADLs and IADLs).

Methods: The analysis is based on secondary data from the Turkish Statistical Institute (TUIK) for 2019 and 2022. The study focuses on disparities in both basic and instrumental activities of daily living (ADLs and IADLs) among the elderly population. Prevalence rates of unmet care needs were calculated, and socio-demographic and health-related determinants were examined. Gender differences were also analyzed, particularly with IADLs.

Results: The findings indicate that older adults with poor health, low social support, and limited access to care face a higher risk of care poverty. Based on the analysis, care poverty prevalence was found to be 14% for basic ADLs and 34.9% for IADLs. While no significant gender difference was observed in basic ADLs, women were more disadvantaged than men in instrumental ADLs.

Conclusion: This study reveals a substantial prevalence of care poverty among the elderly in Turkiye. It highlights the role of health inequalities, social vulnerability, and gender in access to care. The results provide evidence to support more inclusive and equitable long-term care policies, especially in middle-income countries experiencing population aging.

Keywords: Care poverty, unmet needs, social inequality, long-term care policies

INTRODUCTION

The aging population presents significant social, economic, and healthcare challenges globally. Rising life expectancy and declining fertility have increased the proportion of older adults, with the global population aged 60 and over expected to reach 2.1 billion by 2050.[1] In Turkiye, the elderly population surpassed 9 million in 2024, accounting for over 10.6% of the total population.[2] This demographic shift places growing pressure on healthcare systems, pensions, and social care infrastructures.

Long-term care (LTC) has become a critical policy issue, especially in middle-income countries like Turkiye, where formal care systems remain limited. Despite increasing demand, 90 countries still lack legal frameworks for LTC, and only 20 have regulated home care systems, leaving millions without adequate support.[3] One of the most urgent issues in this context is care poverty, defined as the insufficient receipt of care, either formal (state or market-based) or informal (family or community-based), despite existing need.[4] Unlike the narrower concept of unmet care needs, which often focuses on formal medical barriers such as staffing shortages or long waiting times,[5] care poverty offers a broader lens. It encompasses both formal and informal care and highlights the structural mismatch between the need for care and the availability of support.

The concept of care poverty not only refers to unmet care needs but also seeks to analyze the underlying social policy shortcomings and structural inequalities that contribute to inadequate care provision. Situated within the framework of the welfare state—where access to health and social services is treated as a right—this concept underscores that the level of social protection is shaped by political decisions.[4] Inequality manifests in the differing opportunities individuals have in accessing health, education, and public services, often stemming from imbalances in access, rights, and power.[6] Welfare policies play a critical role in shaping individuals' capacity to meet their care needs by determining the scope, quality, and accessibility of care services. However, widespread, affordable, and high-quality care is not achieved automatically; it requires deliberate policy interventions. In the absence of publicly subsidized services, individuals are often faced with unequal choices between purchasing formal care or relying on informal support. Care poverty is used to describe these types of institutional and structural deficiencies that produce and reproduce social inequalities. Therefore, care poverty is not solely a matter of financial insufficiency; it also stems from the limited availability, accessibility, or affordability of care services—whether public, non-profit, or for-profit.[4-6] It emerges as a multidimensional form of inequality shaped by the intersection of individual-level deprivations (such as the lack of close family members)

Corresponding Author: Aysun Danayiyen, aysun.danayiyen@izu.edu.tr

and structural limitations (such as underdeveloped welfare state capacities).

In Turkiye, traditional family-based caregiving has long been dominant. However, urbanization, changing family structures, increased female labor force participation, and internal migration have weakened these patterns. While government-provided care allowances exist, they fail to fully offset the erosion of familial care capacity, especially in rural areas with poor infrastructure.[7] Despite its policy relevance, most care poverty research has focused on high-income countries.[4,8,9] Middle-income contexts like Turkiye remain underexplored, despite their growing elderly populations and reliance on informal care. Recent studies indicate that many older adults in Turkiye face unmet care needs in both basic and instrumental daily activities.[10]

This study uses nationally representative data from the 2019 and 2022 Turkiye Health Surveys to assess the prevalence and determinants of care poverty among older adults. It also explores the role of social support, assistive technologies, and access to home care services in mitigating these risks. The findings aim to inform more inclusive, equitable, and sustainable LTC strategies in Turkiye and similar settings undergoing demographic transition. In this context, the study seeks to answer the following research questions: (1) What are the socio-demographic and health-related factors associated with care poverty among older adults in Turkiye, and how do these vary across different regions and gender groups? (2) To what extent do current care structures—both formal and informal—meet the needs of older adults, and what policy interventions can be proposed to reduce care poverty in a rapidly aging, middle-income country context?

METHODS

Study Design and Participants

This study is based on the Turkiye Health Survey dataset, which is regularly conducted by the Turkish Statistical Institute (TUIK). The study population consists of survey data collected within this framework, while the sample includes older adults over 65 from the 2019 and 2022 datasets. The analysis was conducted using pre-approved official data obtained from TUIK, and the study adhered to the principles of the Helsinki Declaration.

The Turkiye Health Survey aims to address existing gaps in health indicators and provide data for a better understanding of national health and care needs. The survey covers households, excluding institutional populations such as soldiers, nursing home residents, and prisoners, as well as small settlements with low population density. In this study, the 2019 and 2022 datasets were merged to focus on older adults 65+, enhancing the representativeness of the research. Before conducting the analysis, missing observations were removed, and necessary adjustments were made.

Data Collection Tool

The study's dependent variables are: Unmet care needs in activities of daily living (ADL), unmet care needs in Instrumental Activities of Daily Living (IADL), and overall care poverty, representing individuals experiencing unmet care needs in at least one of these domains. Measuring care needs objectively is challenging, and there is no universally accepted standard for assessing unmet care needs in the literature. The most common approach involves surveying older adults about their ability to perform essential daily activities. TUIK employs two widely recognized scales:

The activities of daily living (ADL) scale: Developed by Katz (1983), this scale assesses bathing, dressing, toileting, mobility, and eating. Responses follow the same 1–4-point rating system.[11]

The instrumental activities of daily living (IADL) scale: Developed by Lawton and Brody (1969), this scale evaluates more complex daily tasks, including telephone use, meal preparation, household chores, managing finances, transportation, medication management, and shopping. Responses follow the same 1–4-point rating system.[12]

After completing these scales, participants were asked: "Do you regularly receive assistance for the most difficult activity?" Those who answered "yes" were further questioned: "Do you need more assistance than you currently receive?". Individuals responding "yes" to the second question were classified as experiencing care poverty, following the conceptual framework proposed by Kröger.[14]

Independent variables: The independent variables used in this study include: Gender (male, female), age group (65-74, 75+ years), marital status (married, not married [widowed, divorced, never married]), income level (categorized based on the national minimum wage: below, at, or above minimum wage), general health status (self-reported on a scale of 1 [very good] to 5 [very poor]), social support (individuals reporting "no close and reliable person" were classified as lacking social support), use of special equipment (yes, no), presence of a caregiver (yes, no), geographical region (seven regions based on TUIK's Level-1 Statistical Regional Classification: Marmara, Aegean, Central Anatolia, Mediterranean, Southeastern Anatolia, Eastern Anatolia, Black Sea), access to home care services (yes, no).

Statistical Analysis

Chi-square tests were used to analyze differences between independent and dependent variables. Binary Logistic Regression Analysis was conducted to identify the determinants of care poverty. First, multicollinearity analysis was performed using the variance inflation factor (VIF) values, and no multicollinearity issues were detected. Then the goodness-of-fit of logistic regression models was assessed using the Hosmer-Lemeshow Test, while model explanatory power was reported using Nagelkerke R^2 and Cox and Snell R^2 values. All analyses were performed using SPSS 25 (Statistical Package for the Social Sciences).

RESULTS

Table 1 presents the prevalence of care poverty in ADL and IADL. The study highlights variations in care poverty rates between ADLs and IADLs, reflecting differences in assistance needs.

Table 1. Prevalence of unmet care needs in ADLs and IADLs

	No care needed n (%)	Receiving adequate care n (%)	Needed more care (care poverty rate) n (%)
ADLs (basic)	4353 (77.7)	467 (8.3)	782 (14.0)
IADLs (instrumental)	2476 (44.2)	1171 (20.9)	1955 (34.9)
ADLs and IADLs total	3272 (58.4)	276 (4.9)	2054 (36.7)

ADL: Activities of daily living, IADL: Instrumental activities of daily living

This study finds that 14% of older adults in Turkiye experience care poverty in ADLs, and 34.9% in IADLs, with an overall rate of 36.7%. These findings align with Kröger's[4] study in Finland, which reported care poverty rates of 17% for ADLs, 26% for IADLs, and 26% overall. Similarly, Simsek et al.[10] found higher rates among older adults aged 80+, with 46.6% overall care poverty, including 39.3% in ADLs and 42.8% in IADLs.

Differences in prevalence rates across studies can be attributed to variations in age groups, methodology, and care system structures. Previous research has reported care poverty rates between 32.8% and 67.5%, particularly higher among the oldest adults.[8-10] Given the functional differences between ADLs and IADLs, it is expected that instrumental activities involve greater unmet needs. These results confirm that IADL-related care poverty is a critical concern, reflecting broader issues in maintaining independence in later life.

Table 2 presents the analysis of care poverty in ADLs across socio-demographic and health-related variables.

The analysis shows that age, education, health status, caregiver availability, and region significantly influence care poverty in basic ADLs. Older adult aged 75+, those with poor health, and those without caregivers are at markedly higher risk ($p<0.001$). Care poverty was also more common among less educated older adults ($p<0.05$), and regional disparities were

Table 2. Unmet basic activities of daily living (ADL) needs by demographic characteristics

		Unmet ADL needs		Met ADL needs		
		n	%	n	%	Test*
		543	60.4	329	70.4	
	Male	239	30.6	138	29.6	p>0.05
Age group	65-74	297	38.0	244	52.2	
	75 and above	485	62.0	223	47.8	p<0.001
	Illiterate/no formal education	493	63.0	260	55.7	
Education			33.2	180	38.5	p<0.05
	Gender	Female	3.7	27	5.8	
	Married	353	45.1	234	50.1	
Marital status	Not married (widowed, divorced)	429	54.9	233	49.9	p>0.05
	Low	284	36.3	146	31.3	
Income	Middle	402	51.4	262	56.1	p>0.05
	High	96	12.3	59	12.6	
	Poor	567	72.5	217	46.5	
General health status	Moderate	204	26.1	212	45.4	p<0.001
	Good	11	1.4	38	8.1	
	Yes	172	26.1	27	7.1	
Caregiver	No	488	73.9	355	92.9	p<0.001
	Yes	737	94.4	441	94.4	
Social support	No	44	5.6	26	5.6	p>0.05
	Yes	141	21.4	25	6.5	
Use of special equipment	No	519	78.4	357	93.5	p<0.001
	Marmara	210	26.9	103	22.1	
	Aegean	70	9.0	58	12.4	
	Central Anatolia	158	20.2	108	23.1	
	Mediterranean	57	7.3	47	10.1	
Region of residence	Southeastern Anatolia	44	5.6	28	6.0	p<0.05
	Eastern Anatolia	711	9.1	41	8.8	
	Black Sea	72	22.0	82	17.6	
	Yes	88	11.3	22	4.7	
Home care services	No	694	88.7	445	95.3	p<0.001

* p-values based on Chi-square tests

observed, with higher rates in Marmara, Central Anatolia, and the Black Sea regions.

While gender differences were not significant for basic ADLs, women were more disadvantaged in IADLs, consistent with Simsek et al.[10] and Özbek Yazıcı et al.[13] However, findings in the literature are mixed—Kröger[14] reported no gender gap, whereas Wilkinson-Meyers et al.[8] found women at greater risk. These discrepancies may reflect differences in dependency patterns, access to services, or cultural norms. Overall, the findings point to persistent gender inequalities in care access. Promoting gender-sensitive policies and recognizing women's caregiving labor remain essential steps in addressing care poverty in Turkiye.

The differential analysis of care poverty associated with IADL, based on socio-demographic and health-related variables, is presented in Table 3.

Analysis of IADL-related care poverty shows significant associations with gender, age, education, marital status, income, health, caregiver presence, assistive equipment, and region. Women were more likely than men to experience care poverty (71.7% vs. 28.3%; p<0.001), and prevalence was higher among older adults aged 75+ (45.6%; p<0.001).

Care poverty was most common among those with low education (51.4% among illiterate older adults vs. 7.6% among high school graduates; p<0.001) and unmarried older adults (48.4% vs. 37.3%; p<0.001). It also declined with rising income (p<0.01) and better health status (p<0.001). Notably, lack of a caregiver (82.4%) and absence of assistive equipment (86.3%) were associated with drastically higher care poverty rates (p<0.001).

Regionally, higher rates were observed in Marmara (28.7%), Central Anatolia (20.9%), and Black Sea (21.2%) regions,

Table 3. Unmet instrumental activities of daily living (IADL) needs by demographic characteristics

		Unmet IADL needs		Met IADL needs		
		n	%	n	%	Test*
Gender	Female	1401	71.7	727	62.1	p<0.001
	Male	554	28.3	444	37.9	
Age group	65-74	1064	54.4	723	61.7	p<0.001
	75 and above	891	45.6	448	38.3	
Education	Illiterate/no formal education	1004	51.4	510	43.6	p<0.001
	Primary/middle school graduate or equivalent	803	41.1	538	45.9	
	High school graduate and above	148	7.6	123	10.5	
Marital status	Married	1008	51.6	734	62.7	p<0.001
	Not married (widowed, divorced)	947	48.4	437	37.3	
Income	Low	582	29.8	276	23.6	p<0.01
	Middle	1087	55.6	705	60.2	
	High	286	14.6	190	16.2	
General health status	Poor	938	48.0	351	30.0	p<0.001
	Moderate	844	43.2	623	53.2	
	Good	173	8.8	197	16.8	
Caregiver	Yes	230	17.6	37	5.2	p<0.001
	No	1079	82.4	673	94.8	
Social support	Yes	1881	96.2	1117	95.4	p>0.05
	No	74	3.8	54	4.6	
Use of special equipment	Yes	179	13.7	28	3.9	p<0.001
	No	1130	86.3	682	96.1	
Region of residence	Marmara	561	28.7	279	23.8	p<0.001
	Aegean	168	8.6	154	13.2	
	Central Anatolia	409	20.9	280	23.9	
	Mediterranean	164	8.4	98	8.4	
	Southeastern Anatolia	89	4.6	46	3.9	
	Eastern Anatolia	149	7.6	132	11.3	
	Black Sea	415	21.2	182	15.5	
Home care services	Yes	101	5.2	27	2.3	p<0.001
	No	1854	94.8	1144	97.7	

* p-values based on Chi-square tests

while Aegean, Mediterranean, and Southeastern Anatolia had significantly lower prevalence (p<0.001).

The logistic regression analysis presented in Table 4 examines the determinants of care poverty in basic ADL, IADL, and overall care poverty encompassing both domains.

Regression models examined factors influencing care poverty across ADLs, IADLs, and combined daily activities. In the ADL model, older adults with poor health were 2.6 times more likely to experience care poverty (OR=2.589; p<0.001), while those aged 75+ had a 40% higher risk (OR=0.601; p<0.01). Use of assistive equipment (OR=2.011; p<0.01), caregiver support (OR=3.132; p<0.001), and home care services (OR=1.916; p<0.05) were also associated with higher ADL care poverty.

In the IADL model, women faced a significantly higher risk than men (OR=0.700; p<0.01), and poor health again emerged as a key determinant (OR=1.677; p<0.001). Assistive equipment (OR=2.155), caregiver support (OR=2.546), and home care (OR=1.699) were all significantly linked to increased IADL care poverty (all p<0.05).

The combined model revealed that women (OR=1.914; p<0.001), older adults aged 75+ (OR=1.289; p<0.01), and unmarried older adults (OR=1.292; p<0.01) were at greater risk. Poor health increased care poverty risk by 48% (OR=0.483; p<0.001). Notably, the use of assistive equipment (OR=0.430), caregiver support (OR=0.433), and home care services (OR=0.455) were associated with significantly reduced care poverty risk (all p<0.01).

DISCUSSION

This study examines the prevalence and determinants of care poverty among older adults in Turkiye, contributing to the global discourse on LTC inequalities and offering evidence-based recommendations for policy development in middle-income countries facing similar demographic and structural transitions.

The findings reveal that 14% of older adults aged 65+ experience care poverty in basic daily activities (ADLs), while 34.9% face unmet needs in instrumental activities (IADLs), resulting in an overall poverty rate of 36.7%. These results highlight the growing care gap, particularly in more complex daily tasks, and underscore the limitations of both formal and informal care structures in addressing the needs of an aging population. Building on nationally representative data, this study explores the socio-demographic and health-related factors associated with care poverty among older adults, focusing on unmet needs in both basic (ADLs) and instrumental (IADLs) daily living activities. Although no significant gender difference was observed in ADL-related care poverty, women were found to be considerably more disadvantaged in IADLs. This finding is consistent with previous research by Simsek et al.[10] and Özbek Yazıcı et al.,[13] which reported higher dependency rates among older women. However, the literature remains inconclusive—while Kröger[14] reported no gender-based disparity, Wilkinson-Meyers et al.[8] identified a higher risk of care poverty among women in New Zealand. Such discrepancies may stem from gendered patterns of dependency in instrumental tasks and persistent structural barriers to accessing services. These gendered disadvantages must also be interpreted through the lens of unpaid care labor, societal expectations of caregiving roles, and higher rates of living alone among older women. Feminist gerontology emphasizes that gender is not merely a demographic variable but a structural axis that organizes access to power, resources, and support across the life course. In aging populations, especially in societies where traditional gender roles persist, women's lifelong engagement in unpaid caregiving leads to cumulative disadvantages in later life. They are not only expected to provide informal care but are

Table 4. Association of unmet ADL and IADL needs by socio-demographic characteristics–a binary logistic regression analysis

	Model 1	Model 2	Model 3
	OR (95% CI)	OR (95% CI)	OR (95% CI)
Gender	0.996 (0.710-1.398)	0.700 (0.558-0.878)**	1.914 (1.570-2.333)***
Age group	0.601 (0.450-0.803)**	0.949 (0.774-1.163)	1.289 (1.076-1.545)**
Education	1.046 (0.807-1.355)	1.016 (0.855-1.206)	0.911 (0.782-1.061)
Marital status	1.036 (0.761-1.409)	1.174 (0.949-1.453)	0.774 (0.640-0.936)**
Income	0.991 (0.795-1.237)	1.034 (0.883-1.211)	0.950 (0.826-1.093)
General health status	2.589 (2.018-3.322)***	1.677 (1.444-1.948)***	0.483 (0.423-0.550)***
Social support	0.945 (0.516-1.731)	0.856 (0.541-1.355)	1.328 (0.891-1.978)
Use of special equipment	2.011 (1.219-3.317)**	2.155 (1.385-3.352)**	0.430 (0.291-0.635)***
Caregiver	3.132 (1.953-5.023)***	2.546 (1.732-3.744)***	0.433 (0.312-0.602)***
Region of residence	0.972 (0.914-1.033)	0.977 (0.936-1.020)	1.027 (0.989-1.066)
Home care services	1.916 (1.089-3.370)*	1.699 (1.023-2.821)*	0.455 (0.279-0.742)**
Cox and Snell R2	0.147	0.083	0.162
Nagelkerke R2	0.202	0.114	0.217
Hosmer and Lemeshow	ProbChi-Sq (8):0.792	ProbChi-Sq (8):0.537	ProbChi-Sq (8):0.656
Number of observations	1042	2019	2588

*p<0.05; **p<0.01; ***p<0.001, ADL: Activities of daily living, IADL: Instrumental activities of daily living, OR: Odds ratio, CI: Confidence interval

often left without sufficient institutional support when they themselves become dependent. As highlighted by Calasanti,[15] feminist gerontology urges scholars and policymakers to consider how normative caregiving expectations, combined with structural inequalities in access to care, result in the double burden faced by older women—as lifelong caregivers and later as marginalized care recipients. In the Turkish context, where the family remains the main care provider and state support is limited, these dynamics are even more pronounced, further exacerbating care poverty among aging women. Similarly, Soneghet's[16] ethnographic study on home-based palliative care in Brazil demonstrates that care is not simply a physical task, but a "social arrangement" shaped by emotional exhaustion, limited material resources, and unequal social expectations. In contexts like Turkiye, where family-based care is prevalent and formal support systems remain underdeveloped, this care burden overwhelmingly falls on women, intensifying their vulnerability to care poverty and reinforcing gendered inequalities in old age.[16] In line with these findings, Hernández et al.'s[17] qualitative study in Mexico highlights how poor women internalize the belief that low-quality public healthcare is the only care they deserve, reinforcing a cycle of resigned acceptance and care poverty linked to both economic and gender-based marginalization. Intersectional factors—such as being older, female, widowed, and economically disadvantaged—amplify vulnerability to care poverty.[18,19] Importantly, care poverty should not be interpreted solely as a matter of individual deprivation or familial failure. As The Polish LTC system is predominantly based on familial care, reflecting a family-oriented welfare model. Poland's experience illustrates that reliance on informal family care and fragmented governance can hinder the equitable development of LTC systems, posing significant risks as demographic shifts accelerate.[20]

Although income was not a significant determinant in regression models, lower-income older adults reported higher IADL care poverty, supporting previous findings that financial capacity limits access to formal services. This may relate to widespread low pension incomes and the impact of inflation in Turkiye. Poor general health was the most consistent predictor of care poverty, but its effect decreased in the full model, suggesting that older adults with poor health may also receive more formal support. This underlines the importance of integrated health and social care approaches.[18] The models also highlighted the mitigating effects of assistive equipment, caregiver support, and home care services. Lack of caregiver support and assistive technologies emerged as major barriers to meeting care needs. Access to home care services significantly reduced care poverty risk, especially in the full model. Although regional differences were not significant in regression models, Chi-square tests showed higher care poverty in Marmara, Central Anatolia, and the Black Sea regions. The higher prevalence in Marmara, despite being more urbanized and economically developed, may relate to internal migration patterns, higher proportions of older adults living alone, and pressure on urban care systems. In Central Anatolia and the Black Sea regions, traditional family structures are eroding while public services remain inadequate. Moreover, female labor force participation and availability of community-based services vary significantly across regions, which may explain the unequal distribution of care burdens. A regional map or heat chart could help visualize this disparity and support policy design. This suggests the need for more regionally equitable care policies. The high prevalence in urbanized regions like Marmara highlights service access issues even in resource-rich areas.

In the Turkish context, where gender inequality remains deeply embedded in social and institutional structures, the findings reinforce the pressing need for gender-responsive care policies and the formal recognition of women's unpaid caregiving roles within the welfare system. Advancing age and marital status also emerge as critical determinants of care poverty. Individuals aged 75 and above were found to be 1.3 times more likely to experience unmet care needs, consistent with previous research by Kröger[4] and Simsek et al.[10] The elevated risk among unmarried older adults—particularly widowed women—can be attributed to the absence of spousal support, which often serves as the primary source of informal care in later life. Such patterns are not merely individual vulnerabilities but reflect broader systemic and policy-level deficits in the development of equitable and sustainable LTC systems. In middle-income countries like Turkiye, which are undergoing rapid demographic aging, these challenges demand urgent and strategic investment in care infrastructure, workforce capacity, and inclusive service models to ensure social protection for an increasingly dependent population.

Limitations

It relies on self-reported, cross-sectional survey data, which may introduce perception-based bias and limit causal inference. The dataset includes a limited number of variables and categories, restricting the depth of analysis. Future research should employ longitudinal and mixed methods approaches to better understand care poverty dynamics and older adults' lived experiences.

CONCLUSION

The cumulative disadvantages identified in this study underscore the necessity of formulating LTC strategies that are both targeted and equitable, addressing structural inequalities accumulated across the life course. Reducing care poverty among older adults requires a multifaceted approach centered on the expansion of home care services, the provision of sustained support for caregivers, and improved access to assistive technologies.

Policy priorities should include the development of gender-sensitive care infrastructure, the formal recognition of unpaid caregiving—particularly by women—and the institutionalization of a comprehensive LTC insurance scheme. Within this framework, the Turkish government's 2024 electoral commitment to establishing an elderly care insurance system represents a significant policy window. However, for such a scheme to be effective and inclusive, it must clearly define the scope of home care services, incorporate financial support mechanisms for informal caregivers, and ensure coverage for gerontechnological devices that enhance independent living.

Furthermore, policy design should account for persistently low female labor force participation and the disproportionate burden of informal care shouldered by women. To this end, integrating systematic care needs assessments into the Family Physician Program and introducing a caregiver credit (A policy tool that protects pension rights of informal caregivers by recognizing unpaid care work as contributory) mechanism under the Social Security Institution (SGK) could serve as practical and scalable solutions. These measures would not only provide formal recognition of informal caregiving but also contribute to financial security for caregivers, thereby enhancing the sustainability of the broader care system.

Finally, international experiences—such as LTC insurance models implemented in countries like Germany and South Korea—offer valuable policy templates that may be adapted to the Turkish context, provided that local demographic, cultural, and institutional factors are carefully considered in the process of implementation.

ETHICAL DECLARATIONS

Ethics Committee Approval

This study utilized publicly available secondary data, and therefore, ethical approval and informed consent were not applicable, in accordance with national regulations.

Informed Consent

Because the study was based on secondary data obtained from TUİK, no written informed consent form was obtained from participants.

Referee Evaluation Process

Externally peer-reviewed.

Conflict of Interest Statement

The authors have no conflicts of interest to declare.

Financial Disclosure

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Author Contributions

All of the authors declare that they have all participated in the design, execution, and analysis of the paper, and that they have approved the final version.

REFERENCES

1. Bozkurt C, Karalar BC, Hoşaf S, Karadakovan A. Yaşlı bireylerin günlük yaşam aktiviteleri ile düşme riski arasındaki ilişkinin incelenmesi. *Sürekli Tıp Eğitimi Dergisi*. 2022;31(3):219-229. doi:10.17942/sted.991482
2. Turkish Statistical Institute (TUIK). Statistics on Turkiye 2024. Available from: https://data.tuik.gov.tr
3. International Labour Organization (ILO). Care at work: Investing in care leave and services for a more gender equal world of work. Addati L, Cattaneo U, Pozzan E, eds. Geneva: International Labour Office; 2022. Accessed May 13, 2025. https://www.ilo.org/publications/major-publications/care-work-investing-care-leave-and-services-more-gender-equal-world-work
4. Kröger T, Puthenparambil JM, Van Aerschot L. Care poverty: unmet care needs in a Nordic welfare state. *Int J Care Caring*. 2019;3(4):485-500. doi:10.1332/239788219X1564129156429
5. Allin S, Grignon M, Le Grand J. Subjective unmet need and utilization of health care services in Canada: what are the equity implications? *Soc Sci Med*. 2010;70(3):465-472. doi:10.1016/j.socscimed.2009.10.027
6. Pickard L. A growing care gap? The supply of unpaid care for older people by their adult children in England to 2032. *Ageing Soc*. 2015;35(1):96-123. doi:10.1017/S0144686X13000512
7. Oglak S. Long-term care in Turkey: challenges and opportunities. In: The Routledge Handbook of Social Care Work Around the World. London: Routledge; 2017.
8. Wilkinson-Meyers L, Brown P, McLean C, Kerse N. Met and unmet needs for personal assistance among community-dwelling New Zealanders 75 years and over. *Health Soc Care Community*. 2014;22(3):317-327. doi:10.1111/hsc.12091
9. Dubuc N, Dubois MF, Raîche M, Gueye NDR, Hébert R. Meeting the home-care needs of disabled older persons living in the community: does integrated services delivery make a difference? *BMC Geriatr*. 2011;11(1):1-13. doi:10.1186/1471-2318-11-67
10. Simsek H, Erkoyun E, Akoz A, Ergor A, Ucku R. Unmet health and social care needs and associated factors among older people aged ≥80 years in Izmir, Turkiye. *East Mediterr Health J*. 2021;27(8):772-781. doi:10.26719/emhj.21.009
11. Shelkey M, Wallace M. Katz's index of independence in activities of daily living (ADL). *Int J Older People Nurs*. 2012;2(3):204-212.
12. Graf C. The Lawton instrumental activities of daily living (IADL) scale. *Medsurg Nurs*. 2009;18(5):315-316.
13. Özbek Yazıcı S, Kalaycı İ. Yaşlı hastaların günlük yaşam aktivitelerinin değerlendirilmesi. *Müh Bilim ve Tasarım Derg*. 2015;3(3):385-390.
14. Kröger T. Lone mothers and the puzzles of daily life: do care regimes matter? *Int J Soc Welf*. 2010;19(4):390-401. doi:10.1111/j.1468-2397.2009.00682.x
15. Calasanti T. New directions in feminist gerontology: an introduction. *J Aging Stud*. 2004;18(1):1-8. doi:10.1016/j.jaging.2003.09.002
16. Soneghet LF. Care and the burden of finitude in the contexts of poverty in Brazil. *New Sociological Perspectives*. 2023;3(1):63-76.
17. Hernández IT, Arenas LM, Treviño-Siller S. "Without money you're nothing": poverty and health in Mexico from women's perspective. *Rev Latino-am Enfermagem*. 2005;13(5):626-633. doi:10.1590/S0104-11692005000500005
18. Arun Ö, Holdsworth JK. Integrated social and health care services among societies in transition: insights from Turkiye. *J Aging Stud*. 2020;53:100850. doi:10.1016/j.jaging.2020.100850
19. Ferraro KF, Shippee TP. Aging and cumulative inequality: how does inequality get under the skin? *Gerontologist*. 2009;49(3):333-343. doi:10.1093/geront/gnp034
20. Golinowska S. The system of long-term care in Poland. CASE Network Studies & Analyses No.416. Warsaw: CASE-Center for Social and Economic Research; 2010. https://ssrn.com/abstract=1710644