Healthy Ageing and Long-term Care Policies in Asia-Pacific Countries

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Chapter 1. Introduction

1.1 Background

1.1.1 Global Population Aging and the Significance of Policy Responses

Globally, population ageing has been identified as one of the most significant social transformations of the 21st century, exerting widespread impacts across healthcare, welfare, the economy, and labor markets. In particular, the Asia-Pacific region is experiencing one of the fastest rates of demographic ageing in the world. The rapid increase in the older population is not merely a demographic shift, but a structural transformation that demands a comprehensive reconfiguration of societal systems.

Ageing presents a complex set of policy challenges across multiple sectors. In healthcare, the growing demand for services related to chronic and multi-morbid conditions has raised concerns about the long-term sustainability of health insurance financing. In the welfare sector, the need for long-term care, community-based support, age-appropriate housing, and income security is rising sharply. Economically, the decline in the working-age population and the increasing economic dependency of older adults are putting pressure on national growth potential and fiscal stability. At the same time, labor markets are facing the need for policy adjustments related to retirement age extension, re-employment of older workers, and intergenerational job reallocation.

As such, population ageing calls for integrated responses that go beyond single-sector interventions. Countries in the Asia-Pacific region are actively exploring and developing 'Healthy Ageing' policies that are tailored to their respective institutional and financial capacities.

1.1.2 Policy Directions for Addressing Population Ageing

One of the key policy challenges in ageing societies is narrowing the gap between life expectancy and healthy life expectancy. The goal is not merely to extend lifespan, but to increase the number of years lived in good health, free from disease and disability—a concept known as the compression of morbidity. Achieving this not only enables older adults to maintain physical and cognitive functions and participate in social and economic activities for a longer period, but also helps reduce the societal burden of healthcare and long-term care (LTC) costs, making it a critical strategy for long-term sustainability.

To this end, there must be a shift away from reactive, treatment-focused approaches toward proactive and preventive health management systems. International organizations such as the WHO, OECD, and ADB have emphasized the importance of a life-course approach, which promotes healthy behaviors, early diagnosis, and preventive care across all stages of life.

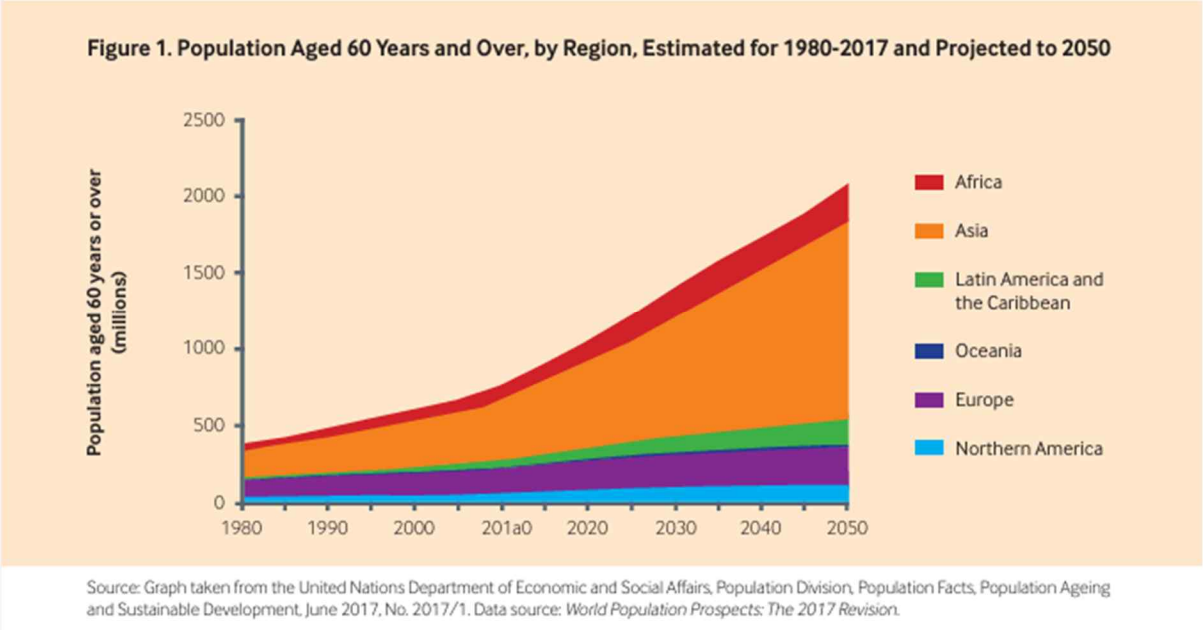
In addition, strengthening LTC policies for older persons in need of support is an urgent priority. LTC refers to the integrated provision of a broad range of services for individuals who require ongoing assistance with activities of daily living (ADLs) due to chronic physical or mental conditions (OECD, 2005). These services are essential for supporting older persons who experience functional limitations and require continuous personal care. In the absence of sufficient formal LTC infrastructure, the burden often falls on informal caregivers, such as family members, which can lead to reduced workforce participation and increased physical and emotional stress—ultimately resulting in broader social and economic costs. Expanding public support for home-based care, increasing the supply of care facilities, and training care workers are critical steps.

Cross-sectoral integration between health and social protection systems also plays a vital role. There is growing interest in person-centered integrated care strategies that link medical, social welfare, and LTC services. This growing attention stems from the recognition that existing care systems are often fragmented across sectors, leading to significant challenges in service delivery. In particular, for older people who require both medical treatment and social support, services are frequently provided separately—medical care through the health system and personal support through the welfare or LTC systems. This fragmentation results in unmet needs, as individuals are often unable to access the necessary combination of services in a timely and coordinated manner. It also leads to inefficiencies, such as duplicated services or gaps in care, ultimately wasting resources and reducing the effectiveness of the system. As a result, there is increasing emphasis on integrated care models that coordinate services based on the individual's functional status and needs, enabling older adults to maintain autonomy and age in place within their communities. The WHO has proposed the *Integrated Care for Older People (ICOPE)* framework to support this approach. ICOPE aims to optimize the intrinsic and functional capacities of older adults by providing coordinated services that enable them to age in place. This model is increasingly recognized as a sustainable policy solution that enhances both the quality of life of older people and the efficiency of healthcare resource utilization.

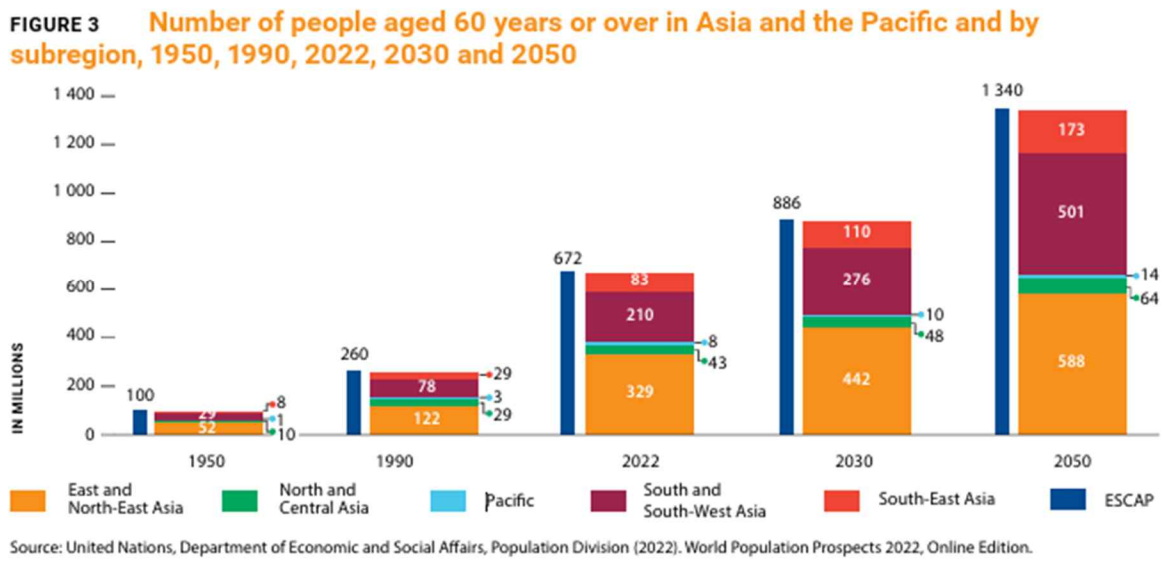
1.1.3 Characteristics of the Asia-Pacific Region

The Asia-Pacific region is experiencing the fastest rate of population ageing in the world, with East and Southeast Asian countries, in particular, undergoing an exceptionally rapid demographic transition. Many countries in the region have already entered an aged society, and within the next 20 to 30 years, a significant number are expected to become super-aged societies, where individuals aged 65 and older comprise more than 20% of the total population.

As of 2020, approximately 13.6% of the region's population was aged 60 or older. This proportion is projected to reach around 25% by 2050. During the same period, the number of people aged 60 and over is expected to more than double, from approximately 630 million to over 1.3 billion. This rapid demographic shift is particularly notable because it reflects a compressed ageing process—what took several decades in countries like those in Europe is occurring within a single generation in many developing countries in the Asia-Pacific (UNFPA, 2017).



Source: United Nations Population Fund (UNFPA). (2017). *Perspectives on population ageing in the Asia-Pacific region*. UNFPA Asia and the Pacific Regional Office.



Source: United Nations Economic and Social Commission for Asia and the Pacific (ESCAP). (2022). *Asia-Pacific report on population ageing 2022: Trends, policies and good practices regarding older persons and population ageing*. United Nations.

In addition, although life expectancy continues to rise, the rate of increase in healthy life expectancy has been relatively slower, resulting in a widening gap between the two. According to WHO statistics, from 2000 to 2019, global life expectancy increased by 6.4 years, while healthy life expectancy increased by only 5.3 years—a trend similarly observed across many Asia-Pacific countries.

As a result, the burden of chronic diseases and disability among older populations is growing, leading to a sharp increase in the demand for medical and LTC services. However, many countries in the region still lack well-established LTC systems (ADB, 2024), and the proportion of life spent in good health relative to total life expectancy continues to decline. Consequently, the demand for LTC is expected to rise even more rapidly in the coming years.

1.1.4 The Importance of Cross-Country Comparative Research and Enhanced Cooperation

Comparing and analyzing policy strategies across countries is a highly effective approach to identifying successful models and promoting mutual learning in the context of population ageing. This is particularly important in the Asia-Pacific region, where countries face similar ageing-related challenges but differ significantly in their socio-cultural and institutional contexts. These differences mean that even common policy issues require context-specific solutions, underscoring the value of cross-country comparative research for generating practical insights.

For instance, high-income countries such as Japan and the Republic of Korea have traditionally relied on family-based informal caregiving as the core of LTC. However, socio-economic transformations—such as nuclearization of families, rising educational attainment, increased female labor force participation, and urbanization—have gradually weakened the capacity for informal care. In response, public investment in formal LTC services has expanded significantly. Similar transitions are now unfolding in many Southeast Asian countries, where changing family structures and the erosion of traditional caregiving capacity are becoming increasingly evident. Recent demographic projections and policy analyses suggest that countries such as Indonesia, the Philippines, and Viet Nam are also likely to face growing gaps in informal care provision, highlighting the urgent need for policy intervention (ADB, 2024).

In this context, while the design and implementation of LTC policies differ across countries, they share a common trajectory toward the gradual transition towards enhanced formal care systems. The diverse experiences and institutional responses observed across countries therefore offer valuable references for policy development and implementation in other settings, providing actionable insights for designing context-sensitive LTC strategies.

To support structured knowledge exchange and policy collaboration, it is important to actively leverage multilateral cooperation mechanisms. Although a wide range of reports, guidelines, and best practices on ageing have been accumulated, there remains a lack of dedicated platforms for comparative policy exchange within the Asia-Pacific region.

International cooperation fosters collective intelligence, which can generate far greater impact than isolated national efforts. It enables countries to rapidly access and adapt proven solutions to their own contexts. Strengthening regional policy collaboration and joint response mechanisms is therefore essential for addressing the complex and shared challenges of population ageing.

1.2 Research Objectives

This study aims to analyze the current status of healthy ageing and LTC policies in the Asia-Pacific region and, based on this analysis, to identify opportunities for cross-country collaboration. To achieve this goal, the study first reviewed key international recommendations and policy trends related to healthy ageing and LTC, and explored relevant prior studies and analytical frameworks suitable for cross-national comparison.

Using the analytical framework developed in this process, case studies were conducted for nine countries in the Asia-Pacific region. Each country's policy context was systematically reviewed and comparatively analyzed. In addition, expert input was gathered to enhance the validity of the findings and further refine proposals for intergovernmental cooperation.

The study's key outputs can be summarized as follows:
(1) a review of global recommendations on healthy ageing and LTC policies,
(2) a comparative analysis of the current policy landscape in selected Asia-Pacific countries, and
(3) propose directions for improving policy and establishing a collaborative research and policy agenda across countries.

1.3 Scope and Content of the Study

1.3.1 Selection of Countries

Table 1: Comparative Indicators of Population Ageing and Life Expectancy in Selected Asia-Pacific Countries

Country	Year of Entry into Ageing Society[1] (Projected)	Year of Entry into Aged Society[2] (Projected)	Life Expectancy at Age 60[3]	Healthy Life Expectancy at Age 60[4]	Gap Between Life Expectancy and Healthy Life Expectancy at Age 60
Japan	1970	1994	26.6	20.4	6.3
South Korea	2000	2018	26.2	19.6	6.5
Thailand	2004	2022	22.7	17.1	5.6
China	2000	2023	21.2	16.2	5.0
Sri Lanka	2008	2030	21.6	15.9	5.7
Viet Nam	2019	2036	19.6	15.1	4.5
Indonesia	2023	2047	15.4	11.9	3.5
Fiji	2028	-	14.5	10.8	3.6
Uzbekistan	2030	-	17.5	13.5	4.0

This study selected nine countries in the Asia-Pacific region to conduct a comparative analysis of healthy ageing and LTC policies. One of the most important selection criteria was the status and the speed of population ageing. Using data from UN DESA and the WHO, countries were prioritized based on the year of entry into ageing society as well as the number of years it took for the proportion of the population aged 65 and older to increase from 7% (the onset of ageing society) to 14% (entry into aged society). For instance, Japan reached

[1] **Ageing society** refers to the year when the population aged 65 and older first exceeded 7% of the total population.
Source: UN DESA World Population Prospects 2024

[2] **Aged society** refers to the year when the population aged 65 and older first exceeded 14% of the total population.
Source: UN DESA World Population Prospects 2024

[3] **Life expectancy at age 60**, based on 2021 estimates.
Source: WHO Data Platform

[4] **Healthy life expectancy at age 60**, based on 2021 estimates.
Source: WHO Data Platform

this threshold in 24 years, while Korea and Thailand did so in 18 years, and China in 23 years—demonstrating particularly rapid ageing trends.

To align with the study's objectives, the selection included not only policy-leading countries but also those in urgent need of policy development. Japan and Korea represent advanced models in the field of healthy ageing and LTC, whereas Uzbekistan, and Fiji were included as countries where institutional foundations remain less developed.

In addition, regional diversity was taken into account. The nine countries represent a wide range of geographic subregions within Asia and the Pacific: East Asia (Japan, Korea, China), Southeast Asia (Thailand, Vietnam, Indonesia), South Asia (Sri Lanka), Central Asia (Uzbekistan), and the Pacific Islands (Fiji). This selection reflects differences in socioeconomic conditions, health systems, and policy responses, and provides a balanced sample for cross-country comparison.

1.3.2 Country Case Studies

The country case studies were structured around three main components: (1) the status of population ageing and healthy life expectancy, (2) national healthy ageing policies, and (3) LTC service policies for older people.

First, the analysis of ageing and health status involved assessing the level and pace of population ageing in each country using demographic data from UN DESA and other sources. WHO and UN DESA data were also used to compare life expectancy and healthy life expectancy. To understand the gap between these two indicators, contributing factors such as disease burden and socioeconomic conditions were also reviewed. The burden of major chronic and non-communicable diseases (NCDs) was evaluated using health indicators like Disability-Adjusted Life Years (DALYs).

Second, the analysis of healthy ageing policies focused on national strategies and frameworks aimed at closing the life expectancy–healthy life expectancy gap. The study examined whether countries applied the life-course approach and addressed the social determinants of health (SDH), such as income, education, and housing. In addition, government roles and institutional coordination mechanisms were analyzed, with particular attention to collaboration among health, welfare, labor, and finance ministries.

Third, the analysis of LTC policy reviewed factors such as the existence of public LTC insurance schemes, the scale of government financial support, and overall LTC system coverage. The study also reviewed the modes of service delivery—home-based, institutional, or community-based—and whether care services were financed through insurance mechanisms or public budgets. Furthermore, it reviewed the extent of service integration across health, welfare, and LTC sectors, the adoption of person-centered integrated care models, and the presence of quality assurance standards and monitoring systems.

1.3.3 Comparative Analysis of Findings

This study conducted a comparative analysis of healthy ageing and LTC policy cases across nine countries in the Asia-Pacific region. Based on these comparative findings, the study aimed to draw policy implications for enhancing healthy ageing and developing LTC systems. It proposes research directions and practical pathways for policy improvement that can be applied within individual countries. Furthermore, the study presents a regional cooperation agenda to promote joint research and policy collaboration among Asia-Pacific countries, laying the groundwork for future strategic dialogue and coordinated action in this field.

1.4 Methods

To achieve study objectives, the study employed two primary research methods: a desk review and expert consultations.

First, through a comprehensive desk review, an analytical framework was developed to assess the status of healthy ageing, LTC, and integrated care policies (Annex 1 & 2). Using this framework, relevant data and policy documents were collected and organized for the nine selected countries. Key indicators such as ageing trends, life expectancy, and healthy life expectancy were reviewed using official statistics from major international organizations, including UN DESA, WHO, ADB, and OECD. In addition, both academic literature and grey literature were reviewed extensively to examine existing strategies aimed at improving healthy life expectancy and reducing the gap between life expectancy and healthy life expectancy. Based on the developed analytical framework, the study conducted a cross-country examination of national strategies and implementation status, identifying key similarities and differences among the case countries.

To ensure the validity of the findings and incorporate practical perspectives, expert input was gathered with expert consultation including participation in international conferences. Specifically, interim findings were shared with international experts, by leveraging events as the International Health Economics Association (IHEA) Congress or international expert meetings engaging multilateral organizations. These expert insights were reflected in the final interpretation of results and in shaping policy agendas.

1.5 Contributions

This study is expected to contribute to the formulation of agenda for international collaboration by providing a comparative and comprehensive analysis of population ageing and healthy life expectancy challenges in the Asia-Pacific region. By sharing diverse policy experiences among countries and identifying effective strategies for promoting healthy ageing and developing long-term care systems, the study aims to clarify key areas of interest that could enhance policy effectiveness and cross-country learning through international collaboration. In particular, the study's findings are anticipated to be utilized in the establishment and operation of the Asia-Pacific Network on Healthy Ageing and Long-term

Care. The results are expected to inform mid- to long-term planning during annual meetings attended by policy makers and experts from across the region.

References

- Asian Development Bank (ADB). (2024). *Aging well in Asia: Asian Development Outlook 2024 thematic chapter*.
- OECD. (2005). *Long-term care for older people.* OECD Publishing.
- United Nations, Department of Economic and Social Affairs, Population Division. (2024). *World population prospects 2024.*
- United Nations Economic and Social Commission for Asia and the Pacific (ESCAP). (2022). *Asia-Pacific report on population ageing 2022: Trends, policies and good practices regarding older persons and population ageing*. United Nations.
- United Nations Population Fund (UNFPA). (2017). *Perspectives on population ageing in the Asia-Pacific region*. UNFPA Asia and the Pacific Regional Office.
- World Health Organization (WHO). (2021). *Global Health Observatory data repository.*

Chapter 2. International Policy Recommendations for Healthy Ageing and Long-term Care

2.1 Global Policy Frameworks and Conceptual Foundations

International policy approaches to population ageing have gradually evolved over time. The *Madrid International Plan of Action on Ageing* (2002) marked a turning point by setting key goals such as the protection of older persons' rights, promotion of social participation, and expansion of access to health and social services. Building on this foundation, the World Health Organization (WHO) introduced a new policy paradigm in its *World Report on Ageing and Health* (2015), redefining "Healthy Ageing" as the process of maintaining functional ability through interaction with one's environment—moving away from a disease-centered approach to healthcare. This concept was further institutionalized through the *UN Decade of Healthy Ageing* (2021–2030), which outlines specific policy areas and implementation strategies focused on reducing ageism, creating age-friendly environments, delivering integrated care, and ensuring long-term care (LTC).

The overall policy direction emphasizes the protection of older people's rights, the provision of integrated health and social services, and the promotion of their active participation in policymaking processes. Moreover, it underscores the importance of enabling older adults to live independently and safely in familiar communities for as long as possible (Ageing in place) and to remain engaged in various social roles such as employment, volunteering, and cultural participation. This comprehensive approach goes beyond care provision to support the maintenance of functional ability and well-being, strengthen intergenerational solidarity, and enhance social inclusion as core pillars of healthy ageing policy (WHO, 2021).

2.1.1 Madrid International Plan of Action on Ageing (2002)

The *Madrid International Plan of Action on Ageing* (MIPAA), adopted at the Second World Assembly on Ageing in 2002, is widely regarded as a landmark policy document that marked a historical turning point in the international community's approach to population ageing in the 21st century. Rather than focusing solely on the welfare and protection of older persons, the MIPAA redefined them as individuals entitled to dignity and rights, and as active contributors to social development.

MIPAA called for a shift away from treating ageing as a fragmented policy issue confined to health and welfare sectors. Instead, it proposed an integrated perspective that positions ageing within the broader frameworks of individual life courses, social solidarity, economic development, and human rights. Under its guiding vision of "A society for all ages," MIPAA promoted a society in which all generations coexist based on mutual respect and cooperation, and sought to institutionalize the participation of older persons in all stages of policymaking.

MIPAA proposed three Priority Directions:

First, *Older persons and development*: Older people should not be seen merely as recipients of development benefits but as active participants in the development process. MIPAA emphasized the importance of encouraging their contributions across society—including in employment, lifelong learning, and volunteerism—to fully harness their potential and strengthen intergenerational solidarity.

Second, *Advancing health and well-being into old age*: MIPAA underscored the goal of not just extending life but achieving quality health in old age. It advocated for improved access to primary health care, better chronic disease management, and a health system focused on prevention and rehabilitation. A comprehensive concept of health, encompassing mental and social well-being, was also emphasized.

Third, *Ensuring enabling and supportive environments*: MIPAA called for age-friendly reforms across physical and social environments—such as urban planning, housing, transportation, and access to information—to ensure that older persons can live independently and participate actively in society. The importance of families, communities, and informal care networks was also highlighted.

One of MIPAA's most distinctive features is its integration of ageing issues with broader themes such as development, human rights, gender equality, and intergenerational solidarity. It signaled a paradigm shift—urging that population ageing be understood not simply as an increase in welfare expenditure but as a structural transformation of society. To prevent the economic and social exclusion of older persons and to ensure their rights, MIPAA called for comprehensive legal, institutional, and governance reforms at the national level.

Moreover, MIPAA recognized that population ageing is a global issue affecting not only developed countries but also developing nations at an accelerating pace. It therefore proposed flexible implementation principles that could be adapted to countries at different stages of development. MIPAA also emphasized international cooperation, including technical and financial support, demographic monitoring, and coordinated action to reduce regional disparities.

In sum, MIPAA was the first global policy framework to frame ageing not merely as a welfare issue, but as a catalyst for structural societal transformation and a redefinition of the social contract across generations. It laid the essential groundwork for later conceptual and strategic developments, including the WHO, UN, and OECD frameworks on Healthy Ageing.

2.1.2 WHO World Report on Ageing and Health (2015)

The *World Report on Ageing and Health*, published by the World Health Organization (WHO) in 2015, is recognized as a landmark document that formally introduced and defined the concept of "Healthy Ageing" at the global level. It declared the need for a fundamental policy shift in how ageing is addressed. The report critically assessed conventional approaches, which had focused narrowly on the presence or absence of disease and the inevitability of decline, and instead proposed Healthy Ageing as the process of maintaining functional ability that enables older people to do what they value throughout their lives.

In this report, *Healthy Ageing* is defined as "the process of developing and maintaining the functional ability that enables well-being in older age." Functional ability, in this context, is not limited to physical health but is determined by the interaction between an individual's intrinsic capacity and their surrounding environment. This framework challenges the notion that age-related decline is inevitable. It goes beyond simply delaying or mitigating the loss of intrinsic capacity, emphasizing instead that functional ability can be maintained or restored through integrated support across various domains—including health, LTC, the physical environment, and social support—within an age-friendly environment.

The report calls for a departure from traditional, medically centered approaches and highlights the importance of building integrated systems across multiple sectors—health, social care, physical environments, and technology infrastructure. It urges a redesign of health systems to address the complex needs of older people, including the management of multiple chronic conditions, LTC, rehabilitation, and the promotion of social inclusion. To this end, WHO advocates for multidisciplinary teamwork, continuity of care through primary health services, and older-person-centered service design.

In guiding national policy development, WHO identifies several strategic directions:

First, health systems must move beyond disease-centered models and be reoriented around maintaining and enhancing the *functional ability* of older people. This entails a focus not only on *intrinsic capacity* but also on how individuals interact with their environments.

Second, physical and social environments must be shaped to support mobility, safety, and social engagement among older adults. Community-level accessibility and inclusive infrastructure are particularly emphasized as key to enabling healthy ageing.

Third, public health policies should adopt a life-course approach that includes *preventive strategies* and *early interventions* throughout the ageing process. Such approaches can help mitigate or delay declines in intrinsic capacity.

Finally, the report stresses that older people should not be seen merely as passive recipients of care, but as active agents of change. It underscores the importance of inclusive policies that reflect the rights, preferences, and needs of older individuals in both the formulation and implementation of ageing-related strategies.

Importantly, the report declares that "Healthy Ageing is not just a medical issue—it is a social imperative requiring a whole-of-government, whole-of-society response." It calls for integrated policymaking across diverse sectors, including education, labor, housing, and urban planning.

The *World Report on Ageing and Health* has served as a foundational framework for subsequent global strategies, including WHO's *Integrated Care for Older People (ICOPE)* model and the *UN Decade of Healthy Ageing* (2021–2030). Core concepts emphasized in the report—such as functional ability, environmental interaction, and the need for integrated care—have since become central to international efforts to address the challenges of population ageing.

2.1.3 UN Decade of Healthy Ageing (2021–2030)

Adopted through a United Nations General Assembly resolution in 2020, the *UN Decade of Healthy Ageing* (2021–2030) serves as the international community's collective strategy to address population ageing over the course of ten years. Based on the concept of *Healthy Ageing* introduced in WHO's *World Report on Ageing and Health* (2015), this initiative aims to translate the vision of enhancing the quality of life and social inclusion of older people into concrete actions and mechanisms for multi-stakeholder collaboration. Rather than remaining a symbolic declaration, the Decade is positioned as an action-oriented strategic framework, providing countries with practical guidance and a structured foundation for the design and implementation of ageing-related policies.

At the heart of the Decade lies the principle of achieving well-being in older age by maintaining and improving *functional ability*. To realize this goal, the Decade outlines four strategic action areas:

First, *Combating ageism* involves global campaigns and legal reforms to eliminate age-based stereotypes and discrimination while fostering intergenerational respect and inclusion.

Second, *Creating age-friendly environments* focuses on transforming both physical and social environments—including urban planning, transportation, housing, and access to information—so they are supportive of older persons. This includes the expansion of WHO's Age-Friendly Cities and Communities Network and the promotion of digital inclusion strategies.

Third, *Delivering integrated care and health services* seeks to build comprehensive, person-centered care systems rooted in primary health care. WHO's ICOPE (Integrated Care for Older People) model serves as a key foundation, emphasizing multidisciplinary collaboration, care coordination, and seamless service delivery.

Fourth, *Ensuring long-term care and enhancing care quality* aims to guarantee universal access to long-term care for older individuals with cognitive or physical dependency. This includes support for family caregivers, capacity-building for care workers, and the promotion of public-private partnerships.

Importantly, the Decade does not approach ageing and care as issues to be tackled solely at the level of individual national health systems. Instead, it encourages all countries—regardless of income level—to develop context-specific strategies. Recognizing the diverse capacities and resources across nations, the Decade promotes phased and scalable implementation approaches, particularly for low- and middle-income countries. An international cooperation structure has also been established to support this, involving multiple actors and sectors.

To facilitate implementation, WHO operates a global knowledge-sharing platform known as the *Decade Platform*. UN agencies, along with partners such as the OECD and the ADB, contribute to the Decade through financial support, data provision, technology transfer, and policy advisory roles. A multi-stakeholder governance structure has also been established, including the Global Network on Age-Friendly Cities and Communities (GNAFCC), UN

regional commissions, and civil society organizations, to enhance policy coordination and implementation effectiveness.

Above all, the Decade emphasizes the *agency* of older persons—not merely viewing them as passive beneficiaries of policy, but as active participants in the planning, execution, and evaluation of ageing-related strategies. This principle ensures that the lived experiences and voices of older people are meaningfully reflected in policy processes, thereby enhancing the relevance, inclusiveness, and real-world impact of the Decade's initiatives.

2.2 Strategic Recommendations from non-UN International Institutions

2.2.1 OECD

The OECD has consistently advocated for policies aimed at improving the quality of life for older adults and promoting health equity. Its core strategies for achieving Healthy Ageing include strengthening the preventive functions of health systems, expanding integrated care based on primary healthcare, and adopting structural approaches to reduce health disparities.

From a system design perspective, the OECD's 2013 report *A Good Life in Old Age?* proposed a multidimensional approach that positions quality of life as the primary outcome indicator. This approach incorporates factors such as patient experience, maintenance of functional ability, and respect for autonomy (OECD & European Commission, 2013), aligning closely with the WHO's Healthy Ageing framework centered on functional ability. It reflects the OECD's recommendation to shift policy goals beyond merely extending life expectancy toward ensuring a meaningful and fulfilling later life.

In addition, the OECD's 2011 report *Help Wanted? Providing and Paying for Long-Term Care* outlined comprehensive policy directions for promoting Healthy Ageing and ensuring the sustainability of LTC systems. The report highlights the importance of reducing the burden on informal caregivers and preventing functional decline through expanded family caregiver support, the development of home- and community-based care, the qualitative and quantitative strengthening of the care workforce, and the promotion of preventive and self-management programs. These strategies are closely aligned with the WHO's Healthy Ageing framework, emphasizing the need to build integrated systems that support functional ability and enhance quality of life.

The OECD has also stressed the importance of standardized health data, cross-country comparability, and indicator-based policy monitoring. It recommends that countries develop metrics to quantitatively assess the effectiveness and equity of ageing-related policies and establish feedback systems to track progress and guide ongoing improvements. At the same time, the OECD warns against the uncritical transfer of policy models across countries. It emphasizes the need for implementation strategies that consider institutional context, infrastructure capacity, and political feasibility. In particular, it calls for a balance between universal principles and local adaptation in the provision of care services (OECD & European Commission, 2013).

Building on this policy foundation, the 2024 *Health at a Glance: Asia/Pacific* report draws attention to the rapid pace of population ageing in the Asia-Pacific region and identifies the development of sustainable primary healthcare infrastructure for chronic disease management in older adults as a top priority. The report repeatedly underscores the need to shift from treatment-centered models toward prevention, early intervention, and self-care to extend healthy life expectancy (OECD/WHO, 2024). From a health equity standpoint, it highlights socioeconomic disparities in access to care and health outcomes, emphasizing the need for targeted interventions for older adults in non-urban areas and those with lower education levels.

Over the past several decades, the OECD has played a leading role in shaping policy research and implementation strategies on Healthy Ageing and long-term care, particularly among high-income countries. Its collaborative efforts with the WHO Kobe Centre on LTC financing are part of this ongoing work. As ageing becomes a global concern beyond high-income nations, there is now a pressing need for the OECD to demonstrate stronger leadership by sharing its accumulated expertise and policy experience more actively across the Asia-Pacific region and beyond.

2.2.2 Asian Development Bank

The Asian Development Bank (ADB) recognizes population ageing as a major socioeconomic challenge in the context of developing countries and outlines strategic policy directions to achieve *Healthy Ageing* in its recent publication, *Aging Well in Asia* (2024). Rather than viewing ageing simply as an issue of expanding welfare, ADB positions it as a key variable influencing economic growth and social cohesion. The report emphasizes the need to enhance the efficiency of public spending and ensure the long-term sustainability of social protection systems.

First, ADB stresses the importance of early intervention and a preventive shift in health and social protection systems to promote healthy ageing. In rapidly ageing Asian countries, it highlights the need to provide chronic disease management and rehabilitation services through primary healthcare and to scale up cost-effective interventions (ADB, 2024).

Second, the report repeatedly emphasizes the need to strengthen community-based service delivery systems to maintain the quality of life of older persons. As urbanization and changing family structures weaken traditional family-based care systems, there is a growing demand for the development of community-level eldercare services and social participation support infrastructure (ADB, 2024).

Third, ADB recommends reprioritizing fiscal investment in ageing-related policies, focusing on enhancing the effectiveness of public expenditure and fostering public-private partnership models. To reduce health inequalities among older populations, the report calls for clearly identifying areas where increased public funding is needed and continuously monitoring outcomes through performance-based indicators (ADB, 2024).

Moreover, ADB identifies disparities in health outcomes and service utilization based on gender, income level, and geographic location as key policy issues, and recommends the

development of gender-sensitive and equity-focused health and social welfare policies that reflect the needs of vulnerable populations (ADB, 2024). This approach is also reflected in the ADB's long-standing use of the Social Protection Indicator (SPI) framework, which evaluates the level and effectiveness of public spending for older persons across countries (ADB, 2023).

In particular, in the Asia-Pacific region, LTC has traditionally been managed not by ministries of health but by ministries of social welfare or labor. Given its organizational structure covering both health and social protection, ADB holds a strategic advantage in coordinating and designing integrated ageing-related policies in the region.

Ultimately, ADB proposes practical and incremental Healthy Ageing and LTC strategies tailored to the institutional and fiscal realities of Asian countries, aiming to transform ageing from a challenge to development and social cohesion into an opportunity for inclusive growth.

2.2.3 World Bank

The World Bank approaches the issue of population ageing from the perspective of "Healthy Ageing," closely linking it to human capital and social protection systems. It identifies the functional health and social participation of older adults as core components of human capital, viewing them as essential for maintaining economic productivity and ensuring the long-term financial sustainability of welfare systems (World Bank, 2016). Accordingly, the Bank strategically recommends the establishment of an integrated policy framework connecting health, pensions, and care systems, with adaptive implementation strategies tailored to each country's institutional and political-economic context as a key principle (World Bank, 2023; 2016).

Specifically, the report *Silver Opportunity Case Studies: Experiences with Building Integrated Services for Older Adults around Primary Health Care* (2024) presents the development of a person-centered and integrated service system based on primary health care (PHC) as a core strategy for achieving healthy ageing. To support this, it proposes the FIRE framework—Financing, Innovation, Regulation, and Evaluation—which calls for integrated planning across sustainable resource mobilization, innovative service delivery models, intersectoral governance coordination, and evidence-based policy improvement. Drawing on case studies from diverse countries, the report emphasizes the importance of aligning strategies with each country's context and highlights the need for phased expansion of formal LTC services, community-based support, enhanced health equity, protection for vulnerable populations, and evidence-based policymaking.

Meanwhile, the report *Unlocking the Power of Healthy Longevity: Demographic Change, Non-communicable Diseases, and Human Capital* (2024) focuses on strengthening the prevention and management of non-communicable diseases (NCDs) across the life course. This includes prevention of major risk factors such as smoking, alcohol use, and obesity; early diagnosis and treatment; and policy interventions that promote both health equity and cost-effectiveness. The Bank also recommends health taxes, expansion of social protection systems, development of community-based long-term care services, investment in global

public goods (GPGs) and data infrastructure, promotion of older adults' labor force participation, and integration with social protection as strategic policies for promoting healthy ageing. The report notably positions healthy ageing as a cornerstone of human capital formation and long-term national development strategy, beyond the scope of traditional health policy.

In addition, the report *Health and Long-Term Care Needs in a Context of Rapid Population Aging* (2024) systematically summarizes the World Bank's strategic policy directions. These include strengthened prevention and chronic disease management, development of integrated, person-centered service systems based on PHC, improvement of LTC quality and support for informal caregivers, promotion of health equity, integration of health and social services, and ensuring financial sustainability. In particular, the report underscores the importance of building a continuum of care focused on maintaining and restoring functional ability and expanding multidimensional, community-based interventions.

In conclusion, the World Bank presents healthy ageing not as a single health policy but as a multidimensional strategy combining life-course–based prevention and health promotion, integrated service delivery centered on PHC, and the expansion of long-term and community-based care. This direction is closely aligned with those of other major international organizations.

2.3 Conclusion

International policy discourses on healthy ageing have increasingly converged toward a shared understanding that simply prolonging life is insufficient. The goal is to ensure that additional years are lived in good health and with preserved functional capacity—a vision commonly referred to as the compression of morbidity. This shift is reflected in the core concepts of the Madrid International Plan of Action on Ageing, WHO's Healthy Ageing framework, and the UN Decade of Healthy Ageing, all of which emphasize functional ability, autonomy, and social participation as central objectives of ageing policy.

A recurring theme across all institutional frameworks is the need to build formal LTC systems that are person-centered, rights-based, and context-sensitive. As family-based and informal care arrangements weaken due to demographic and social changes, institutional preparedness becomes essential. Organizations such as the OECD, WHO, ADB, and World Bank all underline that the absence of structured LTC systems leads to fragmented care, unmet needs, and growing inequality in access to support services for older adults, especially those with chronic illnesses, disabilities, or cognitive decline.

Equally important is the integration of LTC with a broader healthcare system. Healthy Ageing is not just about standalone interventions in old age—it requires the continuity of care across the life course and across sectors. WHO's Integrated Care for Older People (ICOPE) model, OECD's emphasis on primary care-based coordination, and the World Bank's call for integrated PHC-based delivery all stress the necessity of seamless transitions between acute, rehabilitative, and supportive care settings**.** Integrated care enables efficient resource allocation, prevents functional decline, and facilitates ageing in place.

Another critical element is the adoption of a preventive, life-course approach to ageing. Preventing or delaying the onset of chronic diseases and disabilities through early intervention, health promotion, and risk reduction strategies is not only cost-effective but also essential to achieving the compression of morbidity. This perspective is embedded in all major institutional strategies, including the ADB's emphasis on cost-effective PHC delivery, the WHO's life-course model, and the World Bank's framing of Healthy Ageing as a foundation of human capital development.

Financial sustainability and equity are additional pillars in international recommendations. Without adequate financing models—particularly those that combine public investment, insurance mechanisms, and targeted subsidies—formal LTC systems cannot be scaled or maintained. Institutions stress the importance of equitable access for vulnerable groups, especially in rural areas and among lower-income populations. Both the OECD and ADB recommend the use of performance-based monitoring and data systems to track gaps and evaluate policy effectiveness.

Institutional coherence and multi-sectoral governance are also seen as prerequisites for effective implementation. Healthy Ageing is a multidimensional issue that extends beyond the remit of health ministries, requiring coordination across social welfare, housing, labor, transportation, and education sectors. Global frameworks repeatedly call for "whole-of-government" and "whole-of-society" approaches to overcome policy silos and ensure that older persons are not merely recipients but co-creators of ageing policy.

In sum, the international community has moved toward a comprehensive and integrated vision for healthy ageing—one that seeks to compress morbidity, expand access to formal LTC, and ensure that services are coordinated across the continuum of care. For countries at all income levels, this requires long-term planning, institutional investment, and the political will to reframe ageing not as a burden, but as an opportunity to build more inclusive, equitable, and resilient societies.

References

- Araújo, E., & Garcia, M. (2024). *Health and long-term care needs in a context of rapid population aging: What are the policy options?* World Bank Policy Research Working Paper No. 10560. Washington, DC: World Bank.
- Asian Development Bank. (2023). *The Social Protection Indicator for Asia.* Asian Development Bank.
- Asian Development Bank. (2024). *Aging Well in Asia: A policy guide for longevity with dignity.* Asian Development Bank.
- OECD & European Commission. (2013). *A good life in old age? Monitoring and improving quality in long-term care*. OECD.
- OECD/WHO. (2024). *Health at a Glance: Asia/Pacific 2024*, OECD.
- World Bank. (2016). *Live long and prosper: Aging in East Asia and Pacific*. World Bank.
- World Bank. (2024a*). Silver Opportunity Case Studies: Experiences with Building Integrated Services for Older Adults around Primary Health Care*. World Bank.
- World Bank. (2024b). *Unlocking the Power of Healthy Longevity: Demographic Change, Non-communicable Diseases, and Human Capital*. World Bank.
- Gentilini, U., Almenfi, M., Iyengar, H. T. M. M., Valleriani, G., Okamura, Y., Urteaga, E. R., Aziz, S., Bin Noruzi, M. F. A., & Chu, M. (2023). *Tracking global social protection responses to inflation* (Social Protection & Jobs Discussion Paper No. 2305). World Bank.
- United Nations. (2002). *Madrid International Plan of Action on Ageing*. United Nations.
- World Health Organization. (2015). *World report on ageing and health*. World Health Organization.
- World Health Organization. (2019). *Integrated care for older people(ICOPE) implementation framework: Guidance for systems and services*. World Health Organization.
- World Health Organization. (2021). *UN Decade of healthy ageing: Plan of action 2021-2030*. World Health Organization.

Chapter 3. Country Cases of Healthy Ageing and Long-term Care Policies in the Asia-Pacific Region

This study reviews nine country cases using two complementary frameworks. For healthy ageing, we employed an adapted framework grounded in WHO's Decade of Healthy Ageing, emphasizing life-course orientation and alignment with LTC and UHC objectives to assess how national policies promote intrinsic capacity and delay care needs. For long-term care (LTC), we applied the revised WHO Framework on integrated LTC, focusing on four core system functions—service delivery, workforce, sustainable financing, and governance—to evaluate whether national systems support person-centered and integrated care for ageing in place. Together, these frameworks provide a structured basis for cross-country comparison of both upstream health promotion strategies and downstream LTC systems, highlighting how countries in the Western Pacific region approach sustainable, person-centered ageing policies. Further details on the frameworks are provided in the Annex.

3.1 Japan

3.1.1 Introduction

Japan stands as the world's most aged society, a demographic reality that profoundly shapes its health and social policies. As of 2024, nearly 30% of Japan's population is aged 65 or older, a figure projected to climb to approximately 35.4% by 2040 (United Nations Department of Economic and Social Affairs, n.d.). This demographic trajectory, characterized by decades of low birth rates and remarkable increases in longevity, positions Japan as a critical case study for understanding and navigating the complexities of healthy ageing. The national focus has increasingly shifted from merely extending lifespan to ensuring that these additional years are lived in good health and independence, a concept encapsulated in the emphasis on "health span" (kenko jyumyo) alongside overall life expectancy (Nomura et al., 2022).

Japan has achieved extraordinary gains in life expectancy, which is now among the highest globally. In 2025, life expectancy at birth reached 82.0 years for men and 88.0 years for women (United Nations Department of Economic and Social Affairs, n.d.). This marks a substantial improvement from 1960, when these figures were approximately 65.3 years for men and 70.2 years for women (United Nations Department of Economic and Social Affairs, n.d.). For individuals who reach the age of 65, the remaining life expectancy is considerable, averaging around 19.9 additional years for men and 24.7 for women as of 2021 (Organisation for Economic Co-operation and Development, 2025). These advancements were initially driven by reductions in infectious diseases and infant mortality post-World War II, and more recently by significant declines in adult mortality from chronic conditions such as stroke and heart disease (Ikeda et al., 2011).

Alongside these gains in total lifespan, healthy life expectancy (HALE)—the average number of years a person can expect to live in full health without activity limitations—has also steadily increased in Japan. The World Health Organization (WHO) data for 2021 indicated a HALE of 71.9 years for men and 74.8 years for women (World Health Organization, 2025). This represents an improvement of several years since 2001, when HALE was approximately 70 years for men and 74 years for women.

Despite these achievements, a persistent gap remains between total life expectancy and healthy life expectancy. Based on 2021 data, Japanese men can expect to live approximately 9.8 years with health limitations (81.7 LE - 71.9HALE), while for women, this period is even longer, at around 12.4 years (87.2 LE - 74.8 HALE) (World Health Organization, 2025). While healthy life years have increased roughly in tandem with overall longevity, preventing a significant widening of this "health span gap," the substantial duration of unhealthy years, particularly for women, is a major concern. This phenomenon, where women live longer than men but spend a greater proportion of their extended lives in less than full health, underscores a critical policy challenge. It highlights the necessity for interventions that not only prolong life but specifically target the conditions contributing to late-life morbidity and disability, which are often more prevalent or have a greater impact on women due to their longer lifespans. This also has considerable implications for long-term care (LTC) needs and the burden on caregivers, as women are frequently both primary caregivers and, later in life, recipients of care for extended periods. Closing this gap and achieving "morbidity compression"—where the period of infirmity is shortened towards the end of life—is a paramount objective of Japan’s healthy ageing policies (Nomura et al., 2022).

The disease burden in Japan's older population is dominated by chronic non-communicable diseases (NCDs) (Nomura et al., 2022). Cardiovascular diseases and various forms of cancer are the principal health challenges for seniors. Strikingly, dementia, particularly Alzheimer's disease, has emerged as a leading cause of death and disability, in some comprehensive burden of disease studies surpassing stroke and ischemic heart disease. The prevalence of diabetes is also a growing concern, indicating a worsening trend in metabolic health.

This NCD burden is underpinned by a complex profile of lifestyle-related risk factors (Nomura et al., 2022). Japan exhibits a "dual nature" in this regard: on one hand, traditionally healthy dietary aspects (rich in fish and vegetables) and low national obesity rates have offered some protection against certain NCDs like ischemic heart disease. On the other hand, persistent traditional risks such as high salt intake (though public health efforts have achieved reductions, hypertension remains a major risk factor) and historically high rates of tobacco smoking, especially among older men (making smoking the leading preventable cause of death), continue to exert a significant toll. Compounding these are risks associated with modernization and changing lifestyles: physical inactivity and sedentary behaviors are becoming more common, and the adoption of more Westernized dietary patterns is contributing to a rise in metabolic syndrome and a worsening diabetes burden. Harmful alcohol consumption also remains a culturally embedded risk factor.

Furthermore, social determinants of health are increasingly recognized as influential (Nakatani, 2019). While Japan has historically been known for relative income equality, health disparities linked to socioeconomic status are becoming more apparent. Social isolation among older adults is another significant risk factor, associated with poorer physical and mental health outcomes, including increased mortality and cognitive decline. This

complex interplay of enduring traditional risks and emerging modern challenges necessitates multifaceted and adaptive public health strategies.

In response to these demographic and epidemiological realities, Japan has developed a comprehensive policy framework. Key pillars include the national health promotion plans (Nomura et al., 2022), collectively known as "Health Japan 21," and the establishment of a universal Long-Term Care Insurance (LTCI) system in 2000 (Fu et al., 2023). These policies emphasize preventive care, the extension of "health span," and a move towards a "Community-Based Integrated Care System" intended to be fully operational by 2025, which aims to provide holistic and accessible care within local communities (Otaga, 2024). Governance is multi-layered, involving national policy direction, significant responsibilities for local government implementation, and efforts towards inter-sectoral coordination.

3.1.2 Healthy ageing policies

Contexts

The cornerstone of Japan's national health promotion efforts is the "Health Japan 21" series of plans, mandated under the Health Promotion Act (Nomura et al., 2022). This initiative has evolved through several iterations, reflecting a dynamic approach to public health challenges.

The first Health Japan 21 plan, launched in 2000 for the decade leading to 2010, established 59 specific targets related to lifestyle factors (diet, physical activity, smoking, alcohol), disease screenings, extension of healthy life expectancy (HALE), and reduction of health disparities (Nakatani, 2019). However, a 2011 evaluation revealed that while some progress was made, many targets were only partially achieved or saw no significant change, particularly those related to obesity, metabolic syndrome, and daily exercise levels.

This critical assessment informed the development of Health Japan 21 (Second Edition), which commenced in 2013 and was initially planned to conclude in 2022 but was extended through fiscal year 2023. The second plan placed a more explicit priority on extending HALE and narrowing health gaps between Japan's 47 prefectures. It refocused efforts on preventing the onset and progression of major NCDs, maintaining the functional abilities of older adults, and fostering supportive environments for health.

Building on the experiences and evaluations of the preceding plans, Health Japan 21 (Third Term) was formulated for a 12-year period from fiscal year 2024 to 2035 (Nomura et al., 2022). This latest iteration continues the life-course approach and the emphasis on HALE extension and disparity reduction but introduces refined targets (51 in total) and incorporates new priority areas. These include a stronger focus on women's health across the lifespan, the importance of sufficient sleep, addressing COPD, promoting "naturally healthy environments" that facilitate healthy choices, enhancing workplace health initiatives, and leveraging health data more effectively. A key slogan for the third term, "leaving no one behind in health promotion," signals an intensified commitment to health equity.

The evolution of Health Japan 21 from its first to its third term clearly demonstrates a system of iterative policy learning. Each phase has built upon the evaluations and lessons of its predecessor, adapting to emerging health challenges and refining strategies for greater impact. For instance, the limited success in achieving some behavioral change targets in the first term led to a more focused approach on HALE and regional disparities in the second. Similarly, the transition to the third term reflects a deeper understanding of contemporary issues, such as the need for systemic environmental changes to support health and a more explicit commitment to equity across various population segments. This iterative cycle, characterized by long-term strategic planning (typically 10-12 years per plan) coupled with periodic evaluations and course corrections, suggests a responsive and adaptive policy-making process committed to continuous improvement in public health outcomes for an aging society.

Policy foundations

Goal setting

A central objective across all iterations of Health Japan 21 has been the extension of healthy life expectancy (HALE) and the reduction of health disparities. The second term (2013-2022) explicitly aimed to extend HALE and reduce regional differences in life expectancy, setting quantifiable targets such as keeping the gap in average life expectancy between the highest- and lowest-ranking prefectures within 2.0 years for men and 2.7 years for women. The target for HALE by 2022 was to ensure its increase surpassed that of total life expectancy, effectively aiming for a compression of morbidity (National Institute of Health and Nutrition, n.d.). The third term (2024-2035) continues this focus with 51 specific targets, carrying over unmet targets from the second term (often with the same numeric goals) and revising achieved targets to more ambitious levels. The underlying aim is not just longer lives, but more years lived free of disability and in good health.

GEDSI (Gender, Equity, Diversity, and Social Inclusion)

The consideration of equity has evolved within Health Japan 21 (National Institute of Health and Nutrition, n.d.). The second term prominently targeted the narrowing of health gaps between prefectures. It also acknowledged that certain community interventions, like "community salons," were more likely to be attended by socially or economically disadvantaged older adults, thereby potentially contributing to reducing health inequalities. The third term significantly strengthens this focus with its "leave no one behind" motto, indicating intensified efforts to reduce health inequalities across socioeconomic groups and regions. A notable development in the third term is the specific inclusion of "women's health across the lifespan" as a priority area. It suggests a recognition that achieving inclusive healthy aging requires targeted interventions that address the specific needs and vulnerabilities of diverse population segments.

Life-Course Orientation

The life-course approach is a fundamental principle (National Institute of Health and Nutrition, n.d.). Health Japan 21 (Second Term) explicitly adopted this perspective, structuring targets and strategies according to different life stages: for children and adolescents (e.g., fostering healthy habits, improving nutrition, maternal and child health); for working-age adults (e.g., addressing NCD risk factors, promoting mental health, creating supportive work environments); and for older adults (e.g., supporting healthy aging, maintaining functional ability, preventing frailty and dementia, encouraging social participation). Health Japan 21 (Third Term) continues to uphold "health promotion based on a life-course approach" as one of its core pillars, ensuring that interventions are tailored and continuous throughout an individual's life.

Shift to Prevention

A strong emphasis on prevention is evident in both Health Japan 21 (National Institute of Health and Nutrition, n.d.) and related policies like the Long-Term Care Insurance (LTCI) system (Otaga, 2024), which aims to keep older adults healthy and delay or reduce their need for LTC services. However, translating this emphasis into effective outcomes and optimal resource allocation has presented challenges. For example, initial preventive efforts within the LTCI system that targeted only high-risk individuals showed limited success. This led to a policy shift in 2015 towards a more comprehensive, community-wide approach that focuses on the social determinants of health and aims to reach all older adults, not just those identified as high-risk (Otaga, 2024). The mixed results of the first phase of Health Japan 21 in changing certain entrenched behaviors also highlight the difficulties. This indicates that while the policy intent for a shift to prevention is strong, its practical realization requires ongoing refinement of strategies, sustained investment, and potentially a significant rebalancing of resources from curative to preventive services. The third term of Health Japan 21's focus on creating "naturally healthy environments" represents a further step in this direction, aiming for systemic changes that support prevention.

Evidence-based Risk Factor Prioritization

The development and refinement of Health Japan 21 plans are grounded in evidence (Nomura et al., 2022; Takimoto et al., 2024). This includes formal evaluations of previous plan outcomes and thorough analyses of current health statistics, such as trends in NCDs and the prevalence of major risk factors like smoking, high salt intake, and physical inactivity. The annual National Health and Nutrition Survey (NHNS) serves as a critical data source for monitoring these factors and informing policy adjustments.

Policy Alignment

Health Japan 21 is designed to align with other significant national health strategies (National Institute of Health and Nutrition, n.d.). This includes disease-specific programs (e.g., for cancer control, cardiovascular disease management) and elder-focused initiatives like the national Dementia Strategy (known as the "New Orange Plan"). Reforms within the LTCI system, particularly the development of the Community-Based Integrated Care System, are also coordinated with broader health system objectives (Otaga, 2024). The third term of Health Japan 21 further emphasizes this alignment by explicitly calling for linkages with other national strategies, such as those related to "health and productivity management" in workplaces and the "Active Guide" for physical activity.

Policy Governance and Funding Structure

The governance of Japan's health promotion policies, particularly Health Japan 21, involves a multi-layered structure with distinct roles for national and local entities, as well as collaboration with various sectors.

Lead institutions

The Ministry of Health, Labour and Welfare (MHLW) is the primary national agency responsible for formulating, leading, and overseeing Health Japan 21 (National Institute of Health and Nutrition, n.d.). The MHLW's work is supported by various expert committees, such as the Health Japan 21 Promotion Expert Committee, which includes academics and stakeholders who guide implementation and evaluation. Technical expertise, data analysis, research, and evaluation support are provided by specialized institutions like the National Institute of Health and Nutrition (NIBIOHN) and the National Institute of Public Health (NIPH).

Multisectoral Collaboration (HiAP)

Recognizing that health is influenced by a wide range of factors, Japan employs several mechanisms for inter-ministerial and cross-sector collaboration (National Institute of Health and Nutrition, n.d.). The Cabinet Office houses a Council on Ageing Society, which plays a crucial role in formulating the Basic Policy on Ageing and ensuring alignment between health policies (led by MHLW) and those related to pensions, community development (Ministry of Land, Infrastructure, Transport and Tourism), and labor. At a broader societal level, the Health Japan 21 National Liaison Council facilitates cooperation by bringing together numerous private and civil sector organizations to support the national health campaign. A prominent example of public-private partnership is the "Smart Life Project," initiated by MHLW, which has successfully rallied citizens and thousands of private companies to commit to and implement healthier habits and wellness programs. The third term of Health Japan 21 aims to further strengthen such cross-sector collaboration, for instance, by

coordinating with the Ministry of Economy, Trade and Industry on promoting corporate health and productivity management programs.

Decentralization

A notable feature of Japan's health promotion governance is the significant role played by local governments. Prefectural and municipal governments are critical implementers of Health Japan 21 (National Institute of Health and Nutrition, n.d.). Under the Health Promotion Act, each prefecture is responsible for formulating its own Prefectural Health Promotion Plan, which must align with national goals but can be tailored to local needs and circumstances. Municipalities are similarly encouraged to develop and implement local health plans and initiatives. These local entities are also responsible for administering LTCI benefits and organizing a wide array of community-based health programs, such as health check-ups, lifestyle classes, and the widely adopted "community salons" for older adults.

Funding mechanisms

The financing of health promotion activities in Japan, including Health Japan 21, appears to be largely integrated within the general budgets of the MHLW at the national level, and prefectural and municipal governments at the local level, rather than relying on a single, large, earmarked national fund. The national government provides subsidies and guidelines to local governments for a range of health and welfare services. For example, The Health Promotion Act mandates that the national government bears the costs associated with conducting national health and nutrition surveys.

Policy Implementation

Health workforce involvement

A range of health professionals and community members are involved in delivering health promotion initiatives. The MHLW has also developed online resources to support health literacy for both patients and health workers. Community Health Workers (CHWs), who are largely organized as local volunteers drawn from the general populace in the Japanese context, play a role in NCD prevention such as promoting healthy diets, encouraging physical activity, and linking residents to community health programs, and there is a recognized need for their training to enhance health literacy and specific competencies in NCD prevention (Imamatsu et al., 2024). The NIPH offers specialized training programs for personnel already working in public health, environmental health, and relevant social welfare fields, including physicians, public health nurses, and registered dietitians (National Institute of Public Health, n.d.). The NIPH also conducts specific training for local government personnel on methodologies for monitoring and analyzing health promotion plans using data from health and nutrition surveys (Ishikawa et al., 2025).

Incentives for Local Resource Engagement

Local governments are central to the implementation of Health Japan 21, tailoring national plans to their specific contexts (National Institute of Health and Nutrition, n.d.). This local engagement is fostered through various means. Community-based initiatives like "ikoi no saron" (community salons) are widespread; these are typically run by local volunteers with support from municipalities in the form of venues, small operational budgets, and by keeping participation fees very low to ensure inclusivity. Furthermore, some municipalities have proactively introduced incentivized health promotion programs. These programs may offer financial rewards, such as regional gift certificates (with values reportedly up to 24,000 yen per year), to residents for participating in health activities, achieving specific health goals (like increased daily steps or improved body composition), or undergoing regular health check-ups. The MHLW also provides Health and Labour Sciences Research Grants, which can fund research that informs local health interventions (National Institute of Health and Nutrition, n.d.), and may select specific regions for priority assistance in community healthcare planning. The Health Promotion Act itself mandates that prefectural and municipal governments develop and implement local health promotion plans, providing a legal framework for their activities. This combination of national guidance, legal mandates, and local innovation, including financial incentives, creates a dynamic environment for health promotion.

Strategies for Older Adults

Given Japan's demographic profile, strategies for older adults are a critical component of health promotion. Health Japan 21 (Second Term), for instance, specifically focused on healthy aging, maintaining functional abilities, preventing frailty and cognitive decline (dementia), and encouraging social participation among older individuals. The national Dementia Strategy, known as the "New Orange Plan," provides a framework for dementia care and prevention. Community-level initiatives like the aforementioned "community salons" aim to reduce social isolation and keep older adults physically and mentally active. In some rural areas, innovative approaches like the "Watchover Service" by Japan Post, where mail carriers check on isolated elderly residents, have been implemented to promote purpose and engagement, "Silver Human Resource Centers" offer opportunities for paid community work for seniors, and lifelong learning programs are also available.

Monitoring & Performance

Standardized Indicators

Health Japan 21 employs a comprehensive set of specific targets and associated performance indicators (National Institute of Health and Nutrition, n.d.). The second term of the plan included 53 targets, and the third term has 51 targets. These indicators cover a wide range of areas, including healthy life expectancy, NCD prevalence and mortality (e.g., cancer,

cardiovascular disease, diabetes, COPD), lifestyle behaviors (e.g., nutrition, physical activity, smoking, alcohol consumption), mental health, children's health, older adults' health, and the development of health-supportive social environments.

Data and Monitoring Sources

Progress towards these targets is monitored using data from various national surveys and statistical sources. The annual National Health and Nutrition Survey (NHNS) is a cornerstone for tracking lifestyle habits and physiological measures. Data for calculating HALE and assessing living conditions are drawn from the MHLW's "Comprehensive Survey of Living Conditions". Mortality data, crucial for tracking NCD outcomes, comes from the Vital Statistics Survey. The NIBIOHN plays a key role by managing an "analysis and evaluation project" for Health Japan 21, which includes tracking prefectural-level data to identify regional variations and progress. Furthermore, Health Japan 21 (Third Term) aims to enhance data utilization by emphasizing the use of robust, publicly available data sources and exploring ways to visualize and leverage individuals' health information (e.g., from health check-ups) for more personalized prevention efforts.

Evaluation and Feedback Loops

The Health Japan 21 initiative incorporates systematic evaluation processes to assess its impact and inform future policy directions. Each iteration of the plan typically undergoes formal mid-term and final evaluations. For example, Health Japan 21 (Second Term) was subject to a mid-term evaluation around 2018 and a final evaluation in 2022. The findings from these evaluations, which assess progress on the set targets and identify areas of success or continued challenge, are published and play a critical role in shaping subsequent health promotion strategies and the formulation of the next iteration of the plan.

At the local level, prefectures and municipalities are encouraged to adopt a PDCA (Plan-Do-Check-Act) cycle for their respective health promotion plans, fostering a continuous improvement approach to implementation and adaptation based on local outcomes and needs.

3.1.3 Long-term care policies

Contexts

The establishment of Japan's LTCI system in April 2000 marked a landmark transformation in how the nation addresses the needs of its aging population (Fu et al., 2023). It signified a fundamental shift from a model heavily reliant on informal family care and acute medical institutions to a formalized social insurance system designed to provide comprehensive LTC services.

Several critical socio-economic and systemic pressures drove the introduction of the LTCI. Firstly, Japan was experiencing rapid population aging, leading to an escalating number of older individuals requiring care and for longer durations. Secondly, traditional family-based caregiving structures were eroding due to significant societal changes, including the rise of nuclear families, increased labor force participation among women (traditionally the primary caregivers), and the aging of caregivers themselves, diminishing the capacity for informal care (Yamada & Arai, 2020). Thirdly, the existing system was characterized by "social hospitalization," where frail older individuals occupied hospital beds for extended periods, often due to a lack of appropriate alternative care settings or because hospital care (covered by health insurance) was perceived as less costly for some families than (self-paid) LTC or means-tested welfare services. This practice not only strained medical resources and increased healthcare expenditures but also often failed to provide care optimally suited for long-term needs. The pre-LTCI welfare services for the elderly were often means-tested, limited in scope, and lacked user choice, while medical and welfare services for long-term needs were fragmented (Yamada & Arai, 2020).

The design and deliberation phase of the LTCI system during the 1990s involved extensive debate on several key aspects. A primary aim was to "socialize the burden of care" across society, moving beyond individual family responsibility (Abe, 2010). The system was envisioned to support the independence of older adults, be user-oriented by allowing choice of services and providers, and integrate the previously fragmented long-term medical and welfare services (Yamada & Arai, 2020).

A crucial debate centered on the financing model. Ultimately, a social insurance model was adopted. This involved financing through a combination of dedicated LTCI premiums (levied on individuals aged 40 and over) and subsidies from general tax revenues (national, prefectural, and municipal). The level of co-payments by users was another point of discussion; an initial flat rate of 10% was set for all covered services, with considerations for its impact on individuals previously receiving heavily subsidized or free care under targeted public assistance programs. This led to transitional measures to lower co-payments for low-income individuals in the initial years. Later, co-payments were differentiated based on income, rising to 20% or 30% for higher-income beneficiaries (Yamada & Arai, 2020).

Eligibility criteria were designed to be universal for individuals aged 65 and older based on an assessment of need, irrespective of income or family support. Coverage was also extended to individuals aged 40 to 64 with specific age-related diseases like stroke or dementia. The standardized, computerized needs assessment process itself was subject to debate, with initial

criticisms that the algorithm, developed primarily from nursing home data, tended to favor those with higher physical needs and might not adequately capture the needs of individuals with cognitive impairments. Minor revisions were made to the assessment tools and algorithms based on pilot testing and early feedback (Ikegami, 2007).

The balance between institutional care and home/community-based care was a significant consideration. While the policy aimed to promote home-based care to enable aging in place (Abe, 2010), concerns about the rising costs of the system, particularly for facility-based services, led to subsequent revisions to further encourage the use of home and community options and to introduce user charges for "hotel costs" (meals and accommodation) in institutions (Yamada & Arai, 2020).

The role of the provider market also saw substantial changes. The LTCI system allowed new for-profit and non-profit organizations to enter the home care market, thereby increasing consumer choice and competition, and breaking the virtual monopoly previously held by social welfare corporations and public entities. Entry into the institutional care sector for these new providers was initially more restricted (Ikegami, 2007).

Since its implementation, the LTCI system has undergone continuous evolution. There has been a growing emphasis on preventive care services aimed at maintaining health and functionality among older adults to delay or reduce the need for more intensive LTC services. An initial focus on high-risk individuals for preventive care proved to have limited success, prompting a shift in 2015 (via an LTCI Act revision) towards a broader, community-wide prevention strategy that addresses social determinants of health and targets all older adults. A major ongoing policy direction is the development of the Community-Based Integrated Care System (CBICS), which aims to be fully implemented by 2025 (Otaga, 2024). CBICS envisions a "one-stop" support structure within each local community, seamlessly integrating healthcare, LTC, preventive services, housing, and social support to enable older individuals to age in place for as long as possible. As part of this, prefectures have been mandated to develop plans for reallocating medical and care resources to support this integrated model. This continuous adaptation reflects the LTCI system's response to emerging challenges, demographic shifts, and lessons learned from its operation, underscoring its role as a dynamic instrument of social policy in a super-aged society. The introduction and evolution of LTCI thus represent a fundamental re-socialization of eldercare responsibility, moving from a system heavily reliant on families and acute hospitals to a more structured, publicly financed, and community-oriented approach.

Governance

Long-term care legislation and strategy

The legal foundation for the system is the Long-Term Care Insurance Act, which was enacted in 1997 and came into effect in April 2000 (Ministry of Justice of Japan, 1997). This Act established the framework for a universal, mandatory social insurance system for LTC. Beyond this foundational law, the LTCI system is guided by national strategic plans. The Ministry of Health, Labour and Welfare (MHLW) develops a Basic Plan for Long-Term Care Insurance Services, which is updated every three years (Fu et al., 2023). This national plan

outlines policy directions, service development goals, and financial projections, and serves as a guiding framework for municipalities in developing their own local LTCI service plans.

Governance structure

The LTCI system operates with a significant degree of decentralization in its administration and service delivery, though within a strong national regulatory framework (Fu et al., 2023). The MHLW is responsible for setting the overall policy direction, including defining national standards for benefit packages, eligibility criteria, care need assessment protocols, and the national fee schedule for LTC services. It oversees the system's general operation and proposes major legislative revisions. Municipalities (cities, towns, and villages) function as the primary insurers and operational managers of the LTCI system for their residents. Their key responsibilities include: 1) Collecting LTCI premiums from residents aged 65 and older (premiums for those aged 40-64 are typically collected alongside health insurance premiums); 2) Pooling these funds at the municipal level to finance LTC services; 3) Conducting or overseeing the needs assessment process to determine eligibility and assign care-need levels to applicants; 4) Contracting with a diverse range of public, non-profit, and for-profit LTC service providers; 5) Developing and implementing local LTC service plans that align with national guidelines but are tailored to local demographics, needs, and resources; 6) Overseeing the quality of local LTC services.

This decentralized structure, where municipalities act as insurers, is a distinctive feature of Japan's LTCI. It is intended to foster local accountability and responsiveness. Since municipalities are responsible for managing their local LTCI budgets (which are funded by local premiums and tax contributions, alongside national subsidies), they have an inherent incentive to manage costs efficiently and invest in preventive measures that could reduce future LTC demand and thus help control local premium rates (Ministry of Health Labour and Welfare of Japan, 2016). However, this model also presents challenges. The financial capacity and demographic pressures can vary significantly across municipalities, potentially leading to disparities in LTCI premium rates and, to some extent, in service availability or accessibility despite national standards. This creates an ongoing tension between the goals of national equity and consistency, and the realities of localized implementation and financial management. The national government's role in providing financial support (subsidies) to municipalities, particularly those with greater needs or fewer resources, and in ensuring adherence to core service standards, is therefore critical in mitigating these potential inequities.

Financing

The financing of Japan's LTCI system is based on a social insurance model, with revenue derived from multiple sources, including insurance premiums, public tax funds, and user co-payments (Ikegami, 2021).

Expenditure

Public expenditure on long-term care has grown substantially since the LTCI's inception, reflecting the increasing number of eligible older adults and rising service utilization. In fiscal year 2021, total public LTC expenditure reached 2.0% of Japan's GDP, with institutional care accounting for a significant portion (1.3% of GDP) (OECD). The total cost of LTCI benefits (including co-payments) more than doubled from approximately 4.0 trillion yen in fiscal year 2000 to 8.4 trillion yen by fiscal year 2011, and was projected to exceed 15 trillion yen by 2025. This continuous growth in expenditure poses an ongoing challenge for the system's financial sustainability.

Revenue raising

The LTCI system is financed through a roughly equal split between insurance premiums and public funds (taxes), supplemented by user co-payments (Fu et al., 2023). All individuals aged 40 and older are required to pay LTCI premiums. For those aged 65 and over (Category 1 insured), premiums are set by each municipality based on the individual's income level and the municipality's projected LTC expenditures. These premiums are typically collected via direct deduction from pensions or by direct billing. For those aged 40 to 64 (Category 2 insured), premiums are collected together with their health insurance premiums, with rates varying depending on their health insurance scheme (e.g., employment-based or residence-based).

The other half of the system's funding comes from general taxation, from the national government (typically covering 25% of benefit costs, with an additional portion for low-income support), prefectural governments (12.5%), and municipal governments (12.5%).

Beneficiaries are required to pay a portion of the cost of the services they receive (Fu et al., 2023). Initially, this was a flat 10% co-payment for all services. However, to address rising costs and ensure fairness, the co-payment system was revised. For individuals with higher incomes, the co-payment rate was increased to 20%, and subsequently to 30% for those with the highest incomes, for most services. There are income-related monthly caps on total co-payments to protect individuals from excessive financial burdens. Costs for meals and accommodation in institutional care facilities are generally paid out-of-pocket by users, although there are reductions and waivers for low-income individuals (Yamada & Arai, 2020).

Pooling resources

LTCI funds are pooled at the municipal level (Fu et al., 2023). Each municipality manages its own LTCI budget and is responsible for balancing its revenues (premiums, tax transfers) and expenditures. These LTCI funds are kept separate from health insurance funds.

Purchasing goods and services

Municipalities, acting as insurers, contract with a wide range of LTC service providers, including public, private non-profit, and private for-profit organizations (Fu et al., 2023). The MHLW sets a national fee-for-service schedule (reimbursement tariff) that dictates the payment rates for different LTC services. These fees are standardized across the country but are differentiated based on the beneficiary's assessed level of care need (i.e., services for individuals with higher care needs are reimbursed at higher rates) and the type and intensity of service provided. Provider reimbursement is typically volume-based, which set fees for predefined units of service (Ikegami, 2021). Japan has also introduced some performance-based incentives for LTC providers, linking a portion of reimbursement to quality indicators. To account for regional cost variations or to manage financial balance, some mechanisms like region-based fee adjustments (conversion factors) exists.

Workforce

The delivery of long-term care services in Japan relies on a substantial workforce, primarily composed of personal care assistants, with ongoing efforts towards capacity-building and professionalization, though challenges such as staff turnover persist.

Existing Workforce

Personal Care Assistants (PCAs), known as *kaigo shokuin*, form the backbone of the LTC workforce, constituting approximately 66% of the total in 2023. Nurses and assistant nurses make up a smaller but significant portion, around 17%, while Allied Health Professionals (AHPs) such as physical or occupational therapists account for about 2%, and administrative staff around 11% (Long-term care Labor Stabilization Center, 2024). The PCA workforce is predominantly female (approximately 73.9%). A majority of PCAs (53.2%) are in the 40-59 age group, indicating a mature workforce (Long-term care Labor Stabilization Center, 2024). Historically, the reliance on foreign workers in Japan's LTC sector has been minimal, described as "almost negligible" but with an increasing trend. Recognizing future workforce needs, the MHLW has incorporated policies regarding foreign care workers into broader strategies like the "Circular Elderly Health Strategy (Ministry of Health Labour and Welfare of Japan, 2024a)". This strategy aims to create a "virtuous cycle" by sharing Japan's advanced long-term care knowledge to attract foreign caregivers to Japan, who can then introduce these improved practices back in their home countries upon their return.

Capacity-building and professionalization

To work as a PCA and provide physical care (involving direct bodily contact), individuals generally need to obtain a national qualification, such as the "Certified Care Worker" (*kaigo fukushi shi*) status, which requires specific education, training, and passing a national examination (Long-term care Labor Stabilization Center, 2024; Takeda, 2023). There are also

introductory qualifications like the "Care Worker Initial Training" (*kaigo shokuin shoninsha kenshu*). Japan has implemented a career grade system for care workers, which can allow PCAs to advance to roles such as skill assessors or team leaders, providing some pathway for professional development within the field (Elderly Service Providers Association, 2023).

Service delivery

Eligibility and gatekeeping

Access to LTCI services is universal for individuals aged 65 and older, and for those aged 40 to 64 who have one of 16 specified age-related diseases (e.g., stroke, dementia, terminal cancer) and are assessed as needing care (Fu et al., 2023). The process begins with an application to the local municipal government. Eligibility and the level of care required are then determined through a standardized, two-stage needs assessment process. This includes an initial computerized assessment based on a home visit and interview to evaluate physical and cognitive functions, followed by a review by a local "Certification Committee for Needed Long-Term Care," which includes medical and welfare experts. This committee makes the final determination, assigning applicants to one of several care-need levels: two "Support Levels" (*yo-shien* 1-2) for those requiring preventive or light support, and five "Care Levels" (*yo-kaigo* 1-5) for those with more substantial care needs, with Level 5 representing the most severe state. This graded system acts as a gatekeeping mechanism, determining the scope and monthly expenditure cap for services the beneficiary can receive under LTCI (Fu et al., 2023).

Settings for public LTC support

The LTCI system provides services primarily in-kind, across a continuum of settings to support aging in place where possible, while also offering institutional options for those with higher needs. A wide array of services are available to support individuals living in their own homes or in community settings (Fu et al., 2023). This includes day care centers (*tsusho kaigo*), which are a common feature. For individuals requiring more intensive or 24-hour care, various types of residential facilities are also covered. Direct cash benefits to beneficiaries or their families to purchase care or compensate informal caregivers are generally not a feature of Japan's LTCI system, which prioritizes the provision of formal, regulated services (Campbell & Ikegami, 2000). The provision of cash allowances to family caregivers was not adopted, partly due to opposition from feminist groups and others who argued that such payments could reinforce societal pressures on women to provide care and might not lead to optimal care quality (Campbell & Ikegami, 2000).

Service provided

The LTCI system covers a comprehensive range of services tailored to the assessed care-need level of the beneficiary (Ministry of Health Labour and Welfare of Japan, 2024b). Japan's

Long-Term Care Insurance (LTCI) system was strategically designed to resolve the issue of costly "social hospitalizations," where elderly patients remained in hospitals for non-acute care, straining the health insurance system. Consequently, various medically-oriented services—including long-term care beds in facilities, home-visit nursing, and rehabilitation—were intentionally transferred from the health insurance scheme to the LTCI framework. This historical context explains why Japan's LTCI system now contains a unique mix of intermediate and integrated services that, while medical in nature, are reimbursed under the long-term care model to better manage chronic and functional support needs (Ikegami, 2021). A table detailing these services is provided below (Table 3.2.1).

Table 3.1.1: Overview of Publicly Funded Long-Term Care Services in Japan under LTCI

Category	Service Type	Description
Home-Based Services	Home-Visit Care (Domestic Help/Personal Assistance)	Assistance with ADLs (bathing, dressing, toileting, meals) and IADLs (housekeeping, shopping).
	Home-Visit Bathing	Specialized bathing assistance at home, often using portable bathtubs.
	Home-Visit Nursing	Skilled nursing care by registered nurses under physician's orders (e.g., wound care, medication management).
	Home-Visit Rehabilitation	Physical, occupational, or speech therapy provided at home.
	Management/Guidance for In-Home Medical Care	Guidance from non-physician professionals (e.g., pharmacists, dietitians). Medical management by physicians is covered by Health Insurance
Facility-Based (Non-Residential/Respite)	Adult Day Care (*Tsusho Kaigo*)	Center-based services including meals, bathing, recreation, and light rehabilitation during the day.

	Adult Day Health Care (*Tsusho Rehabilitation*)	Similar to day care but with a stronger emphasis on medical care and rehabilitation.
	Short-Term Respite Stay (*Tanki Nyusho Seikatsu/Ryoyo Kaigo*)	Temporary admission to an LTC facility for respite for caregivers or post-hospital recovery.
Institutional Services (Residential)	Special Elderly Nursing Homes (*Tokubetsu Yogo Rojin Homu*)	Long-term residential care for individuals with high care needs.
	Geriatric Health Service Facilities (*Kaigo Rojin Hoken Shisetsu* / *Roken*)	Intermediate care facilities focusing on rehabilitation, medical care, and nursing to facilitate return home.
	Sanatorium Type Medical Facilities for Long-term Care (*Kaigo Iryoin*)	Facilities providing long-term medical treatment and nursing care for individuals with chronic medical conditions requiring ongoing medical management.
Community-Based Services	Group Homes for People with Dementia	Small residential settings providing specialized care for individuals with dementia in a home-like environment.
	Small-Scale Multifunctional In-Home Care	Integrated services (home visits, day care, short stays) provided by a single local agency, offering flexibility and continuity.
	Night time Home-Visit Care	Scheduled and on-call home visits during nighttime hours.
	Regular Home-Visit and On-Call Support	Combination of scheduled home visits and 24-hour on-call support for urgent needs.
Preventive Services (for Support Levels)	Preventive Home-Visit Care/Day Care/Rehabilitation, etc.	Services similar to regular LTC services but tailored and often less intensive, focusing on maintaining function and

		preventing decline for those with lower support needs.
Other Support	Loan of Assistive Equipment	Rental of items like wheelchairs, hospital beds, walkers, air mattresses.
	Purchase of Specific Assistive Equipment	Subsidies for purchasing certain items like portable toilets or bathing aids.
	Home Modification Subsidies	Financial assistance for minor home renovations (e.g., installing handrails, modifying bathrooms, eliminating steps) to improve safety and accessibility.

Integrated care and person-centered care pathways

A major policy thrust in Japan is the establishment of the CBICS, which aims to provide comprehensive and coordinated services—spanning medical care, nursing care, preventive care, housing, and livelihood support—within familiar community settings, ideally by 2025 (Otaga, 2024). This system is designed to ensure seamless transitions and continuous support for older adults. A key element in achieving person-centered care is the role of care managers (*kea maneeja*). These professionals, often affiliated with local "Community General Support Centers" (*chiiki hokatsu shien senta*) or private care management agencies, are responsible for developing individualized care plans based on the beneficiary's assessed needs, personal preferences, and living situation. Beneficiaries generally have the freedom to choose their LTC service providers from a competitive market, which is intended to promote responsiveness to individual needs (Fu et al., 2023; Sano et al., 2023). Despite these structural arrangements, challenges in achieving full integration persist. For instance, ensuring smooth information sharing and effective collaboration between different providers, such as hospitals, clinics, home-visiting nurses, and LTC agencies, can sometimes be difficult, potentially leading to fragmentation in practice.

Quality assurance

Several mechanisms are in place to monitor and promote the quality of LTC services (Fu et al., 2023). Municipal governments are responsible for issuing permits to LTC service providers, ensuring they meet minimum national standards regarding staffing, facility requirements, and operational protocols. Providers are also required to report accidents and serious incidents to municipal authorities.

The MHLW and prefectural governments conduct periodic evaluations and surveys of service quality. Some of these quality indicators are linked to financial incentives within the reimbursement system, meaning providers who demonstrate higher quality may receive bonus payments, while those with poor performance might face penalties. Information on the quality of LTC providers is sometimes made publicly available to help consumers and their families make informed choices when selecting services. However, the development of a uniform, comprehensive system for measuring and disclosing care quality across all provider types is an ongoing process.

Performance of long-term care service delivery

Surveys indicate generally high levels of satisfaction among users and their caregivers with LTCI services. For example, a study conducted in Nagoya City found that 86.8% of family caregivers were satisfied with the LTCI care services their relatives received (Umegaki et al., 2014). Other research has also pointed to high overall satisfaction among beneficiaries. However, satisfaction is not universal. Some studies have identified dissatisfaction among certain family caregivers, particularly concerning the long-term sustainability of the system and the adequacy of services to fully meet complex needs (Tsutsui, 2010).

Despite the universal nature of the LTCI system, evidence suggests that a portion of care needs remain unmet. Data from the National Survey of the Japanese Elderly (covering waves from 2002 to 2021) indicated that 15.5% of older adults reported unmet needs for support with Activities of Daily Living (ADLs) or Instrumental Activities of Daily Living (IADLs) (Okamoto et al., 2023). An important finding from the same survey was that 62.5% of older individuals who had limitations in ADLs or IADLs were not certified to receive LTCI services, suggesting potential gaps in either accessing the certification process or in the criteria themselves for those with perceived needs.

The introduction of LTCI has had a positive impact on reducing family caregiver burden for many. The Nagoya City survey found that 68.8% of caregivers reported a reduction in their care burden due to LTCI services (Umegaki et al., 2014). Nevertheless, family caregiver burden remains a significant issue in Japan. Research shows that high caregiver burden is inversely associated with the subjective well-being of caregivers, particularly women, although this can be moderated by factors like social participation (Noguchi et al., 2020).

One of the goals of the LTCI system, particularly with its emphasis on home and community-based services and the subsequent development of the CBICS, is to support "aging in place" and reduce unnecessary or premature institutionalization, including the phenomenon of "social hospitalization". The significant increase in the number of in-home care users since LTCI's inception suggests some success in shifting care towards community settings. The CBICS framework further aims to strengthen this trend by making comprehensive support services more readily available within local communities.

While LTCI aims for universal coverage, issues of equity in access and utilization have been identified. The National Survey of the Japanese Elderly revealed a pro-higher education inequity in the standardized use of public LTC services, particularly among women and the oldest-old (aged ≥80 years) (Okamoto et al., 2023). This suggests that individuals with higher

educational attainment may be more successful in navigating the system and accessing services, even when controlling for need. Addressing such disparities to ensure that all eligible individuals, regardless of their socioeconomic background or other characteristics, can effectively access and benefit from needed LTC services is crucial for fulfilling the system's promise of universality and fairness.

3.1.4 Conclusion

Japan's approach to healthy ageing is characterized by comprehensive, long-term national strategies, most notably the "Health Japan 21" series for health promotion and the universal LTCI system for eldercare. These policies have evolved significantly over several decades, reflecting a commitment to addressing the profound challenges posed by the nation's status as the world's most super-aged society. Key tenets underpinning these strategies include a strong emphasis on prevention, the adoption of a life-course perspective in health interventions, and a concerted push towards community-based integrated care designed to support older adults in living healthy, independent, and fulfilling lives in their familiar environments.

The nation has achieved remarkable successes, including world-leading life expectancy and high, albeit lagging, healthy life expectancy. The establishment of universal health coverage and the LTCI system has provided broad access to medical and LTC services for its citizens. Japan's policy development process is characterized by iterative learning and evidence-informed adjustments, as seen in the evolution of Health Japan 21 through its successive terms and the ongoing reforms of the LTCI system, such as the development of the CBICS. Furthermore, the significant role assigned to local governments in the implementation of both health promotion and LTC policies has fostered a degree of community-specific innovation and responsiveness.

Despite these strengths and achievements, Japan confronts persistent challenges. A critical issue is the enduring gap between total life expectancy and healthy life expectancy, meaning that Japanese citizens, particularly women, spend a considerable number of years living with chronic conditions or disabilities. The effective implementation of national health goals into consistent local outcomes and tangible changes in population health behaviors remains an ongoing task. The escalating burden of dementia poses a severe strain on care systems, families, and societal resources. The mental health and social well-being of older adults, particularly issues like social isolation, require greater attention and more effective interventions.

The long-term sustainability of both the health and LTC financing mechanisms, as well as the adequacy and stability of the care workforce, are paramount concerns in the face of a shrinking working-age population and increasing numbers of older adults requiring complex care. Ensuring equity in health outcomes and access to care across different regions and socioeconomic groups continues to be a priority. Moreover, the formal LTC system, while comprehensive, has not fully alleviated the burden on family caregivers, and issues of unmet care needs persist for a segment of the older population. Against these backdrops, addressing the projected shortages in the care workforce will necessitate innovative strategies for recruitment, training, retention, and improving working conditions, potentially including a greater role for technology and foreign care workers.

References

- Abe, A. (2010). Changing shape of the care diamond: the case of child and elderly care in Japan.
- Campbell, J. C., & Ikegami, N. (2000). Long-Term Care Insurance Comes To Japan: A major departure for Japan, this new program aims to be a comprehensive solution to the problem of caring for frail older people. Health affairs, 19(3), 26-39.
- Elderly Service Providers Association. (2023). Long-term Care Professional Career Grade System [介護プロフェッショナルキャリア段位制度]. Retrieved July 25, 2025 from https://careprofessional.org/careproweb/summary
- Fu, R., Iizuka, T., & Noguchi, H. (2023). Long-term Care in Japan.
- Ikeda, N., Saito, E., Kondo, N., Inoue, M., Ikeda, S., Satoh, T., Wada, K., Stickley, A., Katanoda, K., & Mizoue, T. (2011). What has made the population of Japan healthy? The Lancet, 378(9796), 1094-1105.
- Ikegami, N. (2007). Rationale, design and sustainability of long-term care insurance in Japan–in retrospect. Social Policy and Society, 6(3), 423-434.
- Ikegami, N. (2021). Case study: Japan. In S. Barber (Ed.), Pricing long-term care for older persons. World Health Organization.
- Imamatsu, Y., Iwata, Y., Yokoyama, A., Tanaka, Y., & Tadaka, E. (2024). Empowering Community Health Workers in Japan: Determinants of Non-Communicable Disease Prevention Competency. Healthcare (Basel), 12(3).
- Ishikawa, M., Hemmi, O., Wada, Y., Ohmi, K., Ando, Y., Takimoto, H., & Yokoyama, T. (2025). Efforts and systems by local governments to improve participation rates in national and local health and nutrition surveys in Japan: Findings from a workshop 2019-2024. PLoS One, 20(3), e0314798.
- Long-term care Labor Stabilization Center. (2024). Survey on the Employment Status and Attitudes of Long-term Care Workers [介護労働者の就業実態と就業意識調査] https://www.kaigo-center.or.jp/content/files/report/2023_jittai_chousa_roudousya_honpen.pdf
- Ministry of Health Labour and Welfare of Japan. (2016). Long-term care insurance system of Japan. Retrieved July 25, 2025 from https://www.mhlw.go.jp/english/policy/care-welfare/care-welfare-elderly/dl/ltcisj_e.pdf
- Ministry of Health Labour and Welfare of Japan. (2024a). Global Health Vision of Ministry of Health, Labour and Welfare of Japan Tokyo: Ministry of Health, Labour

and Welfare of Japan Retrieved from https://www.mhlw.go.jp/content/10501000/001295190.pdf

- Ministry of Health Labour and Welfare of Japan. (2024b). Regarding the Revision Items in the 2024 Long-Term Care Fee Revision [令和6年度介護報酬改定における改定事項について]. Tokyo: Ministry of Health Labour and Welfare of Japan Retrieved from https://www.mhlw.go.jp/content/12300000/001230329.pdf

- Ministry of Justice of Japan. (1997). Long-Term Care Insurance Act. Retrieved July 25, 2025 from https://www.japaneselawtranslation.go.jp/en/laws/view/3807/en

- Nakatani, H. (2019). Population aging in Japan: policy transformation, sustainable development goals, universal health coverage, and social determinates of health. Global health & medicine, 1(1), 3-10.

- National Institute of Health and Nutrition, J. (n.d.). Health Japan 21 Analysis and Assessment Project. Retrieved June 1 from https://www.nibn.go.jp/eiken/kenkounippon21/en/kenkounippon21/mokuhyou.html

- National Institute of Public Health, J. (n.d.). Training. Retrieved June 1 from https://www.niph.go.jp/en/entrance-index2-en/

- Noguchi, T., Nakagawa-Senda, H., Tamai, Y., Nishiyama, T., Watanabe, M., Kamiya, M., Wakabayashi, R., Hosono, A., Shibata, K., & Ichikawa, M. (2020). The association between family caregiver burden and subjective well-being and the moderating effect of social participation among Japanese adults: A cross-sectional study. Healthcare,

- Nomura, S., Sakamoto, H., Ghaznavi, C., & Inoue, M. (2022). Toward a third term of Health Japan 21–implications from the rise in non-communicable disease burden and highly preventable risk factors. The Lancet Regional Health–Western Pacific, 21.

- Okamoto, S., Yamada, A., Kobayashi, E., & Liang, J. (2023). Socioeconomic inequity in long-term care access among older people in Japan. medRxiv, 2023.2006. 2012.23291290.

- Organisation for Economic Co-operation and Development. (2024). OECD Data Explorer. https://data-explorer.oecd.org/

- Organisation for Economic Co-operation and Development. (2025). Life expectancy at 65. OECD. Retrieved September 6 from https://www.oecd.org/en/data/indicators/life-expectancy-at-65.html

- Otaga, M. (2024). Community-based inclusive society and integrated care in Japan Concepts and challenges for practice. Journal of the National Institute of Public Health, 73(1), 32-41.

- Sano, J., Hirazawa, Y., Komamura, K., & Okamoto, S. (2023). An overview of systems for providing integrated and comprehensive care for older people in Japan. Archives of Public Health, 81(1), 81.

- Takeda, S. (2023). Factors related to turnover and intention to leave the care working profession in Japan: a review. Yonago Acta Medica, 66(2), 196-201.

- Takimoto, H., Matsumoto, M., Morooka, A., & Yokoyama, T. (2024). Toward the Promotion of Health Japan 21 (the Third Term). The Japanese Journal of Nutrition and Dietetics, 82(3), 79-86.

- Tsutsui, T. (2010). The current state and future development of the long-term care insurance system in Japan. Journal of the National Institute of Public Health, 59(4), 372-379.

- Umegaki, H., Yanagawa, M., Nonogaki, Z., Nakashima, H., Kuzuya, M., & Endo, H. (2014). Burden reduction of caregivers for users of care services provided by the public long-term care insurance system in Japan. Archives of Gerontology and Geriatrics, 58(1), 130-133.

- United Nations Department of Economic and Social Affairs. (n.d.). UN Population Division Data Portal. Retrieved 6 September 2025 from https://population.un.org/dataportal/home?df=d067ecf9-4e21-466e-b0aa-06d9f5386a31

- World Health Organization. (2025). Japan. World Health Organization. Retrieved September 6 from https://data.who.int/countries/392

- Yamada, M., & Arai, H. (2020). Long-Term Care System in Japan. Ann Geriatr Med Res, 24(3), 174-180.

3.2 Republic of Korea

3.2.1 Introduction

South Korea is experiencing rapid population ageing alongside significant improvements in longevity. The country's life expectancy is now among the highest globally, and it is projected to become a "super-aged" society by 2025, with over 20% of the population aged 65 or older (UN DESA, 2025; United Nations Department of Economic and Social Affairs, 2025). These demographic shifts raise critical questions about not just how long Koreans live (life expectancy), but how long they live in good health (healthy life expectancy). South Korea has achieved remarkable gains in life expectancy over the past few decades. At the national level, life expectancy at birth rose from just 62.3 years in 1970 to 83.5 years by 2023 (Statistics Korea, n.d.). While the largest contribution to the life expectancy increase was found to be due to reductions in infant mortality (Yang et al., 2010), improved survival of the older people was also significant.

For those who reach age 65, the remaining life expectancy has steadily grown in Korea. According to Statistics Korea (n.d.)'s 2023 life tables, a 60-year-old Korean man can expect to live 23.4 additional years on average, while a 60-year-old woman can expect 28.2 additional years. These figures represent a substantial increase compared to previous generations; for example, in 1970, life expectancy at 60 in Korea was considerably lower, historical estimates suggest roughly 12.7 years for men and 18.4 for women (Kim et al., 2023). Success in managing chronic diseases may have been major contributors to the gains in life expectancy in Korea. One analysis found that between 1983 and 2005, lower death rates from stroke and hypertensive disease accounted for about 30% of the life expectancy increase in men and 28% in women, while reductions in stomach cancer, liver disease as well as tuberculosis, and external causes contributed another 20–30% (Yang et al., 2010).

While life expectancy tells us how long people live, healthy life expectancy (HLE) indicates how long people live in good health, without serious illness or disability. South Korea has made progress on this front as well, though a gap remains between total and healthy years. According to the World Health Organization (n.d.), healthy life expectancy at birth in Korea increased from about 66.6 years in 2000 to 72.5 years in 2019 (WHO, n.d.; World Health Organization, n.d.). By 2021, Korea's healthy life expectancy (HALE) at birth reached roughly 73 years, one of the highest in the world (ranked 3rd globally) (Lee et al., 2024). However, the gap between life expectancy and healthy life expectancy has persisted during the past decade. According to Korea Health Promotion Institute (n.d.-a), the gap between life expectancy and healthy life expectancy has increased from 10.7 years to 12.6 years during the 2008-2022 period. Indeed, a majority of Korean seniors suffer from one or more chronic diseases: as of 2020, about 54.9% of people aged 65+ in Korea had multimorbidity (Han et al., 2023). In most recent burden of disease study, it showed that chronic non-communicable diseases (NCD) are the major factors explaining the gap: musculoskeletal pain, cardiometabolic diseases (diabetes, heart disease, stroke), and chronic respiratory illnesses remain leading causes of years lived with disability in Korea (Jung et al., 2021; Kim et al., 2019). This aligns with South Korea's epidemiological transition to NCD dominance and its

rapidly aging population, which together ensure that chronic diseases accumulate at older ages and create a sizable morbidity burden.

South Korea’s remarkable gains in life expectancy and healthy life expectancy can be attributed to its robust healthcare system, characterized by universal coverage through the National Health Insurance (NHI) scheme established in 1989. This healthcare system, predominantly treatment-oriented, has provided comprehensive access to medical services, thereby substantially reducing mortality and morbidity from acute and infectious diseases. Significant investments in hospital infrastructure, medical technology, and healthcare workforce training have made advanced medical treatments accessible to the entire population, contributing to significant health improvements over recent decades.

However, as South Korea continues to transition epidemiologically towards NCDs, the limitations of a predominantly curative healthcare system become apparent. Chronic conditions such as diabetes, cardiovascular diseases, and musculoskeletal disorders require preventive measures and sustained management rather than episodic treatment. Consequently, a strategic shift from treatment-centric to preventive and health-promotive approaches is increasingly necessary. Such a rebalancing of the healthcare system towards prevention and health promotion is crucial, not only for enhancing quality of life but also for reducing the growing burden on LTC systems, which are often stressed by increasing numbers of older adults with chronic care needs.

Recognizing this critical challenge, South Korea has implemented comprehensive national strategies aimed at addressing these issues systematically. The Health Plan 2030 (HP2030), South Korea's fifth iteration of its decennial National Health Promotion Comprehensive Plan, exemplifies a nationwide, prevention-oriented health promotion framework. HP2030 sets explicit targets to extend healthy life expectancy, enhance health equity, and reduce major risk factors for chronic diseases through inter-sectoral and evidence-based interventions. Concurrently, South Korea’s universal Long-Term Care Insurance (LTCI), introduced in 2008, provides essential support for older adults who have already developed functional limitations due to chronic diseases or disability. This dual-structured national policy approach—combining proactive health promotion strategies with responsive LTC services—reflects South Korea's commitment to managing its ageing population effectively and sustainably.

Despite these proactive strategies, South Korea faces significant challenges, particularly regarding the sustainability of its healthcare and LTC systems. The rapid ageing population places increasing financial and operational pressures on existing health and social care infrastructure. Addressing these challenges effectively requires a comprehensive assessment of current institutional frameworks and their capacities, alongside evidence-based reforms.

3.2.2 Healthy ageing policies

Contexts

Key health promotion policy in Korea is the National Health Plan, a comprehensive long-term strategy for improving public health. Mandated by the National Health Promotion Act established in 1995, the National Health Plan is a statutory blueprint that sets forth the country's health promotion goals and strategies (Oh, 2021). It is the highest-level plan for health promotion, providing a unifying framework for disease prevention, health education, and health promotion initiatives across the nation.

Following the inaugural Health Plan 2000, subsequent plans—HP2010 and HP2020—continued this statutory planning cycle, systematically expanding and refining health promotion targets and strategies. HP2010 primarily targeted major risk factors and general health indicators, while HP2020 further broadened the approach by placing stronger emphasis on chronic disease management, addressing social determinants of health, and reducing health inequalities. Building on these foundations, HP2030 continues this strategic evolution, emphasizing preventive health care, inter-sectoral collaboration, and health equity, with clearly defined targets for increasing healthy life expectancy. The latest version, HP2030, was prepared over 2017–2020 and involved evaluating the outcomes of the previous plan (HP2020) and gathering input from experts, other ministries, and civil society. The result is a plan that defines priority areas (six divisions and 28 topic areas in HP2030) with specific targets and over 400 performance indicators to be achieved over the next decade (Oh, 2021).

Policy foundations

Goal setting

HP2030 explicitly prioritizes increasing HLE. As an overarching goal, the plan sets a numerical target for HLE by 2030. Based on a new domestic calculation method, Korea's HLE in 2018 was 70.4 years, and HP2030 aims to raise this to 73.3 years by 2030, an increase of about 2.9 years. It also recognizes that Koreans spend a significant portion of their lives in poor health. In fact, analysis showed a gap of roughly 12 years between average life expectancy and healthy life expectancy. However, the plan does not set a specific numeric target for reducing the 12-year morbidity gap, which raises questions about whether the policy focus is sufficiently geared towards improving the quality of later life versus simply extending lifespan.

GEDSI (Gender, Equity, Diversity, and Social Inclusion)

In terms of health equity, HP2030 explicitly strives to reduce disparities in health outcomes across regions and social groups. For example, the plan notes a gap in healthy life expectancy between regions: the top 20% of local areas have about a 2.7-year higher HLE than the

bottom 20% (in 2018). Similarly, socioeconomic disparities are addressed; an analysis cited in the plan found an 8.1-year difference in HLE between the highest and lowest income groups. HP2030 frames its objectives such that improvements in HLE should be realized broadly, with faster gains among vulnerable groups. However, while the plan aims to reduce health gaps caused by income disparities, it is questionable whether health-sector interventions alone can overcome the deep-rooted socioeconomic determinants of health without more robust, cross-sectoral structural reforms.

HP2030 also explicitly emphasizes incorporating gender sensitivity across all health promotion activities. It mandates the use of sex-disaggregated data, analysis of gender-specific health outcomes, and the identification and mitigation of gender-related barriers to program participation. Specifically, the plan sets the principle of establishing gender-separated indicators as fundamental for selecting detailed projects and performance indicators, thus ensuring that gender-related disparities are systematically addressed within health policies.

Life-Course Orientation

The HP2030 embodies a life-course approach as one of the principles to achieve "health for all, at all ages." It envisions a society where everyone enjoys health throughout their life, from birth to old age, with health rights protected across the lifespan (Ministry of Health and Welfare & Korea Health Promotion Institute, 2022). HP2030 ensures that interventions reach every life stage – infants, children, adolescents, adults, and older adults – and are implemented in all settings (home, school, workplace, community) for comprehensive coverage. This integrated strategy combines preventive, behavioral, and systemic measures to support healthy aging across the entire lifespan.

For early-life stages, HP2030 emphasizes reducing infant and maternal mortality through strengthened perinatal healthcare systems, preventive screenings, and promoting healthy infant caregiving practices. During childhood and adolescence, the focus shifts to instilling lifelong healthy behaviors and environments through school-based education, injury prevention, obesity control, tobacco and alcohol avoidance, and mental health support. Working-age adults receive targeted interventions aimed at reducing chronic disease risks, promoting preventive care engagement, and improving occupational health, notably through stricter enforcement of work-hour regulations and enhanced workplace health services.

In older adulthood, HP2030 prioritizes enhancing quality of life and maintaining independence through comprehensive geriatric care, chronic disease management, preventive screenings, and technology-supported healthcare services. Specific focus on dementia is also highlighted. Collectively, these targeted life-course interventions form a robust and coherent framework designed to sustain health and well-being at every age, ultimately supporting healthy aging and reducing the long-term care burden.

Shift to Prevention

HP2030 strongly emphasizes a paradigm shift in Korea's health system from a treatment-oriented approach to a prevention- and promotion-oriented approach. It points out that, despite a substantial increase in funding for the National Health Promotion Fund—due largely to increased tobacco taxes—the actual allocation of these funds toward preventive measures and health behavior improvement remains inadequate, accounting for only about 10.5% of the fund's total expenditure as of 2020. To address this imbalance, the plan proposes expanding funding for community-based health promotion activities, reinforcing cross-sector collaboration through the 'Health in All Policies' framework, and ensuring more systematic, transparent, and outcome-oriented management of the National Health Promotion Fund.

Evidence-based Risk Factor Prioritization

The development of HP2030 was grounded in a systematic collection of evidence on Koreans' disease burden and major risk factors, coupled with extensive expert and public input to prioritize health issues. From the outset, the planning process for HP2030 involved a thorough review of HP2020, examining progress on its 19 key indicators and 369 performance measures, which informed what areas required renewed focus.

Beyond data, the planning process actively incorporated scientific and expert input. Starting as early as 2017, a HP2030 Task Force was convened to investigate major health issues and future trends, including hosting an international forum. In 2019, a formal HP2030 Planning Committee was established, co-chaired by the Ministry of Health and Welfare's Director of Health Policy and a public health professor, to steer the plan's development. Crucially, stakeholder engagement and public input were part of the evidence-gathering and prioritization. The plan documents consultations such as a symposium in collaboration with the Korean Society for Preventive Medicine (October 2019) and policy forums in April and November 2019 to solicit expert recommendations. To gauge on-the-ground needs, a survey was conducted targeting health promotion officers in local governments across the country – 874 respondents provided insight into the challenges and needs at the local level.

Policy Alignment

HP2030 serves as an umbrella strategy under which all other national health promotion initiatives and plans are coordinated. The document explicitly states that the National Health Promotion Comprehensive Plan is designed to systematically link health promotion-related policies established under various laws, to achieve the overall goals of health policy. By law and design, HP2030 is the guiding plan that brings cohesion to diverse health promotion activities across different government agencies and sectors.

Nevertheless, several bottom-up approaches operate effectively alongside this top-down framework. A notable example is the Age-Friendly Cities and Communities (AFCC) initiative. This movement began as a grassroots effort with local governments in South Korea independently joining the World Health Organization's Global Network for Age-friendly

Cities and Communities (GNAFCC). Recognizing the effectiveness and importance of such community-driven initiatives, the central government later established formal support structures through legislative amendments to the Welfare of Senior Citizens Act, scheduled to take effect in January 2026.

An important challenge is the insufficient alignment and integration among related healthcare sectors such as health insurance, public healthcare, and LTCI, highlighting the need for a more cohesive and overarching policy framework. Although Korea's Framework Act on Health and Medical Services stipulates that a comprehensive national healthcare development plan should serve as the highest-level strategic framework, such a plan has notably been absent for approximately 25 years since the enactment of the law. This absence has resulted in fragmented policy implementation and suboptimal coordination across sectors critical to health promotion. This issue could be further echoed by the fact that, while HP2030 explicitly mentions the importance of multi-sectoral collaboration in principle, the actual governance structures designed to facilitate such collaboration remain relatively weak.

Policy Governance and Funding Structure

Lead institutions

Ministry of Health and Welfare (MOHW) functions as the central coordinator and monitor of the HP2030's implementation. After MOHW finalizes the plan (often after deliberation in a health promotion policy committee led by MOHW), it works with relevant ministries and local governments to carry out the plan's programs. MOHW works closely with specialized agencies to manage various aspects of public health. The Korea Disease Control and Prevention Agency (KDCA), for example, serves as the country's central agency for public health protection, focusing on infectious disease control, chronic disease prevention, and health research (Korea Disease Control and Prevention Agency, n.d.). Another key entity is the Korea Health Promotion Institute (KHEPI), founded under the National Health Promotion Act of 1995 as a technical arm to support health promotion initiatives (Korea Health Promotion Institute, n.d.-b). KHEPI also functions as a bridge to local public health infrastructure – it was mandated to offer technical assistance to local public health centers, ensuring that national health promotion initiatives are effectively carried out at the community level.

Multisectoral Collaboration (HiAP)

While MOHW oversees health-specific programs – those directly related to medical services, disease prevention, and health education – many determinants of health fall under the mandate of other ministries. The HP2030 explicitly calls for bolstering such inter-ministerial collaboration, stating that it is necessary to "strengthen collaboration with relevant ministries, local governments, and agencies in various fields" and to foster a "health-friendly environment that considers health in all policy areas (Oh, 2021).

However, despite its principled emphasis on multisectoral collaboration, HP2030 falls short

in clearly outlining how this approach should be practically implemented across diverse policy areas. For instance, while the concept of creating an age-friendly environment is mentioned, the strategies highlighted predominantly focus on healthcare services and social welfare, with limited engagement from sectors such as housing, transportation, urban planning, and education, which are equally crucial for fostering a genuinely comprehensive health-promoting environment. Thus, although the plan explicitly acknowledges the importance of inter-ministerial cooperation in principle, it lacks concrete measures or governance structures to facilitate systematic and sustained collaboration across these varied sectors.

In contrast to the relatively limited cross-sectoral collaboration found within the HP2030 framework, South Korea employs a more structured, legally mandated governance mechanism to coordinate policies addressing demographic challenges, particularly population aging. The Presidential Committee on Low Fertility and Aging Society, established under the Framework Act on Low Birth Rate in an Aging Society (2021), explicitly functions as a central governance body for managing these interconnected demographic issues (FRAMEWORK ACT ON LOW BIRTH RATE IN AN AGING SOCIETY, 2021). Chaired by the President of the Republic and comprising heads of relevant ministries—including Health and Welfare, Employment and Labor, Gender Equality and Family, Education, and Finance—as well as civilian experts, the Committee holds significant political authority and facilitates inter-ministerial coordination and cross-sectoral governance. Its core responsibility includes deliberating on and approving the Basic Plan for Low Fertility and Aging Society, a legally required comprehensive strategy updated every five years. .

Decentralization

While MOHW and its agencies devise strategies and provide guidance, implementation of public health programs largely occurs at the local government level. Local public health centers run diverse health promotion programs tailored to community needs, focusing on areas such as nutrition, physical activity, smoking cessation, and alcohol use. South Korea's approach to health promotion and healthy ageing is coordinated through a multi-level governance system. The central authorities support these efforts by funding initiatives (through mechanisms like the National Health Promotion Fund) and by disseminating best practices via agencies like KHEPI. This arrangement allows national goals to be met through local action: MOHW sets the agenda and standards as well as delivering financial support, KDCA handles epidemiological surveillance and crisis response, KHEPI provides technical support, and local governments execute programs on the ground.

Funding mechanisms

The primary funding source for national health promotion efforts in Korea is the National Health Promotion Fund, which is largely financed by earmarked taxes on tobacco. Notably, a significant increase in the fund's revenue occurred after a hike in tobacco taxes in 2015 – annual health promotion surcharge revenues rose from about 1.6 trillion KRW in 2014 to 2.9 trillion KRW by 2020.

According to HP2030, a substantial portion of the Health Promotion Fund has been used to subsidize other health expenditures, such as the national health insurance program and support for the Korea Disease Control and Prevention Agency (formerly KCDC). In 2020, for example, 55.8% of the fund's budget (about 1.9 trillion KRW) was diverted to NHI operations, and another 16.7% (0.56 trillion KRW) supported KDCA, leaving roughly 10.5% (around 0.35 trillion KRW) for direct health lifestyle promotion programs. In other words, a large share of the earmarked money was being absorbed by treatment services (via insurance) rather than prevention, which HP2030 views as a concern.

Approximately 10.5% of the National Health Promotion Fund budget allocated for direct health promotion activities primarily supports local-level health promotion initiatives, notably through programs such as the Integrated Community Health Promotion Program (ICHPP). Under this arrangement, funding from the national government is provided to local governments in the form of matching funds, structured to encourage local investment and ownership. Specifically, for the ICHPP, local governments within the Seoul metropolitan area receive funds based on a 30:70 matching ratio—meaning the central government covers 30% of costs while local governments fund the remaining 70%. In other regions outside the capital area, the central government's contribution rises to 50%, reflecting an effort to reduce regional disparities in health resources and capacities. This matching-fund model incentivizes local governments to actively implement tailored health promotion programs in alignment with national objectives, yet also highlights the importance of strengthening local accountability and financial commitment to preventive healthcare efforts.

Policy Implementation

Health workforce involvement

The plan identifies key personnel at various levels who are essential for carrying out health promotion and prevention activities, and it outlines measures to strengthen their capacity and training. These include public health physicians, nurses, health educators, dietitians, exercise specialists, mental health professionals, and other practitioners working in settings like public health centers, community health posts, schools, and workplaces.

A significant focus of HP2030 is on boosting the local health promotion workforce. The plan notes that while the number of personnel in local public health institutions (such as municipal health centers) has increased over the years, there remains a heavy reliance on non-permanent staff. As of 2019, roughly 30% of the local health workforce involved in health promotion were non-civil service employees hired on contract, a slight increase in proportion since 2013. However, a critical point to consider is the feasibility of securing a workforce centered on permanent positions, especially in the context of a shrinking labor force driven by population aging. This calls for a pragmatic, long-term human resource plan that addresses these demographic realities.

On the training front, HP2030 emphasizes capacity building and education for health professionals to effectively implement the plan's interventions. HP2030 proposes securing training sites in community settings where trainees (like public health nurses or health educators) can gain hands-on experience in delivering health promotion services. The plan

also includes various initiatives to update and improve the skills of existing health workers – for example, adding modules to the continuing education requirements of relevant professional associations or creating online/offline courses through accredited institutions. Finally, the plan underscores multi-disciplinary and cross-sector collaboration, which implies that key personnel are not limited to the health sector alone. To facilitate this, training and guidelines are extended to these groups as well (for example, educating community care workers and first responders to recognize and refer individuals in need of health services).

Incentives for Local Resource Engagement

While much of the plan's content is prescriptive (setting what should be done), there are also economic and institutional incentives embedded in the structure of HP2030 to encourage active participation by provinces, cities, and counties. One fundamental incentive is the provision of financial resources and infrastructure from the central level to localities. Through the National Health Promotion Fund and national budget allocations, local governments receive funding to implement health programs aligned with HP2030, often utilizing matching fund mechanisms between central and local governments. Institutionally, HP2030 provides a clear mandate and framework for local action, which can be seen as an enabling incentive. The comprehensive plan itself acts as a guiding blueprint that local governments are expected to follow – this expectation is reinforced by law and oversight. This alignment is monitored through reporting and evaluation, creating a system of accountability. The incentive for local governments here is twofold: compliance ensures they continue to receive funding and support, and successful performance can enhance their reputation and the well-being of their constituents. However, the current structure can undermine local accountability and commitment, as the financial savings from successful prevention and health promotion—which reduce costs for the National Health Insurance and Long-Term Care Insurance—accrue entirely to the National Health Insurance Service, leaving no performance-based rewards for the local governments that drove these outcomes.

Strategies for Older Adults

Key initiatives included in HP2030 that specifically focus on older adults include creating age-friendly environments by expanding community-based health services, shifting elder care from disease management alone towards comprehensive services for frailty and overall well-being. Specific interventions include home-visiting health management services, community-based dementia care, tailored nutritional and oral health programs, physical activity promotion for older adults, and enhanced medical accessibility for seniors using advanced technologies such as AI and IoT. Further, dementia management is prioritized through early detection programs, specialized dementia-friendly facilities, integrated service networks, and community outreach programs to mitigate caregiving burdens and improve quality of life for older adults and their families.

Despite the comprehensive scope of aging-related health initiatives outlined in HP2030, explicit mechanisms for direct participation by older adults in policy formulation and program implementation processes are not clearly described. Although there is

acknowledgment of the need for community-level approaches and dementia-friendly environments, the HP2030 do not specifically detail structured participatory frameworks or formal consultative processes that systematically engage older populations themselves in shaping or evaluating these programs. However, at the implementation level, participation from residents—including older adults—is encouraged and institutionalized through guidelines and local ordinances at the municipal level.

Monitoring & Performance

Standardized Indicators

From the design phase, the plan included the development of a comprehensive set of performance indicators for each priority area, complete with baselines and 2030 targets. For example, for the goal of reducing smoking, specific indicators such as the male adult smoking rate have a documented baseline (e.g., 39.0% in 2018 for male workers) and a target (30.0% by 2030). Similar indicators exist for dozens of objectives spanning health behaviors, disease outcomes, service coverage, and determinants. Appendix tables in the plan list total 400 indicators. Notably, a smaller set of "representative indicators" tied to the overarching goals (like healthy life expectancy and health equity measures) allow high-level tracking, while a larger number of detailed indicators (for specific diseases or risk factors) enable more granular monitoring.

Data and Monitoring Sources

To monitor these indicators, HP2030 outlines the creation of a sustainable monitoring system with modern data infrastructure. A key step is making healthy life expectancy an ongoing measurable statistic rather than an occasional research output, e.g., by proposing that the Korea Health Promotion Institute establish a unit with permanent staff and budget specifically to produce healthy life expectancy data on a continuous basis. This involves collaboration with the National Health Insurance Service and Statistics Korea, forming a technical working group to integrate data (on mortality and morbidity) needed for HLE calculations. Moreover, the plan envisions an integrated online platform for monitoring all HP2030 indicators[5]. This platform pulls data from sources like Statistics Korea and other national surveys into a dashboard format. A noteworthy feature is the plan to gradually increase the granularity of data – initially by province, then by city/county, and eventually by sub-district – as data availability improves, to pinpoint local disparities.

Evaluation and Feedback Loops

Each year, action plans are drawn up in alignment with the HP2030's objectives, and MOHW

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tracks key performance indicators to assess how well interventions are working (Oh, 2021). Mid-term evaluations are built into the process; by law, the ten-year Health Plan is reviewed and updated at the five-year mark to respond to new challenges or gaps. MOHW uses these evaluations to adjust strategies and allocate resources where needed. The plan also incorporates communication of performance results as part of feedback. By expanding "public communication and participation," HP2030 intends to keep the public informed and engaged with the plan's progress. Each year, or even each month, health issues related to the plan will be highlighted in media campaigns ("Health Issue of the Month") to maintain public interest and accountability. However, one of the key caveats of existing evaluation and feedback loop is the absence of mechanisms fostering the local government accountability and commitment. Introducing a policy that links local-level monitoring results to performance-based rewards for local governments is a necessary step to enhance their commitment as the key implementers of the policy.

3.2.3 Long-term care policies

Contexts

After the introduction of the "Elderly Long-Term Care Insurance Act" in 2008, the major modality for LTC in Korea shifted from social welfare programs based on the "Elderly Welfare Act" to the LTCI system (Kwon, 2008). Unlike healthcare, LTC has long been considered as a duty of family in Korea. Therefore, public funding for formal LTC was based mainly on tax-based welfare programs of local governments, targeting the poor. This concept has changed to universalism for several reasons. First, the speed of population ageing was projected to be unprecedently high. Considering that disability to perform everyday life activities increases with age (Berlau et al., 2009), it was clear that caregiving needs for everyday activities will increase. Second, because of declining fertility, rapid increase in old age dependency and increase in women's labor participation, potential supply for informal caregiving was projected to decline. Third, inadequate LTC provision had led to "social admissions": many older adults who lacked family care ended up in hospitals (particularly geriatric long-stay hospitals) for extended periods, even when hospital-level medical care was not necessary. Before 2008, access to medical services was assured by universal health insurance, but public financing for LTC was limited – creating an incentive for families to admit frail elders to hospitals (covered by NHI) as a substitute for unavailable home or nursing home care. This practice burdened the health insurance system and indicated a gap in appropriate LTC services. Another important feature to be highlighted is the poverty rate of the elderly. Since the pensions were not sufficient to pay the costs of private LTC and everyday life, geriatrics hospitals covered by NHI was an attractive option even for non-poor older people with LTC needs. In the 2000s, Korea's pension system provided only modest benefits, leaving older adults with limited means to pay for long-term support.

Faced with these challenges, policymakers reached a consensus on establishing a new LTCI system to broaden coverage beyond the poor and reduce the reliance on medical hospitals for social care. The design of the LTCI was intensely debated (Kwon, 2008). Key considerations included the financing approach (general taxes vs. social insurance contributions), the breadth of benefits and services to cover, eligibility criteria and how restrictive they should be, the level of cost-sharing (copayments), whether to include cash allowances or only in-kind services, and how LTCI would interface with the existing health insurance system. Ultimately, Korea followed the precedent of its health system by adopting a mandatory social insurance model for LTC, run by the same agency that runs NHI. This approach leveraged institutional path dependency – the public was more familiar with contribution-based insurance than a tax-funded scheme (Kwon, 2008) – and allowed rapid implementation using NHIS's infrastructure. The LTCI launched in 2008 with the aim of providing universal coverage for LTC needs of the elderly (and some younger disabled), funded by earmarked insurance contributions, government subsidies, and user copayments.

Since its introduction, Korea's LTCI has evolved and expanded. Initially, benefits were focused on adults aged 65+ with severe limitations in activities of daily living, but coverage criteria gradually broadened. Recognizing the growing impact of dementia, eligibility was expanded in 2014 and 2018 to include older adults with cognitive impairment even if physical functions were less impaired. This led to rising enrollment of people with dementia

in LTCI (Kim et al., 2021). The number of LTCI service users increased substantially over the first decade. In 2010, only about 6.1% of Koreans over 65 utilized LTCI services, but by 2022 this share had grown to 12.9%.

Policymakers further launched community-based care initiatives to foster "aging in place." Recognizing the limitations and financial unsustainability of relying heavily on facility-based care amid rapid population aging, Korea has been piloting integrated community-based care programs. This approach aims to enable older adults to remain healthy and independent in their homes and local communities by coordinating medical, preventive, and social services. The ultimate goal is to reduce unnecessary institutionalization, enhance quality of life, and alleviate family caregiving burdens, while simultaneously managing increasing health and LTC costs related to chronic conditions and frailty. In 2018-2019, pilot programs for Community Care were rolled out in 16 municipalities, aiming to integrate housing, health, and care services at the local level to enable seniors to remain in their homes rather than institutions. By 2023, the government outlined a Third Basic Plan for Long-Term Care (2023–2027), reinforcing the policy goal of supporting older adults to live at home as long as possible (Ministry of Health and Welfare of Korea, 2023). In sum, over 15 years, Korea's LTC policy has transitioned from a narrow welfare residual to a more universal system, continually adapting to emerging needs such as dementia care and the integration of services across care settings, ultimately visioning the goal of aging in place.

Governance

Long-term care legislation and strategy

The Korean LTC system is grounded in dedicated legislation and is guided by multi-year strategic plans. The LTCI scheme was established by the Long-Term Care Insurance Act of 2007, which provided the legal framework for a universal, contribution-funded LTCI program starting in mid-2008. This Act defines key aspects of eligibility, benefits, financing, and administration of LTCI. In addition to this core law, LTC is a component of Korea's broader ageing policy agenda. For example, the government's Basic Plans for Low Fertility and Aging Society (multi-sector national strategies updated every five years) include targets to expand community-based LTC services and infrastructure (Korea Institute for Health and Social Affairs, 2018). More recently, the 3rd Basic Plan for Long-Term Care (2023–2027) provides a sector-specific strategy, setting goals for improving LTC service quality, workforce conditions, and integrated care (Ministry of Health and Welfare of Korea, 2023).

The 3rd Basic Plan for Long-Term Care (2023–2027) articulates a clear vision of preparing comprehensively for a super-aged society, guided by two primary goals: first, ensuring older adults have sufficient and diverse long-term care services to support aging in place, and second, creating a sustainable and user-friendly LTC insurance system. Key strategic tasks aligned with these goals include enhancing the adequacy and diversity of home-based services, integrating medical and LTC services more effectively, and establishing robust family support systems. Additionally, the plan emphasizes building customized service systems that proactively prevent care needs, refining care grading criteria to better reflect actual needs, and preparing infrastructure for the incoming generation of older adults (baby boomers). It also aims to improve the quality of LTC services through strengthened

institutional management, systematic service evaluation, and workforce improvements. Finally, to ensure sustainability, the plan seeks to bolster the financial stability and governance of the LTC system while integrating smart technologies into care provision.

Governance structure

South Korea's LTCI is administered centrally and closely linked with the health insurance system. The single insurer NHIS (National Health Insurance Service) is responsible for operating LTCI, in addition to NHI. This unified administration allows coordination in contribution collection. NHIS handles tasks including enrolling beneficiaries, collecting LTCI contributions (usually as a surcharge to health insurance premiums), assessing eligibility, and reimbursing LTC providers. Key policy decisions for LTCI are made at the national level by the Long-Term Care Committee, a deliberation body established under the LTCI Act. This committee, chaired by the Vice Minister of Health and Welfare, includes stakeholders such as officials from the Ministry of Health and Welfare (MOHW) and Ministry of Economy and Finance, NHIS representatives, experts, and representatives of insured persons and providers.

It oversees decisions on contribution rates, benefit levels, provider payment prices, and major program changes. Because financing and rules are set nationally and funds pooled centrally, local governments have a limited role in LTCI administration. Local authorities do not finance LTCI benefits (the central NHIS fund does), nor do they determine eligibility or service standards. However, local governments retain some influence in the planning and authorization of LTC facilities in their jurisdictions. For instance, they may regulate the establishment of new nursing homes through accreditation. Overall, the governance model is is characterized by a centralized structure – fitting Korea's unitary administrative structure – with MOHW setting policy, NHIS implementing it, and oversight through the LTC Committee. This ensures uniformity and equity in LTCI across the country, though it can pose challenges for local adaptation and innovation.

Financing

Expenditure

LTCI expenditure has grown rapidly since 2008, reflecting increasing enrollment and service use. Total public spending on LTC (LTCI benefits) reached 0.37% of GDP in 2018, up from negligible levels before, though still well below the OECD average of 1.7% of GDP for LTC. Even including related health expenditures (long-term hospital stays for chronic patients under NHI), Korea's total public long-term care spending was about 0.68% of GDP in 2018. Given the steep ageing curve, spending is projected to continue rising. However, there is evidence that LTCI has offset some medical costs: one study found that after LTCI's introduction, older persons' annual health care expenses fell by about 9.4%, as some care shifted from hospitals to LTC services (Cho & Kwon, 2023). Hospitalization rates and length of stay for long-stay patients also declined, suggesting LTCI substituted for "social admissions" in hospitals. Despite these savings, overall public costs have still increased because new LTC expenditures outweigh the reductions in health spending (Cho & Kwon, 2023).

Ensuring financial sustainability is an ongoing concern. The Ministry of Health and Welfare regularly evaluates the contribution rate and benefit package to keep the LTCI fund solvent. For example, contribution rates have been raised gradually (reaching 12.95% of the NHI premium as of 2024). Korea's approach of pay-as-you-go financing with annual adjustments faces the challenge of a shrinking working-age base supporting growing numbers of very old beneficiaries. The sustainability of such a system was one of the key reasons why discussions on integrating or better coordinating health and LTC systems have emerged, aiming to improve efficiency and reduce cost-shifting.

Revenue raising

LTCI in Korea is predominantly publicly financed through social insurance, supplemented by government subsidies and user copayments. It is designed as a social insurance scheme like health insurance. At its launch in 2008, the LTCI contribution rate was set at a modest percentage of income (initially set as 4.05% of NHI premium) and gradually increased to keep pace with rising expenditures. General tax revenues also play a role: the government subsidizes a portion of LTCI costs (20% of total LTCI revenue).

It is important to note that LTCI contribution of Korea is levied on all citizens. Whether to levy contributions on people older than certain age was of serious concern because the need for LTC care due to ageing seems remote for many young people, which is one of the reasons that the market for voluntary LTCI is so small (Wittenberg et al., 2002). Therefore, the universality of contribution was a deliberate choice to distribute costs broadly and build social solidarity. There was debate on whether younger people should pay for a service they might not use until decades later, but the decision was to include all ages and allow benefits at younger ages for certain very limited conditions, thereby framing LTCI as an intergenerational support system (Kwon, 2008).

On the private side, out-of-pocket copayments are required for most LTCI services, although Korea's copayment rates are relatively low to promote affordability. Institutional care requires 20% copayment, while home and community-based services require 15% copayment. Certain costs like meal fees in facilities are not covered by insurance, so they are paid fully by users. To protect those with limited means, there are extensive copayment reductions and exemptions: recipients of Medical Aid (the low-income welfare program, roughly 3% of the population) are exempt from LTCI copayments entirely, and lower-income seniors (below 50th percentile of income) receive a 50% reduction in cost-sharing.

Pooling resources

The pooled LTCI fund is kept separate from the health insurance fund within NHIS's accounts. This means LTCI has its own accounting and must be financially balanced through its designated revenue streams. Each year, contribution rates are adjusted based on actuarial estimates to ensure the LTCI fund can cover expenditures. This helps impose fiscal discipline, as deficits in LTCI are not automatically covered by health insurance funds or taxation.

Purchasing goods and services

NHIS functions as the purchaser of LTC services, contracting with a mix of public and (predominantly) private providers. Provider payment in LTCI is mostly on a volume-based approach, using a nationally uniform fee schedule. For home and community-based services (e.g. home care aide visits, day care), providers are paid per visit or per hour at regulated rates. For institutional care (nursing homes), a per-diem rate is paid for each resident's care day.

These fees are negotiated or periodically adjusted at the national level, intended to reflect the cost of care. Notably, the fee schedule differentiates payments by the level of dependency of the beneficiary: individuals with more severe needs (higher LTC grades) correspond to higher reimbursement rates. This tiered payment was designed to discourage providers from cherry-picking lighter-need patients – if all clients paid the same, providers might avoid heavy-care patients. NHIS, as a monopsonistic purchaser, also conducts utilization reviews and audits to prevent overservicing or fraud. Overall, the purchasing approach is centralized and rule-based, given the national scale of LTCI, with less emphasis on price competition or managed care tools at this stage.

Workforce

Existing Workforce

A well-trained and sufficient workforce is critical to deliver LTC services, and Korea's rapid LTCI rollout created new categories of caregivers while facing workforce shortages. The LTC workforce primarily consists of personal care assistants, nurses/nurse assistants, and social workers, with personal care assistants forming the vast majority. At the launch of LTCI, a new certified role called "*yoyang bohosa*" (meaning personal care assistant) was established. Due to limited supply of registered nurses (RNs) and lower pay in LTC compared to hospitals, most nursing tasks in LTC facilities are handled by nurse assistants or the personal care assistants (within their scope) (Kang et al., 2019). Social workers are another key part of the workforce, typically managing care coordination and administrative duties at LTC agencies. According to a national LTC survey in 2019, about 91% of the LTC workforce were personal care assistants, with only 4.3% being nursing staff (nurses or nurse assistants) and 4.0% social workers. Women make up an overwhelming share of LTC workers (around 95%), many being middle-aged or older women (often in their 50s and 60s) who joined the sector after other careers or family raising (Kang et al., 2019).

A recent projection study suggested that by 2030, Korea will experience a shortage of 89,976 personal care assistants (Lim & Lee, 2021). Against this backdrop, the "3rd Basic Plan for Long-Term Care", released in 2023, announced the introduction of an allowance for workers in vulnerable areas, reduction in the number of recipients per caregiver, increased wage levels and a long-term service incentive system to improve the working conditions of long-term care workers, and an improvement in the education system to strengthen their capabilities(Ministry of Health and Welfare of Korea, 2023).

Capacity-building and professionalization

To become a certified personal care assistant (*yoyang bohosa*), individuals must complete 240 hours of training and pass a qualification exam (administered at the provincial level) (Kang et al., 2019). These requirements are relatively modest (compared to medical or nursing training), reflecting an effort to quickly build a workforce to provide basic personal care. Given their limited training, personal care assistant is assigned non-medical caregiving tasks – helping with bathing, dressing, meals, toileting, and other activities of daily living – rather than clinical nursing.

Beyond the basic 240-hour course for personal care assistants, ongoing training requirements have been less formalized, though the government and NHIS encourage continuous education. Personal care assistants do not need college degrees; many are recruited from local communities and given short-course training. Nurse assistants typically have a separate certification (often a one-year training course after high school). Social workers in LTC usually hold a social work license (which in Korea requires a related degree and exam). Recognizing quality concerns, the government has taken steps to strengthen workforce competencies – for example, introducing refresher training programs and developing specialized training modules for dementia care. The 3rd Basic Plan for LTC (2023) proposes improving the education system for LTC workers to enhance their capabilities (Ministry of Health and Welfare of Korea, 2023). Professionalization is still in progress, as LTC in Korea is a relatively new field.

Service delivery

Eligibility and gatekeeping

Access to LTCI services in Korea is need-based, determined by a standardized assessment process, which effectively serves as a gatekeeping function. All citizens aged 65 or older are eligible to apply for LTCI benefits if they have functional limitations or cognitive impairments that require assistance. Individuals under 65 with serious disabilities or illnesses can also qualify in stricter conditions, as the scheme covers LTC needs regardless of age, in principle. To initiate services, an applicant (or their family) submits a request to NHIS, which dispatches a trained assessor to evaluate the person's functional status. The Long-Term Care Needs Assessment includes measures of physical activities of daily living (ADLs), instrumental ADLs, cognitive function, behavioral issues, and nursing or rehabilitative needs.

Based on this evaluation, a numerical score is calculated, and applicants are assigned a care-need grade if they meet the threshold. Originally the system had Grades 1, 2, and 3 (with 1 being most severe disability), but it has since expanded to Grades 1 through 5, plus a special "cognitive impairment" grade, to include mild dementia cases. The assigned grade determines the scope and amount of services the beneficiary can receive. Those with lighter needs (e.g., Grade 5) might be eligible mainly for adult day care and limited home help, whereas those with severe dependency (Grade 1) could receive extensive home care hours or nursing home admission. The stringency of eligibility criteria is a key lever for controlling coverage and costs – for instance, the expansions in 2014 and 2018 that added dementia-only cases increased the number of beneficiaries significantly (Kim et al., 2021).

Settings for public LTC support

Cash-benefits are allowed only in restricted situations, resulting in only negligible proportion being paid in such forms. Since the copayment policy for LTC is generous and cash benefits are restricted, the LTC system is established to discourage informal caregiving. Theoretically, cash benefits have the advantage of enhancing consumer choice and promoting the role of the family by making it possible to provide monetary compensation to informal caregivers, while having the negative effects of potential abuses and low-quality service provided by informal caregivers (Kwon, 2008). Recently, Korea allowed 'family formal caregiver' for home and community-based services, which allows family members to receive training to get certificate and act as their family member's formal caregiver, although the maximum amount of reimbursement is limited to 90 minutes per day and 20 days per month (Yang et al., 2020). This may be more expensive than usual cash-benefits, which are typically restricted to around 10-30% of the value/cost of formal care in very restricted occasions (Ministry of Health and Welfare of Korea, 2025), but may have positive effects regarding the quality of services and potentially less abused compared to cash-benefits. It can also be interpreted as supplying jobs for the elderly, as informal caregiver is often a spouse, who are typically economically inactive older people in Korea (Kang et al., 2019).

Services are generally available from a large network of providers – as of early 2020s, there were thousands of small home-care agencies and day care centers across Korea, and hundreds of nursing homes, most owned by private entities (nonprofits or for-profits). Beneficiaries have free choice of provider, and providers compete on service quality to attract clients. Because the government does not tightly limit provider entry (except for nursing home bed licensing by local authorities), there is adequate supply in most urban regions and waiting times for services are usually short (if one provider is full, another can often be found). However, in rural areas, choices can be more limited due to limited supply of services.

Service provided

As sub-acute care, rehabilitation services, and hospice care are provided by NHI in Korea, the focus of LTC delivery funded by LTCI are supports for activities of daily living. Two categories of services are covered, which are home and community-based services and facility services. Facility services are similar to nursing home settings in other countries. Minimum human resources and infrastructures of LTC facilities are specified by law, which differs by average capacity of beneficiaries that could be admitted. There are some critics that these minimum requirements are not enough to guarantee quality of service, especially because additional reimbursement based on quality assessment isn't high enough to providers compared to the cost of enhancing the quality of services (Lee et al., 2013).

Home and community-based services consist of various services (Table 3.2.2). Services could be categorized as home-visit services which are home-visit care, home-visit bathing, and home-visit nursing, and community-based respite services such as day-and-night care, and short-term services. A predetermined list of welfare equipment is also available for beneficiaries, which are selected by NHIS. Beneficiaries are entitled to receive services under the limit of maximum expenditure per month based on their eligibility grades.

Table 3.2.1: Type of Long-term care In-home benefits, Korea

Type	Content
Home-visit Care	Long-term care benefit of supporting the physical activities and housework, by visiting beneficiary's home.
Home-visit Bathing	Long-term care benefit of supporting bathing using bathing equipment, by visiting beneficiary's home.
Home-visit Nursing	Long-term care benefit of nursing, assisting treatment, providing consultation on care, or dental hygiene services based on doctor's or dentist's prescription.
Day and night Care	Long-term care benefit of providing recipients with care in a facility for a number of hours a day to support their physical activity and provide training and education in order to help them maintain and improve their mental and physical functions.
Short-term Care	Long-term care benefit of providing recipients with care in a facility for a certain period time to support their physical activity and provide training and education in order to help them maintain and improve their mental and physical functions.
Welfare equipment	Long-term care benefit of providing or borrowing equipment which are specified in the list determined by NHIS.

Source: NHIS (2019).

Each eligible beneficiary receives an individualized care plan and a monthly cap on the value of home and community-based services they can use, based on their care-needs grade. Within that cap, the person can mix and match approved services (e.g., some days of day care, some home visits) with the guidance of a care manager or the local LTC service provider.

Integrated care and person-centered care pathways

Integrating medical and social care for the elderly is an important goal in Korea, as many LTC users also have chronic health conditions. The LTCI system includes some measures to coordinate with health services. For instance, home-visit nursing allows medical care at home under doctor's orders, filling a gap between purely social care and healthcare. In facilities, regulations require that nursing homes arrange regular visits by a physician for check-ups of residents.

Despite these efforts, coordination challenges remain. Many families still resort to hospitalizing frail elders when their needs intensify, and long-term hospital stays (over 180 days) for older patients are not uncommon. The government has identified this as an area for improvement: by making LTC services more comprehensive and convenient (e.g., providing rehabilitation or simple medical services through LTCI), they hope to reduce unnecessary hospital use. The push for community care pilots in 2019 was in part to establish local care coordination mechanisms – such as case management teams that connect seniors to both

health services (like home-visit nursing, community health center programs) and social services (like meal delivery, transportation).

Person-centered care approaches are also being introduced, focusing on the individual's preferences and holistic needs rather than a one-size-fits-all service package. For example, there is growing attention to dementia-friendly care practices in day centers and nursing homes, and to training staff in person-centered communication. The 3rd Basic Plan for LTC explicitly calls for improving the needs assessment to better capture each person's circumstances and for expanding comprehensive care planning (integrating health, LTC, and welfare services at the community level) (Ministry of Health and Welfare of Korea, 2023). These reforms are ongoing, with pilot programs being scaled up for more integrated home-care models.

Quality assurance

Quality of care in LTC is monitored and encouraged through several mechanisms under NHIS and MOHW oversight. All LTC providers must meet minimum standards defined by law (e.g., staffing ratios, facility safety codes) as a condition of licensing. However, simply meeting minimum input does not guarantee high-quality outcomes. To drive improvements, NHIS conducts regular quality assessments of LTC providers. These evaluations, like those used in health care, review various aspects of service quality – staffing levels above the minimum, training, care processes, safety incidents, user satisfaction, and documentation. Providers are then rated or scored. The results of these assessments are publicly available, which promotes transparency (family members can see how a nursing home ranks, for example) (Kim et al., 2021). Importantly, the assessment results are tied to financial incentives: providers with higher quality scores receive bonus payments or higher reimbursement, while those with poor results may face penalties or reduced fees.

Performance of long-term care service delivery

Korea's LTCI scheme generally provides a high level of financial coverage for long-term care services, covering approximately 89.1% of total LTC expenses as of 2018. Beneficiaries pay relatively low copayments—20% for facility-based services and 15% for home-based services—with further reductions or exemptions available for lower-income groups and Medicaid beneficiaries. Despite this generous financial coverage, however, there remains a significant level of unmet care need, with recent studies reporting that about one-third (33.6%) of older adults with functional limitations experienced unmet care needs (Leigh et al., 2023). Additionally, the economic burden from informal caregiving remains substantial; for instance, households relying exclusively on informal caregiving provided an average of 87.7 hours per month in 2014 (Ham & Hong, 2017), highlighting significant hidden costs and implications for caregivers' labor market participation and household economic stability (Norton, 2016).

Consumer satisfaction is a key performance indicator of LTC service delivery being tracked annually. In fact, the most frequently measured indicator is the overall satisfaction of LTCI

users and their families with the services. NHIS surveys users each year; recent results show relatively high satisfaction. On a 100-point composite index, customer satisfaction with LTCI services scored around 88-90 points in 2018–2022(National Health Insurance Service, n.d.). A separate national LTC survey in 2019 found similar satisfaction levels among family caregivers (who often benefit from respite provided by LTCI) (Kang et al., 2019). When broken down by service type, satisfaction was highest for adult day care (over 90% satisfied) and home bathing services (85%), and somewhat lower for home nursing (around 70%) and especially short-term respite care (only ~45% satisfied). The primary complaint of those less satisfied with home-based services was insufficient service hours – many felt the allotted home care hours were too limited to meet all needs.

3.2.4 Conclusion

South Korea's HP2030 articulates an ambitious vision to extend healthy life expectancy. Although the strategy does not explicitly single out morbidity compression, its focus on enhancing health expectancy contributes to the same direction. Looking ahead, experiences from countries such as Japan—where policy explicitly emphasizes narrowing the gap between total life expectancy and healthy life years—may provide useful lessons for further refining Korea’s approach to promoting healthy ageing.

Moreover, while HP2030 formally embraces HiAP and acknowledges the significance of social determinants of health, the governance structures for multisectoral collaboration are still in an evolving stage. Some of these aspects are partially addressed by mechanisms such as the Presidential Committee on Low Fertility and Aging Society, yet further opportunities remain to strengthen alignment within key systems such as NHI and LTCI—both managed under the NHIS. In particular, enabling clearer incentives and accountability mechanisms for local governments could enhance the linkage between their preventive actions and long-term benefits to national health and LTC systems.

In this context, the ongoing community-based integrated care pilot programs present a critical opportunity to address these institutional alignment issues. Effective "aging in place" requires not only achieving morbidity compression but also ensuring an appropriate mix of home and community-based health, LTC, and social services. Central to realizing these goals will be the development of clear governance and financing frameworks that delineate roles, responsibilities, and incentives across stakeholders—particularly local governments that deliver health promotion and social services, and national-level institutions such as the NHIS, which administer NHI and LTCI. Resolving these governance and accountability questions is pivotal to achieving cohesive, sustainable health promotion and LTC outcomes in South Korea in the era of rapid population ageing.

References

- Berlau, D. J., et al. (2009). "The prevalence of disability in the oldest-old is high and continues to increase with age: findings from The 90+ Study." International journal of geriatric psychiatry 24(11): 1217-1225.
- Cho, Y.-M. and S. Kwon (2023). "Effects of public long-term care insurance on the medical service use by older people in South Korea." Health Economics, Policy and Law 18(2): 154-171.
- FRAMEWORK ACT ON LOW BIRTH RATE IN AN AGING SOCIETY (2021). FRAMEWORK ACT ON LOW BIRTH RATE IN AN AGING SOCIETY. R. o. K. Ministry of Government Legislation. Act No. 18580.
- Ham, S. and B. Hong (2017). "The Relationship Between Formal Care and Informal Care: Focusing on Home Care Service for Elderly." Korean Journal of Social Welfare 69(4): 203-225.
- Han, E.-J., et al. (2023). "Monitoring healthy ageing for the next decade: South Korea's perspective." Age and Ageing 52(Supplement_4): iv10-iv12.
- Jung, Y.-S., et al. (2021). "Measuring the burden of disease in Korea, 2008-2018." Journal of Preventive Medicine and Public Health 54(5): 293.
- Kang, et al. (2019). The 2019 National Survey of Long-Term Care [2019 년도 장기요양 실태조사]. Sejong, Ministry of Health and Welfare of Korea,.
- Kim et al. (2021). A Study on the Transition to an Integrated Health and Social Care System [초고령사회 노인 돌봄체계 개편 방향: 의료-돌봄 통합체계로의 개편 방안 연구] Sejong, Ministry of Economics and Finance of Korea,.
- Kim, S.-Y., et al. (2023). A study on the decomposition of contributions by age-causes to changes in life expectancy at birth in Korea. Daejeon, Statistics Korea.
- Kim, Y. E., et al. (2019). "Trends and Patterns of Burden of Disease and Injuries in Korea Using Disability-Adjusted Life Years." J Korean Med Sci 34(Suppl 1): e75.
- Korea Disease Control and Prevention Agency (n.d.). "Korea Disease Control and Prevention Agency Official webpage." Retrieved 27 February, 2025, from https://www.kdca.go.kr/index.es?sid=a3.

- Korea Health Promotion Institute (n.d.). "Gap between life expectancy and healthy life expectancy." Retrieved 27 February, 2025, from https://www.khepi.or.kr/hpn/healthLife/healthLifeDiff.do?menuId=MENU01313.
- Korea Health Promotion Institute (n.d.). "Korea Health Promotion Institute official webpage." Retrieved 27 February, 2025, from https://www.khepi.or.kr/eps.
- Kwon, S. (2008). "Future of long-term care financing for the elderly in Korea." Journal of aging & social policy 20(1): 119-136.
- Lee, J.-s., et al. (2013). Strategies for Enhancing the Quality Assessment Indicators of Institutional Long-Term Care [장기요양기관 시설급여 평가지표 개선방안]. Seoul, National Health Insurance Service.
- Lee, Y., et al. (2024). "SOCIOECONOMIC INEQUALITIES IN HEALTHY AGING OF OLDER KOREAN ADULTS: AN AGE-PERIOD-COHORT ANALYSIS." Innovation in Aging 8(Suppl 1): 1276.
- Leigh, J.-H., et al. (2023). "Effective service coverage of long-term care among older persons in South Korea." Age and Ageing 52(Supplement_4): iv162-iv169.
- Lim, J. and Y. Lee (2021). "Analysis and Prospects for the Supply-Demand Gap of Care Workers." The Journal of Humanities and Social Sciences 21 12(6): 2255-2268.
- Ministry of Health and Welfare and Korea Health Promotion Institute (2022). The 5th National Health Promotion Plan. Sejong, Ministry of Health and Welfare.
- Ministry of Health and Welfare of Korea (2023). The 3rd Basic Plan for Long-Term Care [제3차 장기요양기본계획].
- Ministry of Health and Welfare of Korea (2025). Notification on the Standards for Long-Term Care Benefits and Methods for Calculating Benefit Costs, etc. [장기요양급여 제공기준 및 급여비용 산정방법 등에 관한 고시], Ministry of Health and Welfare.
- National Health Insurance Service (n.d.). "Internal Customer Satisfaction Survey [자체만족도 조사]." Retrieved 12 May, 2024.
- Norton, E. C. (2016). Chapter 16 - Health and Long-Term Care. Handbook of the Economics of Population Aging. J. Piggott and A. Woodland, North-Holland. 1:

951-989.

- Oh, Y. (2021). "The National Health Plan 2030: its purpose and directions of development." Journal of Preventive Medicine and Public Health 54(3): 173.
- Statistics Korea (n.d.). "Complete Life Tables." Retrieved 27 February, 2025, from https://kosis.kr/statisticsList/statisticsListIndex.do?vwcd=MT_ZTITLE&menuId=M_01_01#content-group.
- United Nations Department of Economic and Social Affairs (2025). World Population Prospects 2024, United Nations.
- Wittenberg, R., et al. (2002). "Funding long-term care: the public and private options." Chapter 10: 226-249.
- World Health Organization (n.d.). "Republic of Korea." Retrieved February 25, 2025, from https://data.who.int/countries/410?hostName=data.who.#:~:text=In%20the%20Republic%20of%20Korea%2C,73.1%5D%20years.
- Yang et al. (2020). Improving the Policy for Family Members as Certified Long-Term Care Workers [가족인 요양보호사 제도 개선 연구]. Sejong, Ministry of Health and Welfare of Korea.
- Yang, S., et al. (2010). "Understanding the rapid increase in life expectancy in South Korea." American journal of public health 100(5): 896-903.

3.3 Thailand

3.3.1 Introduction

Thailand is undergoing rapid population aging, with 16.5% of the population (11 million people) aged 60+ as of 2018—second only to Singapore in the ASEAN region (Suriyanrattakorn & Chang, 2021). The aged 80 years and above is projected to grow tenfold between 2000 and 2050 (Knodel et al., 2018), contributing to increased prevalence of functional dependence. An estimated one million elderly Thais are homebound or bedridden around 2021 (Suriyanrattakorn & Chang, 2021). These demographic changes strain traditional family-based care systems. At the same time, socio-economic shifts are reducing families' caregiving capacity. The share of older adults living with adult children fell from 77% in 1986 to 51% in 2017. Smaller families, labor migration, and urbanization have led to fewer available caregivers. Women, typically the main caregivers, face rising burdens. While filial piety remains culturally valued, it is increasingly difficult to sustain in practice. These factors highlight the limits of relying solely on informal care (Naoyuki & Shintaro, 2023).

Against this backdrop, Thailand is also grappling with next-generation health challenges that further compound the pressures of aging. Non-communicable diseases (NCDs) have become the dominant cause of death and disability, accounting for roughly 73% of total DALY loss by 2019 – up from 59% in 1999 (WHO, 2024). The country's rapid socioeconomic development and urbanization have led to lifestyle risk factors (such as sedentary behavior, unhealthy diets, and alcohol use) that fuel rising rates of obesity, diabetes, and heart disease. At the same time, demographic change is accelerating: 20% of Thais are already aged 60 or above in 2024(WHO SEARO, 2024). An aging society brings new needs for chronic disease management, long-term care (LTC), and age-friendly communities. In this context, Thailand's policy emphasis has increasingly shifted toward health promotion and prevention as cost-effective strategies to improve population health and curb the NCD epidemic.

Thailand is widely regarded as a pioneer in health promotion in Asia, having established one of the first dedicated health promotion foundations in the region. Over the past several decades, Thailand has achieved dramatic improvements in population health outcomes. Life expectancy at birth rose from around 64 years in the 1980s to over 77 years by 2020, reflecting successful control of infectious diseases and expansion of primary health services. While a gap between life expectancy and healthy life expectancy remains: at age 60, the additional life expectancy is 17.4 years, and the additional healthy life expectancy is 11.8 years in Thailand (WHO SEARO, 2024). The country attained universal health coverage in 2002, which now protects virtually 100% of Thai citizens from catastrophic medical costs (WHO, 2023). These achievements have laid a strong foundation for an increased focus on promoting health and preventing disease. In 2001, Thailand broke new ground by creating the Thai Health Promotion Foundation ("ThaiHealth"), an autonomous state agency funded by a surcharge on tobacco and alcohol taxes – the first organization of its kind in Asia. This model provided sustained financing and impetus for nationwide health promotion initiatives (Sopitarchasak et al., 2015). Thailand's leadership in areas such as tobacco control, road safety, and community health has been recognized globally.

In parallel, Thailand's long-term care (LTC) policy has evolved in response to rapid

population aging. Early measures, including the First National Plan for Older Persons (1982–2001) and the 2003 Elderly Act, prioritized family-based support. Subsequent reforms under the Second National Plan (2002–2021) progressively emphasized community-based care, reinforced by a 2009 national resolution that formally defined LTC. A major policy shift occurred in the 2010s when the National Health Security Office (NHSO), purchaser of the Universal Coverage Scheme (UCS) for the informal sector, allocated BT600 million to implement a community-based LTC pilot project, and by 2020, over 90% of sub-districts nationwide had met the LTC service criteria set by the Ministry of Public Health (MOPH). Embedded within the 20-Year Strategic Plan (2017–2036) and the 12th National Economic and Social Development Plan, LTC has become a central component of Thailand's equity-oriented social policy. This trajectory reflects a transition from reliance on family caregiving to an integrated community-based aimed at addressing both health and social needs of a rapidly aging society.

3.3.2 Healthy ageing policies

Contexts

Thailand's health promotion landscape must be understood in the context of the country's epidemiological and demographic transitions. Over recent decades, Thailand has moved from a predominance of infectious diseases and maternal-child health concerns toward a profile dominated by chronic NCDs and injuries. By 2019, chronic conditions like cardiovascular disease and cancers, along with injuries (notably road traffic accidents), accounted for the vast majority of Thailand's disease burden, whereas communicable diseases had fallen to under 10% of DALYs (WHO, 2024). In comparative terms, Thailand faces particularly high rates of road injury, stroke, and ischemic heart disease relative to countries of similar socioeconomic status (WHO, 2024). These leading causes of death and disability are closely linked to modifiable risk factors – tobacco use, harmful alcohol consumption, unsafe driving, physical inactivity, and dietary habits – which have become key targets of health promotion policy.

The health status of the Thai population has improved over the past two decades. Both life expectancy (LE) and healthy life expectancy (HALE) have increased steadily. However, because the gains in LE have outpaced those in HALE, Thailand has experienced an expansion of morbidity. From 2001 to 2020, life expectancy at birth increased from 71.7 to 76.5 years, a gain of 4.8 years. Over the same period, HALE at birth rose from 62.8 to 66.7 years, an increase of 4.0 years. As a result, the LE–HALE gap widened from 8.9 to 9.8 years. Sex-specific trends reveal greater improvements among males, with LE and HALE increasing by 5.1 and 4.4 years, respectively. Among females, the corresponding increases were 4.4 and 3.6 years. While life expectancy has increased, it remains limited by morbidity from NCDs, and the gap between urban and rural health outcomes persists as a concern (WHO, 2025). Geographic and socio-economic health inequalities are evident, with some regions and sub-populations lagging behind national averages.

Demographic trends add urgency to Thailand's health promotion efforts. The country is experiencing rapid population aging, driven by declining fertility and longer lifespans. The proportion of older persons has been steadily rising; in 2023 about one in every five Thais is over 60 years old, and expected to continue increasing over the coming decades (WHO SEARO, 2024). This demographic shift will likely increase the prevalence of chronic illnesses and disability, placing greater demands on healthcare and social support systems. It also makes preventive health measures across the life-course even more critical, so that people can remain healthy and active in old age. Additionally, Thailand's socio-economic context is that of an upper-middle-income country with a vast informal sector and millions of migrant workers. Economic development and urban migration have improved living standards overall but have introduced new lifestyle risks and created "dual burden" scenarios in some communities where undernutrition and communicable diseases coexist with obesity and degenerative diseases. Environmental and social determinants – such as air pollution in urban centers or risk behaviors among youth – are increasingly part of the health promotion context. The Thai government and civil society recognize that these contextual factors require a broad, proactive approach to health promotion, integrating efforts across different sectors and levels of society.

Policy Foundations

Goal Setting

In Thailand, health promotion activities are primarily undertaken by the Thai Health Promotion Foundation (ThaiHealth). While increasing population life expectancy and improving overall health constitute the foundation's broad objectives, specific strategies to achieve these goals are less clearly defined. For instance, ThaiHealth introduced 10-year strategic goals for 2012–2021 to guide evaluation and planning. These goals were largely issue-based, focusing on areas such as tobacco consumption, alcohol consumption, sexual health, food and nutrition, and physical activity (Sopitarchasak, 2015). In practice, tobacco- and alcohol-related campaigns accounted for more than 40% (41.1%) of ThaiHealth's total expenditure in 2017, followed by community health strengthening (15.8%) and health literacy promotion (12.2%) (Pongutta, 2019). This pattern reflects the financing structure of the foundation, which relies primarily on a surcharge on tobacco and alcohol excise taxes as its dedicated funding source.

Gender, Equity, Diversity, and Social Inclusion (GEDSI)

Thailand's health promotion policies explicitly strive to be inclusive and equitable, ensuring that all population groups benefit from health improvements. Equity has long been a guiding principle: for example, the achievement of universal health coverage (UHC) has greatly reduced disparities in access to care and financial protection (WHO, 2023). To address remaining gaps, current strategies focus on reaching vulnerable and marginalized groups. One priority is the health of non-Thai populations (e.g. migrant workers, ethnic minorities) who historically faced access barriers; in order to tackle this challenge, an initiative of the Local

Health Security Fund (LHF) was piloted in 2004 and expanded to cover nearly all local governments in Thailand (WHO, 2024).

Thailand has also made commitments to gender equality in health. The 2015 Gender Equality Act protects individuals from gender-based discrimination. In addition, policies mandate the use of sex-disaggregated health data and analysis of gender-specific outcomes, so that inequities between women and men can be identified and addressed in programs (WHO, 2023). For instance, the national health promotion plan encourages gender-responsive budgeting – ensuring resources are allocated in ways that consider women's health needs and remove gender-based barriers. A practical example is the focus on reproductive health and the reduction of teen pregnancy, which has involved multi-sector efforts in education and community empowerment targeting adolescent girls (Galbally, 2012). Inclusivity extends to people with disabilities as well. Public health facilities have been upgrading physical accessibility such as disability-friendly toilets. Also, the government has developed a sign language interpretation service to reduce the communication barrier for the deaf (WHO, 2024). By embedding GEDSI principles, Thailand's health promotion framework aims to narrow health outcome gaps across regions, socio-economic strata, genders, and other diverse groups, so that improvements in health are broadly and shared.

Life-Course Orientation

In the ten-year review of Thai Health promotion foundation, the experts point out that while there are initiatives and supports that targets certain population groups such as project to empowering single mothers, there is no evidence of systematic strategy in the life-course area. The authors recommended to develop health promotion strategy that includes every stage of life. For instance, they suggested specific strategy for improving and the health and well-being of older adults, including addressing the risk factors relating to social isolation (Galbally, 2012). However, no significant changes have been implemented following these recommendations (Tangcharoensathien et al. 2024).

Shift to Prevention

A major thrust of Thailand's health policy in the 21st century has been to shift the balance of the health system from curative care toward prevention and health promotion. Historically, like many countries, Thailand devoted most health resources to medical treatment, but policymakers have sought to prioritizing upstream prevention. The establishment of ThaiHealth in 2001 was a landmark in this regard – it created a dedicated institution and funding stream solely for health promotion, thereby institutionalizing prevention as a core focus (Sopitarchasak et al., 2015).

Preventive services are now part of the guaranteed benefits under UHC: the National Health Security Office (NHSO) allocates funding for preventive care (vaccinations, screenings, health education, etc.) for the entire population, not just those actively seeking care (WHO, 2024). In fact, the NHSO Board set a policy target that at least 12% of the total UHC budget be spent on health promotion and disease prevention by 2022, up from about 7–8% a few

years prior (WHO, 2024). This reflects high-level commitment to rebalancing expenditures towards prevention. At the service delivery level, Thailand reoriented its primary care system to emphasize health promotion – government primary care units were rebranded as "sub-district health promoting hospitals," and their staff (nurses, public health officers, etc.) are tasked with community outreach and preventive activities in addition to basic curative care (WHO, 2024). While curative services still account for the bulk of health expenditures, the trajectory is toward greater preventive investment. Thailand's experience shows a clear policy shift: from reactive care of illness to proactive promotion of health.

Evidence-Based Risk Factor Prioritization

Thailand's health promotion policies are data-driven, focusing on the highest-impact risk factors identified through epidemiological evidence. In the early 2000s, the emerging burden-of-disease data and risk factor surveys made clear that a handful of risks were responsible for a large share of preventable death and disability. In response, Thailand developed targeted programs and policies addressing those risks. For example, ThaiHealth spent majority of its budgets to tackle against key risk factors of Thailand, such as tobacco, harmful use of alcohol and substance abuse, physical activity, healthy food and road safety (Pongutta et al., 2018; Sopitarchasak et al., 2015). Tobacco and alcohol were among the first targets: Thailand has continually raised excise taxes on cigarettes and alcohol and implemented comprehensive tobacco and alcohol control laws (the Alcohol Control Act of 2008 and the Tobacco Product Control Act of 2017), resulting in declines in smoking and heavy drinking rates over time (Pongutta et al., 2018; WHO, 2024). Throughout these efforts, Thailand has leveraged research and surveillance to guide action. The country's Burden of Disease studies have highlighted top causes like stroke and ischemic heart disease, reinforcing the focus on hypertension and salt intake reduction (WHO, 2024). When formulating its national health promotion plan, ThaiHealth consulted evidence and best practices, for instance adopting anti-tobacco measures.

Policy Alignment

Underpinning Thailand's success in health promotion is an emphasis on aligning policies across sectors and ensuring health is factored into all areas of governance. Health promotion in Thailand is not seen as the health sector's job alone; instead, it is pursued through a Health in All Policies (HiAP) approach. This is institutionalized via the National Health Assembly (NHA) mechanism, a participatory policy forum established by the 2007 National Health Act. The NHA convenes annually with representatives from government ministries beyond health (such as education, transport, agriculture), civil society organizations, academia, and the private sector to deliberate on priority health issues and propose solutions. For example, the NHA has been successful adopted health policy to control of marketing promotion of foods for infant and young child and the policy became legally enacted (WHO, 2024). In addition, ThaiHealth plays a coordinating role in many cross-sector efforts; for example, its board and networks include leaders from education, media, urban planning, and religious communities, which helps to synchronize messaging and policies across domains (Sopitarchasak et al.,

2015). In summary, policy alignment in Thailand is achieved through formal multisectoral governance structures and legal mandates that integrate health objectives into all policies.

Policy Governance and Funding Structure

Lead institutions

Several key institutions provide leadership for health promotion policy in Thailand. Foremost is the Ministry of Public Health (MoPH), which bears the main responsibility for public health, prevention, and health education under Thai law (WHO, 2024). Within MoPH, the Department of Health and Department of Disease Control (among others) design and oversee national health promotion programs. The MoPH also operates the extensive network of health-promoting hospitals and health centers that implement activities on the ground.

Alongside the MoPH is the Thai Health Promotion Foundation (ThaiHealth) – a unique autonomous state agency dedicated exclusively to health promotion. ThaiHealth was established by the Health Promotion Act of 2001 and is governed by a multi-sector Board of Governors with representatives from government, academia, and civil society (Sopitarchasak et al., 2015, 12.pdf). It functions as an innovative enabler and catalyst, funding projects nationwide and convening partners to advance the health promotion agenda. ThaiHealth's creation effectively added a second "lead" institution to complement the MoPH, one with flexibility and resources to experiment and work across sectors.

Another important body is the National Health Security Office (NHSO), which administers the Universal Health Coverage Scheme. While NHSO's primary mandate is healthcare financing, it also manages and disburses funds for health promotion and disease prevention services under the UHC benefit package ensuring preventive care reaches the population. The National Health Commission Office (NHCO) is a further institutional pillar formed in 2007, which oversees the National Health Assembly process and health policy coordination across sectors. In summary, Thailand's governance structure for health promotion is characterized by a combination of a public health ministry, an independent statutory health promotion foundation, a health financing agency, all of which provide leadership in their respective domains while collaborating with one another (WHO, 2024).

Multisectoral Collaboration

Collaboration across sectors and stakeholders is at the heart of Thailand's health promotion governance. Thai Health's operating model is explicitly multisectoral – it works with partners not only in the health sector but also engages government agencies like the Ministry of Education, Ministry of Transport, law enforcement, as well as private companies, non-governmental organizations (NGOs), academic institutions, media, and community groups. For instance, in the fight against tobacco, Thailand's Action on Smoking and Health Foundation (a civic group) partnered closely with the MoPH and legislators to push through stronger tobacco control (Sopitarchasak et al., 2015).

Decentralization

Thailand is a unitary state, but since the late 1990s it has pursued administrative decentralization, including in the health sector. The Decentralization Act of 1999 legally required the MoPH to devolve health facilities to local governments – health centers were to be transferred to Tambon (sub-district) Administrative Organizations (TAOs), district hospitals to town municipalities, and provincial hospitals to Provincial Administrative Organizations (PAOs). In practice, this devolution has been slow and limited. Initially, there was resistance and concern about local capacity to manage health services, and in 2002 the government paused large-scale transfers. As of 2021, only 84 out of 9,759 MoPH health centers (about 0.8%) had actually been transferred to TAO management – the rest remain under the Ministry's authority. A small number of district hospitals have similarly been transferred to local entities in pilot cases, but most remain centrally run. Thus, the MoPH continues to directly operate the vast majority of frontline health promotion infrastructure such as sub-district health promoting hospitals and community health centers across Thailand (WHO, 2024). Overall, while the legal framework anticipated a big shift of health responsibilities to local governments, the reality has been a more gradual, hybrid model.

Funding mechanisms

The ThaiHealth funding model, a dedicated tax-based financing stream, is a cornerstone of funding for health promotion. By law, ThaiHealth receives a steady 2% surcharge on tobacco and alcohol excise taxes, which translates to an annual budget that has been roughly in the range of 4–6 billion Thai Baht (THB) (approximately USD 120–180 million) in recent years. This sustainable financing mechanism is protected from political fluctuations and cannot be diverted to other purposes, ensuring a reliable flow of resources for health promotion (WHO, 2024). In parallel, the government allocates part of general tax revenues to health promotion through the MoPH and NHSO. Under the Universal Coverage Scheme (UCS), the NHSO sets aside a portion of its capitation funding for prevention and health promotion benefits for all members. Importantly, as noted, this share was mandated to increase to around 12% of the UCS budget by 2022 to bolster preventive care (WHO, 2024). These funds pay for services such as immunizations, screenings, family planning, and health education delivered through the primary care services. The stable financial backing has been frequently cited as key to Thailand's health promotion success.

Policy Implementation

Health workforce involvement

At the primary care level, local health workforce teams are tasked not only with treating illness but also with community health outreach. Each province and district health office has personnel responsible for health promotion and disease prevention programs (WHO, 2024). Beyond professional health workforce, implementing health promotion at scale in Thailand relies on a broad base of health workers and volunteers who integrate promotive activities into communities. A signature element is Thailand's extensive village health volunteer

(VHV) network. There are over one million VHVs nationwide, typically volunteers from the community who receive basic training to serve as health messengers (Perry, 2020). The collective involvement of both formal and informal workers enables Thailand's health promotion messages and services to permeate deep into communities, including remote rural areas.

Incentives for Local Resource Engagement

In addition to ThaiHealth, the country's highly centralized government health promotion agency, a notable feature of Thailand's implementation strategy is the use of incentives and support mechanisms to engage local communities and resources in health promotion. One major approach is the Local Health Security Fund (LHSF) which provides matching funds to encourage local governments to invest in health. Because the national NHSO will double any local budget put towards health promotion, even resource-constrained sub-districts have an incentive to allocate money for community health projects, which enables local governments to evaluate the situations and distribute funds in accordance with local needs (WHO, 2024). In parallel, each volunteer health worker (VHV) receives a monthly salary of 600 baht (about US$ 20). A number of leisure activities, parties, and field trips supported by local health and non-health authorities are other types of incentives. In addition, becoming a VHV is regarded as a privilege. Some VHVs are nominated for regional competition and nationally recognized VHVs receive prestigious awards (Perry, 2020).

Strategies for Older Adults

With Thailand's population aging rapidly, a suite of strategies specifically aimed at older adults' health and well-being has become a vital component of health promotion. The Thai government's commitment to healthy aging is codified in laws. For example, the Older Persons Act of 2003 provides older Thais a range of rights, including access to healthcare services (WHO SEARO, 2024). However, while life-course approach is important for health promotion, there is no evidence of any systematic strategy, especially for older adults. A strategy for improving and maintaining the health and well-being of older adults has been overlooked in Thai Health (Galbally, 2012).

Monitoring & Performance

Standardized Indicators

At a higher level, Healthy Life Expectancy (HALE) has been adopted as a summary measure: Thailand looks not just at life expectancy but at the average number of years people live in good health. There is an explicit policy aiming to increase HALE: health-Adjusted Life Expectancy (HALE) was set as a target in the 10-year strategic plan for the Thai Health (Bundhamcharoen et al., 2017). Unfortunately, more detailed policy information cannot be reviewed since as the documents are only available in Thai. In addition, the MoPH also

conducted the National Health Examination Survey. Though costly, the survey contributed to an in-depth understanding of the health status of the Thai population (WHO, 2024). At a more granular level, Thai Health applies significant attention and resources for monitoring. The foundation supports national surveys that track health-related behaviors such as tobacco use, alcohol consumption, dietary habits, and physical activity (Pongutta et al., 2018). In addition, Thai Health's primary strategy is to fund, facilitate, and support other organizations in implementing health promotion projects, rather than directly conducting these activities itself. Consequently, its monitoring efforts also focus on tracking the performance and outcomes of supported projects (Galbally, 2012)

Data and Monitoring Sources

To populate these indicators and inform policy, Thailand relies on a several data collection system, though one that is somewhat fragmented across different sources. Key sources include: (1) Routine health information systems – such as the national vital registration for birth and death statistics (2) Household surveys – Thailand has a long-running series of national surveys conducted by the National Statistical Office (NSO) and other agencies. Notable among these is the National Health Examination Survey (NHES), a large-scale survey performed roughly every 5 years which collects biometric data and health behavior information from a representative sample. The NHES provides rich data on risk factor trends and prevalence of conditions like diabetes, helping evaluate NCD prevention progress. (3) Research studies and evaluations – e.g. the Burden of Disease studies (WHO, 2024).

Evaluation and Feedback Loops

Thailand places considerable emphasis on evaluating the performance of health promotion policies and feeding lessons learned back into the policy cycle. One prominent example is the ThaiHealth’s 10-Year Review. After its first decade of operation (2001–2011), the Thai Health Promotion Foundation underwent a comprehensive external and internal evaluation to assess its achievements, shortcomings, and impact on Thailand’s health status (Galbally, 2012). Moreover, ThaiHealth has an ongoing monitoring system: it puts a lot of focus and resources into monitoring its plans, partners, and projects. This includes managing projects, checking progress, and making sure that grants are used properly. Their monitoring system is well-developed and works smoothly, with regular audits to keep everything in check (Galbally, 2012) Thailand acknowledges that health promotion is a long-term endeavor requiring continuous improvement. As one review noted, even after over a decade of experience, ThaiHealth considers itself “still on a learning curve,” adapting to new health challenges and evidence (Sopitarchasak et al., 2015).

3.3.3 Long-term care policies

Contexts

Until recently, formal LTC services in Thailand were limited. Elder care was traditionally viewed as a family responsibility, with minimal institutional support. Private LTC services were few and largely unregulated, serving mostly urban elites. Community-based support existed informally—via elderly clubs, temples, NGOs, and Village Health Volunteers (VHVs) (Naoyuki & Shintaro, 2023; Suriyanrattakorn & Chang, 2021). Thailand has developed its long-term care (LTC) policy framework in response to rapid population aging and changing social dynamics.

Early policy efforts focused on promoting family-based care, as reflected in the First National Plan for Older Persons (1982–2001), which stressed the primacy of familial support. Enacted in 2003, the Elderly Act outlined the entitlements of older adults to public support. It identified individuals aged 60 and above as elderly and affirmed their right to receive protection, support, and assistance. The Act also mandated the creation of programs to provide financial aid and physical care for older adults, required annual progress reports, and introduced a caregiving system—including tax benefits for children who look after their parents (World Bank, 2021). Building on the first plan, the Second National Plan for Older Persons (2002–2021) marked a shift toward developing community-based supports. A mid-course revision in 2007 explicitly emphasized the role of communities and formal services in complementing family care.

Policy momentum for LTC accelerated through Thailand's participatory health policy process: notably, the Second National Health Assembly in 2009 passed a resolution endorsing the development of a long-term care system (LTC) and formally defining LTC within the Thai context. This "soft power" consensus among stakeholders laid the groundwork for concrete LTC initiatives. Subsequently, national development strategies began to incorporate LTC objectives. In 2017, the government introduced the 20-Year Strategic Plan and Reform (2017–2036), which included LTC policy under its fourth strategic focus: promoting social equality. The 12th National Economic and Social Development Plan (2017–2021) was launched in alignment with the goals and framework of this long-term strategic plan.

A milestone in Thailand's LTC policy occurred in the 2010s when the National Health Security Office (NHSO), purchaser of the Universal Coverage Scheme (UCS) for the informal sector, allocated BT600 million to implement a community-based LTC pilot project, and by 2020, over 90% of sub-districts nationwide had met the LTC service criteria set by the MOPH. Under the Second National Plan's guidance, the Ministry of Public Health (MoPH) and the Ministry of Social Development and Human Security (MoSDHS) informed by technical cooperation projects with the Japan International Cooperation Agency (JICA), the Thai government moved from concept to action on LTC. The LTC project was initiated with a small project and had been scaled up gradually. In 2016, it introduced a proactive, community-based LTC program aimed at enabling "aging in place". This funding expansion reflected the government's commitment to building LTC capacity in response to rapid demographic aging. Under the umbrella of the Universal Coverage Scheme (UCS) in health care, Thailand's nascent LTC system was thus born, emphasizing community and home-

based services over institutional care (Chanprasert, 2021; World Bank, 2021). The policy trajectory over the past two decades— from family-centric care towards a broader community-based LTC system — illustrates Thailand's evolving strategy to ensure that dependent older persons receive adequate support beyond what informal family care alone can provide.

Governance

Long-Term Care Legislation and Strategy

Thailand's governance of LTC is built on a foundation of legislation and strategic plans that frame the responsibilities of various sectors. The elderly Act (2003) remains the cornerstone law on aging, outlining the rights of older persons and the duties of government and family. In addition to establishing the old-age allowance, this Act and its subsequent amendments mandate support for community-based services and volunteers to assist frail seniors in line with the Act's emphasis on enabling older people to live with dignity at home. The Act also led to the creation of the National Committee on the Elderly (NCE). The Minister of Social Development and Human Security and the President of the Older Person Council Association serve as vice-chairs, representing governmental and non-governmental sectors, respectively. It coordinates aging-related policies across ministries. This inter-ministerial body sets broad policy directions and ensures that LTC is considered in national development agendas (World Bank, 2021).

Strategic planning for LTC has evolved through Thailand's national aging plans. The First National Plan for Older Persons (1982–2001) focused on social welfare and family support, whereas the Second National Plan for Older Persons (2002–2021) incorporated more direct references to developing LTC services. Notably, after the 2009 Health Assembly resolution, the Second Plan was adjusted to promote community involvement in eldercare and the concept of "social care" for dependent elders, anticipating the need for formal care models beyond the family (World Bank, 2021). Many strategic plans were introduced quickly during the late 2000s and early 2010s: pilot projects with technical support from JICA tested community-based LTC models, and by 2014–2015 the government had formulated a roadmap for scaling up LTC nationally.

The inclusion of LTC in the Twelfth National Economic and Social Development Plan (2017–2021) was a strategic milestone, as it explicitly called for improvements in LTC infrastructure and the creation of age-friendly communities. This plan treated LTC as part of Thailand's development priorities, ensuring high-level endorsement and resource allocation (Chanprasert, 2021; World Bank, 2021). Thailand does not yet have a standalone LTC Act ; however, there is growing recognition of the need for dedicated LTC legislation to set quality standards and clarify institutional roles (Asian Development Bank, 2020a). In summary, the strategic framework for LTC in Thailand is anchored by the elderly Act and national aging plans, and it is progressively being refined through policy learning and pilot experiences to guide the expansion of LTC services nationwide.

Governance Structure

LTC governance in Thailand is fragmented across multiple agencies, without a single overarching authority. The National Health Security Office (NHSO) oversees community-based LTC under the universal health coverage scheme, while Local Administrative Organizations (LAOs) are tasked with the practical delivery of services, including social support and environmental modifications for older adults. Regulatory responsibilities are divided among several ministries and agencies. The Ministry of Public Health (MOPH) governs healthcare services and providers, with the Department of Health Service Support (DHSS) specifically regulating residential LTC facilities under the Health Establishment Act B.E. 2559 (2015). The Office of Insurance Commission (OIC) regulates insurance, including LTC-related products, although its role in private LTC insurance remains unsettled. Additionally, the Ministry of Interior supervises local authorities. Despite this extensive institutional involvement, significant challenges remain in ensuring effective inter-agency coordination, as stipulated by the relevant legislation (Asian Development Bank, 2020b).

Financing

Expenditure

Public expenditure on LTC for the older adults in Thailand has grown substantially since the introduction of the community-based LTC scheme. The initial pilot in 2016 was funded at ฿600 million (approximately USD 19 million). This covered services in 1,000 sub-districts and aimed to reach about 100,000 dependent seniors in the first year (Asian Development Bank, 2020b). As the program scaled up, annual budgets increased: in 2017, about ฿900 million was allocated, and by 2018 the budget reached roughly ฿1.159 billion (Suriyanrattakorn & Chang, 2021). Cumulatively, between 2016 and 2018, these investments enabled the LTC program to provide care for an estimated 193,000 older persons with functional dependence (Naoyuki & Shintaro, 2023). While significant, this figure still represented only a portion of total need – for context, roughly 500,000 Thai elders were estimated to have some level of dependency in 2022 (Asian Development Bank, 2020a). By 2020, coverage expanded dramatically – over 90% of all sub-districts had some LTC services – which likely corresponded to further increases in spending (Naoyuki & Shintaro, 2023).

Precise nationwide LTC expenditure data are not fully consolidated yet, in part because spending is split between central NHSO funds and thousands of local government budgets. However, given Thailand's overall health expenditure, LTC remains a relatively small share (Asian Development Bank, 2020a). Government health spending is about 15% of total government expenditure, and LTC is a subset of that. One analysis pointed out that financial resources will need to be secured as LTC expands, warning that sustaining LTC nationwide could strain budgets unless new funding sources are found (Naoyuki & Shintaro, 2023). Nonetheless, policymakers justify the expenditure on LTC by its potential cost-effectiveness. Providing care at home and in communities is viewed as more cost-efficient than hospital-based care for chronic conditions or end-of-life care (Suriyanrattakorn & Chang, 2021). Additionally, Thailand's heavy reliance on trained community volunteers means labor costs

in the LTC program are relatively low compared to formal sector wages (Naoyuki & Shintaro, 2023). Going forward, as the elderly population and prevalence of severe disability increase, Thailand will likely need to expand LTC funding significantly (Srithamrongsawat et al., 2009).

Revenue Raising

Thailand's LTC financing is currently tax-based, with no dedicated LTC insurance or mandatory contributions from the public. General government revenues (comprising mainly taxation) are the primary source of funds, channeled through the NHSO and local government budgets. Under this mechanism, for each participating sub-district, the NHSO allocates a certain amount of funds for LTC, and the local administrative organization contributes a matching amount (often on a 50:50 basis) from its own budget. Unlike some high-income East Asian countries that implemented social insurance for LTC, e.g., Korea and Japan, Thailand consciously avoided an insurance model at this stage. A key reason is the country's large informal sector: roughly 75% of Thailand's workforce was in informal employment around the time universal health coverage was achieved. Implementing a contributory social insurance for LTC would require complex premium collection mechanisms (Naoyuki & Shintaro, 2023).

Thus, to rapidly extend coverage, Thailand chose a tax-financed approach for both health and LTC, maintaining equity and simplicity. This means that older people receiving LTC services do not pay specific premiums or co-payments for those services – the program is essentially free at point of use for eligible seniors. This is a notable difference from many Western LTC systems, where users often share costs. In Thailand, even the concept of co-payment in LTC has not been introduced; LTC is treated as a public good supported by the state (Suriyanrattakorn & Chang, 2021).

Overall, revenue for LTC is pooled from general taxation at both central and local levels. Looking ahead, Thai policymakers are exploring ways to expand the revenue base for LTC. As of now, however, the consensus is that strengthening LTC within the existing tax-funded universal health coverage framework is the most feasible path. High-level inter-ministerial discussions (involving the Ministry of Finance, MOPH, and MSDHS) have been recommended to ensure that funding for LTC keeps pace with the growing needs of an aging society (Naoyuki & Shintaro, 2023).

Pooling Resources

A distinctive feature of Thailand's LTC financing is the Local Health Fund (LHF) mechanism, which serves as pooling resources from different levels of government. When the community LTC program was designed, policymakers decided to utilize the existing Local Health Fund structure – a matching fund initially created to support local health promotion – as a way to channel money into LTC at the community level. The fund is allocated to a newly created LTC fund at the Tambon level (sub-district administrative units) and is jointly financed and managed by the local administrative office (Asian Development Bank, 2020b;

Naoyuki & Shintaro, 2023). This arrangement effectively integrates financing from the national health sector and local government sector, fostering co-ownership of the program. The LTC funds are then used to pay for the various services and inputs of the LTC program, according to agreed care plans.

At a macro level, this decentralized pooling means Thailand doesn't have a single national LTC fund, but rather hundreds of local pools. Risk pooling in the insurance sense is limited – wealthier or more fiscally capable municipalities might put more local money into LTC, whereas poorer areas rely mostly on the central grant (Asian Development Bank, 2020b). Thailand's approach to pooling is hybrid and multi-tiered: it brings together central and local government financing in a shared pool at the community level, aligning incentives for both to invest in elder care. While it may require integrate the pool at a higher level to ensure standardization and cross-subsidy for further development, for now, in line with the Decentralization Act 1999 which highlight the roles and responsibilities of elected government, the LHF-based pooling remains the backbone of LTC financing in Thailand's communities.

Purchasing Goods and Services

In Thailand's LTC system, purchasing is largely carried out at the local level, guided by national frameworks. The purchasing of LTC services is quasi-public and community-oriented, meaning that rather than contracting with a multitude of private providers, funds are often used by local governments to hire or support community-based caregivers and to procure necessary goods for home care: private LTC providers are left outside of the official LTC system. The pooled LTC fund in each sub-district enables the LAO, together with the care manager, to decide how to allocate resources for each enrolled elder. Typically, the largest expenditure is on community caregiver services: LAOs pay stipends or salaries to the trained caregivers.

By 2018, Thailand had trained 44,000 community caregivers under this scheme, and many of them receive a modest monthly payment for their part-time caregiving work (Naoyuki & Shintaro, 2023). Purchasing in this context is straightforward – the LAO essentially employs these caregivers or contracts them per case. Formal medical services, such as home nurse visits or rehabilitation sessions are usually provided by the existing public health system rather than purchased from outside providers. The local sub-district health promoting hospital and the district hospital integrate those services into their normal budget. Care managers, who are often nurses or physical therapists from the public sector, are salaried through the health system, but the LTC fund may compensate overtime or specific assessments they conduct (Asian Development Bank, 2020b).

In urban areas, many private nursing homes operate entirely outside the NHSO/LAO scheme, relying on out-of-pocket payment from families, because no formal purchasing mechanism from public funds to private LTC providers exists yet (Naoyuki & Shintaro, 2023). While it would be worthwhile to consider purchasing LTC services from private providers in response to growing demand in elderly care, for now, the LTC scheme in Thailand can be characterized as a public provision model with local commissioning: funds flow to local governments, which primarily deploy those funds by directly providing services (through hiring caregivers

and leveraging public health services) rather than buying services in a competitive market. This approach has the benefit of simplicity and community control, but as demand grows, Thailand may need to introduce more complex purchasing arrangements (contracts, vouchers, etc.) to broaden service options and ensure efficiency.

Workforce

Existing Workforce

Thailand's LTC workforce is a blend of informal caregivers, volunteer community workers, and formal healthcare personnel, reflecting the country's strategy of building on existing human resources for elder care. Informal caregivers (i.e., family members) remain the cornerstone of care. Even today, upwards of 90% of primary caregivers for Thai older persons are relatives, typically adult children or spouses (Knodel et al., 2018). These family caregivers provide the bulk of daily assistance with activities of daily living (ADLs) such as feeding, bathing, and toileting. However, as noted, demographic shifts are making family care less sustainable on its own, necessitating the emergence of a more structured care workforce.

A unique aspect of Thailand's approach is its mobilization of community volunteers for LTC tasks. The Ministry of Social Development and Human Security in 2003 piloted an "elderly home care volunteer" program in eight provinces, training community members specifically to assist frail older persons. By 2005, this volunteer program was scaled up nationally, often by selecting some experienced VHVs to take on the role of elderly care volunteers in their communities (Naoyuki & Shintaro, 2023). These volunteers would do periodic home visits to check on vulnerable older adults, help with errands, and report problems to authorities. They received minimal compensation, for instance, volunteers get a small monthly stipend for expenses, plus non-monetary incentives like public recognition (Asian Development Bank, 2020a).

This large base of community caregivers formed the backbone of Thailand's subsequent formal LTC scheme. By 2016, when the NHSO-LAO community LTC program started, Thailand already had tens of thousands of active elder care volunteers. This was a valuable resource: rather than hiring entirely new staff, the strategy was to upgrade and train these volunteers into a semi-formal cadre of community caregivers. As mentioned, by 2018 about 44,000 community caregivers were trained and engaged in providing LTC as part of the national scheme (Naoyuki & Shintaro, 2023).

In addition to community caregivers, Thailand's LTC workforce includes formal health professionals who take on new roles. Foremost among these are the care managers, usually nurses or public health officers based at sub-district health facilities. These professionals perform assessments of elders' needs, develop care plans, and supervise the work of community caregivers (Asian Development Bank, 2020b). Another important group is physical and occupational therapists, who provide rehabilitation services to help disabled elders maintain or improve functionality. Thailand faces a shortage of such specialists, especially in rural areas. It's worth noting that private sector caregivers, for example, domestic helpers or privately hired nurses, exist in Thailand, especially in cities. Some families hire migrant workers or trained aides to live with and care for their elderly relatives.

However, these private caregivers are outside the formal system and there is no licensure or standardization for them yet. The expansion of the public LTC program may gradually reduce reliance on unregulated private caregivers by offering an alternative, or it might formalize them by bringing them under training and standards (Naoyuki & Shintaro, 2023)

Overall, Thailand's current LTC workforce is multi-layered: at the base are family caregivers, supported by community-based paid caregivers (formerly volunteers), and overseen and supplemented by healthcare professionals. The approach has been praised for being realistic and leveraging people deeply rooted and devoted to the local community (Naoyuki & Shintaro, 2023). Nonetheless, it faces challenges, including caregiver burnout, limited advanced clinical skills among the volunteer cadre, and uneven distribution of skilled professionals: especially between urban and rural areas. As Thailand moves forward, strengthening the workforce, both in numbers and capabilities will be critical to meet the rising demand.

Capacity-Building and Professionalization

Recognizing that a competent workforce is essential for quality LTC, Thailand has invested in training and capacity-building initiatives as part of its LTC policy roll-out. A cornerstone of this effort was the development of a standardized training curriculum for community caregivers in 2016. The government introduced a 70-hour training program for volunteers who wished to become paid community caregivers (Asian Development Bank, 2020a). In the initial wave, the government provided financial incentives to enroll, e.g., a small training allowance or priority consideration for paid roles upon completion (Suriyanrattakorn & Chang, 2021). By formalizing training, Thailand took a significant step toward professionalizing elder care, transitioning it from purely informal labor to a paraprofessional workforce. Many communities now have at least a few trained caregivers, establishing a core set of LTC competencies within local communities.

Parallel to caregiver training, Thailand has worked on building care manager capacity. Through collaborations with international partners, Thai nurses and health officers were exposed to concepts of geriatric assessment, care coordination, and case management. Starting around 2013, pilot projects like the Long-Term Care Service Development Project (LTOP) provided train for Thai professionals, who then developed local care manager training modules (Naoyuki & Shintaro, 2023). Care managers (usually nurses) receive specialized short courses on comprehensive geriatric assessment and care planning. This is an important professionalization step, as it creates a career pathway (and skill set) for healthcare workers in the field of long-term care. The challenges ahead include scaling training to keep up with demand, preventing turnover by offering career incentives, and enhancing the skill mix.

Service Delivery

Eligibility and Gatekeeping

Thailand's public LTC program targets dependent older persons who require assistance with basic daily activities due to physical or cognitive impairments. The eligibility is generally defined by age, 60 years or older, to align with the official definition of "elderly", and functional status. Care managers, usually nurses, conduct assessments to determine the eligibility of older adults and identify their care needs. The program further refines eligibility by using a grading of frailty in four groups (Asian Development Bank, 2020b):

- **Group 1:** Older adults who are frail with partial mobility limitation. For example, able to walk but slowly. And no serious cognitive disorder.
- **Group 2:** Older adults with significant cognitive impairment (e.g., dementia) but who may or may not have physical limitations.
- **Group 3:** Older adults who are mostly immobile, possibly bedbound or chair-bound, and may have some issues like incontinence or other severe chronic conditions.
- **Group 4:** Older adults who are completely unable to move (bedridden) with complex needs, possibly including those in terminal illness or requiring palliative care.

This stratification helps in care planning and resource allocation – for instance, Group 4 cases might qualify for more intensive caregiver hours or additional medical equipment. All four groups are considered within the target of the LTC program but typically Groups 3 and 4 receive the highest priority. There is no strict means-testing for eligibility; the program is need-based. The gatekeeping process is thus primarily clinical and functional, rather than financial. Once the care manager assesses and confirms eligibility, a care plan is developed and effectively serves as the authorization for services (Asian Development Bank, 2020b). In this way, the care manager acts as gatekeepers, deciding the type and amount of services an older adult will receive. The services are then arranged according to the care plan.

Settings for Public LTC Support

Long-term care (LTC) in Thailand is primarily delivered in home and community settings, most older adults receive care at home, supported by community caregivers and periodic visits from health professionals (Knodel et al., 2018). To complement home care, Thailand is encouraging the development of community centers for older persons as LTC hubs. LAOs are incentivized to establish these centers—often repurposing existing community halls or health facilities—to provide day care, social activities, and caregiver respite (Asian Development Bank, 2020b). While future demographic shifts may require expanded congregate care options, current policy and infrastructure continue to prioritize home-centric care with community support. On the contrary, institutional LTC remains undeveloped in Thailand's LTC system. In 2003, there were 13 public elderly care institutions under the Department of Social Development and Welfare of the Ministry of Social Development and Human Security (MSDHS). By 2015, little change had occurred, and the Department of Older Persons was directly managing only 12 residential homes for older adults (WHO, 2024).

Services Provided

Thailand's LTC scheme offers a comprehensive package of services addressing both health and social care needs of dependent older persons (Asian Development Bank, 2020b). (1) Personal Care Assistance, provided by community caregivers who support older adults (e.g., bathing, feeding, mobility) through scheduled home visits. Light housekeeping is often included. (2) Basic Nursing and Medical Care includes tasks like monitoring vital signs, wound care, medication administration, and pressure sore prevention. (3) Rehabilitation Services are provided by physical therapists (4) Assistive Devices. Although this outlines the intended services, no evaluation has yet verified whether these benefits are consistently delivered across all sub-districts.

Integrated Care and Person-Centered Care Pathways

Integration and person-centeredness are guiding principles of Thailand's LTC system, aiming to ensure that care is holistic and coordinated around each elder's needs. Thailand's approach to integration can be seen in multiple aspects: Health–Social Integration: LTC care plans combine medical and social support (e.g., support for ADLs/IADLs, transportation), delivered by multidisciplinary teams of professionals and volunteers. The Local Health Fund merges budgets to support integrated delivery, and regular case meetings ensure coordination (Asian Development Bank, 2020b).

Quality Assurance

Ensuring quality in long-term care is a complex challenge that Thailand is gradually addressing through training, standards, and oversight mechanisms. Given that the LTC services are delivered in decentralized, home-based settings, traditional healthcare quality assurance methods are not directly applicable. In addition, as in nascent stage of LTC development, Thailand's LTC quality assurance mechanisms are somewhat limited. At the outset, there was no centralized management information system. In 2019, plans to create an online database for implementation support and monitoring and evaluation were approved. Of the two main performance indicators, the first, coverage of LTC services among dependent older adults, is currently tracked, whereas the second, improvement in activities of daily living (ADL) scores, is not yet monitored (Asian Development Bank, 2020b).

Performance of Long-Term Care Service Delivery

Evaluating the performance of Thailand's LTC service delivery involves looking at both quantitative outcomes (coverage, utilization, health impacts) and qualitative outcomes (user satisfaction, caregiver well-being). In its relatively short period of operation, the community-based LTC scheme has demonstrated successes as well as areas for improvement. Thailand's community-based LTC system has expanded rapidly, showing promising results in coverage, service delivery, and elder well-being. By 2018, about 193,000 dependent elders were

reached; by 2020, the program covered over 90% of sub-districts, indicating strong scale-up (Asian Development Bank, 2020b; Naoyuki & Shintaro, 2023). While national level representative results are not available yet since LTC system is still in initial stage, a study reported that beneficially are generally satisfied with LTC services (Suriyanrattakorn & Chang, 2021). Although the number of beneficiaries has grown rapidly, it remains difficult to assess the overall performance due to the absence of well-designed studies on the prevalence of long-term care (LTC) needs. Report indicates that the majority of elder care is still provided by family members, particularly by daughters and spouses, suggesting that public care provision in Thailand does not fully meet the demand of the elderly population. Furthermore, long-term care services are primarily delivered on a voluntary basis, and institutional care is underdeveloped, highlighting the significant challenges that remain (Asian Development Bank, 2020a). In addition, given Thailand's rapid population ageing, the limited matching fund-based LTC financing system, it is anticipated that the supply of LTC services will struggle to meet the growing demand. Evidence from research highlights a substantial and rising level of unmet care needs (Phetsitong & Vapattanawong, 2023). The study demonstrated both an overall increase in household care requirements and a persistent gap between needs and available services. The analysis revealed a clear upward trend in the proportion of households reporting unmet need for caregivers, rising from 14.6% in 2007 to 17.5% in 2011, and further to 22.9% in 2017. Furthermore, significant regional disparities were observed: households in the Northeastern region—the poorest area of the country—were disproportionately more likely to experience unmet needs. Continued evaluation and investment are needed to ensure sustainable, equitable care for all elders.

3.3.4. Conclusion

Thailand's experience in health promotion offers valuable insights for policy-practitioners across the Asia-Pacific region, particularly those working in middle income countries. The country has demonstrated how a comprehensive approach – spanning innovative financing, multi-sector governance, community mobilization, and rigorous monitoring – can translate into measurable health gains. Thailand succeeded in establishing a strong institutional backbone for health promotion: the creation of ThaiHealth in 2001 provided a dedicated driver for prevention activities, while the Ministry of Public Health and National Health Assembly processes ensured health remained a priority across government.

Supported by stable "sin tax" funding and broad political commitment, Thailand implemented aggressive risk-factor interventions that have paid off. For example, adult smoking prevalence fell significantly as a result of sustained tobacco tax hikes, mass media campaigns, and cessation supports. Harmful drinking rates and road traffic injuries, though still concerns, showed signs of reduction following enforcement of alcohol controls and road safety measures. These improvements have contributed to longer and healthier lives for the Thai people, evidenced by rising healthy life expectancy and declines in mortality from some major NCDs over time.

At the same time, Thailand's journey underscores that health promotion is an ongoing endeavor requiring adaptation to new challenges. The country today faces a shifting landscape of health risks: rapid urbanization, demographic shift, and globalization are introducing new issues such as sedentary lifestyles, which fuel conditions like obesity and

diabetes that were less prevalent a generation ago. Moreover, population aging has placed long-term care (LTC) squarely on the policy agenda, linking health promotion and social care in ways that require new forms of integration. Thailand's aging population is bringing issues like dementia and the need for long-term care to the forefront.

Guided by the National Plans on Older Persons and the Elderly Act, the LTC system is integrated into universal health coverage, emphasizing home-based, person-centered care, while institutional care is still underdeveloped. Local governments lead implementation, supported by national funding and standards through mechanisms like the Local Health Fund. This governance model enables both decentralization and coordination. The LTC approach aligns with Thai preferences for aging at home and leverages existing strengths—village health volunteers, strong family networks, and a growing trained caregiver workforce

Nonetheless, several challenges remain. As demand grows, sustainable financing will require broader fiscal strategies, including possible tax reforms or social insurance models. In addition, while the importance of community-based care is widely recognized, the growing number of older adults, particularly increasing proportion of those severely functional dependence, necessitates development of a more skilled formal workforce beyond reliance on volunteers, alongside the expansion of public institutional care to adequately address their needs. Also, the private LTC sector remains largely unregulated, especially in urban areas, creating risks of substandard care.

References

- Asian Development Bank. (2020a). Country Diagnostic Study on Long—Term Care in Thailand. In: Asian Development Bank Manila.
- Asian Development Bank. (2020b). Lessons from Thailand's National Community-Based Long-Term Care Program for Older Persons. *Aging Asia and the Pacific*.
- Bundhamcharoen, K., Supon, L., Khanitta, K., & and Tangcharoensathien, V. (2017). Contributions of national and global health estimates to monitoring health-related Sustainable Development Goals in Thailand. *Global Health Action*, *10*(sup1), 1266175. https://doi.org/10.3402/gha.v9.32443
- Chanprasert, P. (2021). Long-term care policy and Implementation in Thailand'. *Coping with Rapid Population Ageing in Asia*, 36-44.
- Galbally, R. (2012). *10: Ten-year Review of Thai Health Promotion Foundation, Nov. 2001-Nov. 2011*. Thai Health Promotion Foundation.
- Knodel, J., Teerawichitchainan, B., & Pothisiri, W. (2018). Caring for Thai older persons with long-term care needs. *Journal of aging and health*, *30*(10), 1516-1535.
- Naoyuki, K., & Shintaro, N. (2023). Development of the long-term care system in Thailand. *共栄大学研究論集*(21), 13-21.
- Perry, H. (2020). Health for the people: National community health worker programs from Afghanistan to Zimbabwe. In: Maternal and Child Survival Program.
- Pongutta, S., Suphanchaimat, R., Patcharanarumol, W., & Tangcharoensathien, V. (2018). Lessons from the Thai health promotion Foundation. *Bulletin of the World Health Organization*, *97*(3), 213. Ruttana Phetsitong & Patama Vapattanawong (2023) Household Need and Unmet Need for Caregivers of Older Persons in Thailand, Journal of Aging & Social Policy, 35:6, 824-841, DOI: 10.1080/08959420.2022.2132081
- Srithamrongsawat, S., Bundhamcharoen, K., Sasat, S., Odton, P., & Ratkjaroenkhajorn, S. (2009). Projection of demand and expenditure for institutional long term care in Thailand. *Nonthaburi Health Insurance System Research Office*.
- Sopitarchasak, S., Adulyanon, S., & Lorthong, T. (2015). Thai Health Promotion Foundation: innovative enabler for health promotion. *World Health Popul*, *16*(1), 62-71.
- Suriyanrattakorn, S., & Chang, C.-L. (2021). Long-term care (LTC) policy in Thailand on the homebound and bedridden elderly happiness. *Health Policy Open*, *2*, 100026.

- Tangcharoensathien, V., Adulyanon, S., Supaka, N., Munkong, R., Viriyathorn, S., Sirithienthong, S., Kanhachon, S., & Marten, R. (2024). The Thai health promotion foundation: two decades of joint contributions to addressing noncommunicable diseases and creating healthy populations. *Global Health: Science and Practice*, *12*(2).

- WHO. (2023). Thailand country cooperation strategy 2022–2026. In *Thailand country cooperation strategy 2022–2026*.

- WHO. (2024). Thailand health system review.

- WHO. (2025). Data*, Thailand - Health data overview for the Kingdom of Thailand*. Retrieved August 20 from https://data.who.int/countries/764

- WHO SEARO. (2024). *Report of the Regional Meeting on Healthy Ageing in the South-East Asia Region*.

- World Bank. (2021). *Caring for Thailand's Aging Population*.

3.4 China

3.4.1 Introduction

China is experiencing one of the most rapid and consequential demographic transitions in history. With the proportion of the population aged 60 and over projected to exceed 30% by 2050, the country is undergoing a significant shift in its social structure, labor market, and health system demands (ESCAP, 2015) (Feng et al., 2020). These trends stem from decades-long declines in fertility and substantial improvements in life expectancy (Maisonneuve & Martins, 2014). Life expectancy at birth rose from roughly 66 years in 1978 to 77.9 years by 2020, while remaining gaps between total life expectancy and Healthy Life Expectancy (HALE) persist at an estimated 7–9 years (Li et al., 2018) (Feng et al., 2020) (Chen et al., 2022) (World Health Organization, 2023b). At age 60, men can expect to live an additional 19.3 years and women 21.8 years (Yong & Yuan, 2014). Urbanization, changes in family structure, and increased prevalence of chronic diseases further intensify the demographic shift (Yong & Yuan, 2014) (Wu et al., 2021).

The implications of this aging trend are multifaceted. Longer lives reflect successful public health efforts, economic growth, and rising living standards (Feng et al., 2020), yet they place mounting pressure on healthcare services, pension systems, and caregiving resources (Feng et al., 2020). As China's working-age population shrinks and dependency ratios rise, the demand for integrated, equitable, and financially sustainable health and long-term care (LTC) systems becomes increasingly urgent (OECD, 2020).

The Chinese government has adopted a dual-track strategy aimed at promoting population health and establishing foundational systems for LTC. The landmark "Healthy China 2030" blueprint outlines a national vision centered on prevention, health literacy, and equity in health system reform, with measurable goals to increase HALE, reduce premature deaths from non-communicable diseases, and narrow urban–rural gaps (National Health Commission of the People's Republic of China, 2018) (Fang, 2020) (Zhu & Österle, 2019). In parallel, since 2016 China has piloted Long-Term Care Insurance (LTCI) in dozens of cities to test scalable models for home- and institution-based care for people with functional limitations, including financing mechanisms, eligibility assessment, and medical–social care integration (Feng et al., 2020) (Chang et al., 2020) (S. Chen et al., 2021) (Li et al., 2022) (Chen et al., 2022) (Zhan et al., 2012).

Nonetheless, significant challenges remain. China's LTC system is fragmented and lacks national legislation, while caregiving is still shouldered mainly by families, particularly women, without adequate financial or institutional support (Zhan et al., 2012) (Hu, 2013). Health promotion initiatives face implementation bottlenecks, especially in resource-constrained rural areas. Workforce distribution is uneven, and public health infrastructure continues to prioritize curative over preventive services (Wu et al., 2021)..

3.4.2 Healthy ageing policies

Context

China has achieved remarkable gains in longevity over the past four decades. Life expectancy at birth increased from about 66 years in 1978 to 77.9 years in 2020, with substantial contributions from immunization, maternal and child health, sanitation, and infectious disease control (Li et al., 2018) (Feng et al., 2020) (World Health Organization, 2022) (S. Chen et al., 2021). By 2050, over 500 million people will be aged 60 and older (ESCAP, 2015) (Maisonneuve & Martins, 2014). However, increases in HALE have not kept pace: estimates suggest a 7–9-year gap between total life expectancy and HALE, implying prolonged periods of morbidity, multimorbidity, and functional limitations in later life (Chen et al., 2022) (World Health Organization, 2022) (S. Chen et al., 2021; Glass et al., 2013).

Disparities are pronounced across gender, geography, and socioeconomic status. Women outlive men but spend more years in poor health (ESCAP, 2015). Rural residents report worse outcomes than urban dwellers due to lifetime disadvantages in education, nutrition, occupational exposures, and healthcare access, compounded by early-life deprivation among today's older cohorts (Zhu & Österle, 2019) (Chang et al., 2020) (Li et al., 2022). .

Additionally, internal migration has changed traditional caregiving patterns. Young adults often move to urban centers for work, leaving behind elderly parents with little day-to-day support. In the absence of robust community or home-based services, many rural elderly face social isolation and inadequate care (Hu, 2013) (Zhan et al., 2012).

Policy framing for healthy ageing has increasingly emphasized prevention and primary care. Healthy China 2030," launched in 2016, is the country's flagship framework for healthy ageing, reorienting the health system toward prevention, equity, and life-course health. It positions primary care as the frontline—expanding the National Basic Public Health Services Program for health check-ups, chronic disease management, and counseling through township health centers, community health stations, and village clinics—while driving risk-factor reduction via province-wide "Healthy Lifestyle for All" campaigns and age-friendly community design (Tan et al., 2017) (World Health Organization, 2023b) (S. Chen et al., 2021) (Feng et al., 2020) (X. Chen et al., 2021). Digital tools adopted during and after COVID-19 support health education and remote advice, paired with efforts to bridge digital divides for older and rural residents (Chang et al., 2020) (World Health Organization, 2022). A Health in All Policies approach seeks multisectoral alignment across education, transport, agriculture, environment, and urban planning, though challenges in accountability and budgeting persist (Krings et al., 2022) (OECD, 2020). Targets embedded in the 14th Five-Year Plan emphasize raising Healthy Life Expectancy and reducing premature NCD mortality while narrowing urban–rural inequities (Brief, 2020). (World Health Organization, 2023b) (Zhang & Imai, 2024).

To translate this ambition into outcomes, priorities include protected financing for prevention, institutionalized health-promotion roles and workforce training, integration of HALE metrics into planning and performance systems, and sustained, age-appropriate community engagement to maintain function and independence (World Health Organization, 2023b) (Li

et al., 2023) (Feng et al., 2020). Expansion of the National Basic Public Health Services Program, annual health check-ups, chronic disease management, and health education in primary care are central instruments, though implementation and workforce capacity vary by region (National Health Commission of the People's Republic of China, 2018) (S. Chen et al., 2021; World Health Organization, 2023b) (Tan et al., 2017). Remaining gaps include underinvestment in preventive services, uneven primary care distribution, and limited integration of health promotion into financing and performance systems (Maisonneuve & Martins, 2014) (Wu et al., 2021) (OECD, 2021).

Policy Foundations

Goal setting

China's strategic blueprint, "Healthy China 2030," positions health equity and gender inclusion as core principles. It underscores a national commitment to improving Healthy Life Expectancy (HALE), but without articulating specific, measurable, and disaggregated HALE targets. This lack of quantitative benchmarks hampers efforts to monitor progress, evaluate policy impact, and identify gaps in health outcomes across different demographic groups. Particularly for older women, who often live longer but experience higher morbidity, the absence of targeted indicators in both the Healthy China framework and the Women's Development Plan (2021–2030) weakens policy effectiveness. Instituting measurable HALE goals, disaggregated by age, gender, and region, would enable more precise planning, enhance accountability, and direct investments toward closing persistent health gaps (Feng et al., 2020) (Chen et al., 2022).

GEDSI (Gender, Equity, Diversity, and Social Inclusion)

China's healthy-aging and LTC agenda embeds equity as a guiding principle in "Healthy China 2030," but gaps persist in practice (Tan et al., 2017). Women disproportionately shoulder unpaid and low-paid caregiving, facing income insecurity and limited career pathways; rural residents, meanwhile, experience lower service availability, weaker primary care capacity, and digital access barriers. Internal migration and the hukou system compound isolation among "left-behind" older adults, while uneven local resources and fragmented governance produce region-by-region disparities in eligibility, benefit depth, and service quality (Hu & Zhang, 2023). Current monitoring frameworks emphasize HALE and risk-factor reduction, yet they lack consistently disaggregated targets by gender, age, disability, and place, which limits accountability for narrowing gaps (Zhu & Österle, 2019).

Life-course orientation

The Healthy China strategy embraces a life-course perspective, recognizing that health is shaped by cumulative exposures from early life through old age. This principle is reflected in

national initiatives, such as school health promotion, maternal and child health programs, workplace wellness programs for adults, and fitness campaigns for the elderly. However, service delivery remains uneven across life stages. Interventions are most robust during early childhood and adolescence, with diminished attention to mid-life prevention and pre-frail older adults. Moreover, while central guidelines promote comprehensive care across the lifespan, implementation is often fragmented, particularly at the intersection of health and social service sectors. To advance this foundation, China should strengthen service continuity and coordination across life transitions and ensure that preventive services are equally accessible to aging and working-age populations (Feng et al., 2020) (Chen et al., 2022).

Shift to prevention

A pivotal component of "Healthy China 2030" is the systemic shift from treatment to prevention. This has catalyzed national and subnational efforts to expand risk screening, promote health literacy, and reduce exposure to behavioral and environmental hazards. Programs such as the National Basic Public Health Services have increased coverage of preventive services. Meanwhile, prevention remains underfunded, receiving only a fraction of total health expenditures. Community health centers, which are tasked with delivering preventive care, often lack trained staff, earmarked budgets, and performance-based incentives. Without robust fiscal and institutional support, the prevention agenda risks being overshadowed by curative demands. Scaling preventive services will require dedicated public funding, including the incorporation of preventive indicators in health insurance reimbursements, and more substantial local incentives tied to long-term health outcomes (Tan et al., 2017) (Wu et al., 2021).

Evidence-based prioritization

China’s health promotion agenda is anchored in a growing body of epidemiological evidence. Large-scale studies and surveillance systems have pinpointed key risk factors—tobacco use, dietary habits, physical inactivity, and air pollution—as drivers of chronic disease. These insights have informed major policy interventions, including tobacco taxation, pollution control regulations, and nutrition labeling standards.

Policy alignment

Health promotion is conceptually embedded in China’s broader development agenda, including its Five-Year Plans and national modernization strategies. The "Healthy Cities" initiative and the "Health in All Policies" (HiAP) approach exemplify efforts to align health goals across various sectors, including education, housing, transportation, and the environment. However, practical implementation is hindered by structural silos. Ministries and departments operate with separate mandates, budgets, and performance metrics, limiting joint planning and accountability. For example, local transportation projects may neglect age-friendly infrastructure, and school health curricula may be disconnected from local health

authority initiatives. Strengthening this foundation will require institutional mechanisms that incentivize shared goals, such as joint budgeting, cross-sectoral key performance indicators, and inter-ministerial reporting lines. Legal mandates and governance reforms will also be necessary to ensure sustained collaboration beyond pilot efforts (Jiang & Yang, 2023) (Li et al., 2023).

Policy Governance and Funding Structure

Lead institutions

At the core of China's health promotion governance is the National Health Commission (NHC), which plays a central role in setting strategic direction, issuing national guidelines, and coordinating intergovernmental and intersectoral policy implementation under the Healthy China 2030 initiative. The NHC formulates policy blueprints, oversees national indicators, and supports the integration of health goals into broader socioeconomic planning. However, implementation is decentralized: provincial and municipal health authorities are responsible for adapting and executing these strategies based on their demographic, epidemiological, and fiscal contexts.

This governance model enables context-sensitive innovation and responsiveness, but it also yields fragmented interpretations and variable outcomes across regions. In some areas, health promotion programs are robust and data-driven, while in others, they are piecemeal and inconsistently delivered. The central government has taken steps to improve alignment through vertical performance assessments and periodic evaluations; however, enforcement remains uneven, and technical guidance is not always accompanied by the necessary financial support to ensure effective implementation (Wu et al., 2021) (The People's Government of Fujian Province, 2021).

Multisectoral collaboration

China's Healthy China strategy advocates for a comprehensive, whole-of-government approach to health, underpinned by frameworks such as Health in All Policies (HiAP) and the One Health concept. The State Council has mandated the ministries, including those for education, environment, transportation, and housing, to integrate health objectives into sectoral planning. Initiatives such as Healthy Cities encourage local governments to convene health-focused planning councils and align policies across urban design, public transport, environmental monitoring, and school curricula.

Despite this institutional architecture, horizontal collaboration is frequently undermined by siloed budgeting, divergent mandates, and the absence of legally binding responsibilities. At the local level, capacity constraints and limited authority to convene cross-sectoral actors further weaken interdepartmental cooperation. Pilot initiatives in megacities like Shanghai and Beijing show that co-financing mechanisms, shared performance indicators, and digital planning platforms can support better multisectoral alignment. However, without national legislation to codify joint responsibilities or provide stable funding for intersectoral

initiatives, such innovations risk remaining exceptions rather than norms (World Health Organization, 2023b) (S. Chen et al., 2021).

Decentralization

Decentralization has fostered considerable local innovation in health promotion. Cities like Hangzhou, Chengdu, and Shenzhen have launched school-based health surveillance programs, digital health literacy campaigns, and community wellness initiatives tailored to local needs. Some jurisdictions have integrated health goals into their municipal development planning and cross-referenced performance targets with public sector key performance indicators (KPIs). Nevertheless, decentralization has also resulted in inequalities. Localities with stronger economic bases and governance capacity can invest in infrastructure, pilot technologies, and expand preventive service delivery. In contrast, under-resourced countries often lack the institutional or fiscal bandwidth to sustain basic programming. Insufficient national framework for evaluating or comparing local performance hinders policy learning and accountability. Although the Healthy China Monitoring and Evaluation Index provides a reference, it is not uniformly enforced or tied to funding mechanisms. National support for horizontal learning networks, performance-linked fiscal transfers, and capacity-building in low-income areas could help mitigate these disparities (Feng et al., 2020) (OECD, 2020).

In addition, implementation varies widely across regions. Urban centers have made significant strides in enforcing public health laws, whereas rural and peri-urban areas often lack the necessary administrative capacity to do the same. To strengthen this foundation, China could enhance local implementation capacity, embed surveillance data into planning cycles, and ensure that evidence-based interventions are applied equitably across all regions (Gong et al., 2022) (Krings et al., 2022).

Funding mechanisms

Health promotion funding in China is drawn from central subsidies, local government budgets, and basic health insurance schemes. The central government finances strategic national programs and time-limited projects, such as immunization campaigns or health communication initiatives, while local governments are responsible for the day-to-day delivery. Localities with limited fiscal capacity often underfund preventive services or rely on ad hoc donor support. Basic medical insurance covers some preventive services; however, reimbursement policies are inconsistent across schemes and localities, with limited support for behavioral or environmental interventions. Additionally, funding is often short-term and project-based, making it challenging to establish stable institutions or retain trained personnel. Some provinces have experimented with pooled budgeting, co-financing between departments, and performance-based disbursements, but such models remain limited in scope. (Chang et al., 2020)

China will need a more unified and strategic financing model to strengthen the financial foundations of health promotion. This should include earmarked funds for prevention and health education, long-term budgeting horizons, and insurance reimbursement mechanisms

that recognize the value of behavioral interventions and early detection. Expanded use of performance-based budgeting tied to population health outcomes could help align incentives. Furthermore, integrating prevention financing into cross-sectoral budgets—particularly in education, urban planning, and social services—would embed health more firmly into the operational priorities of non-health ministries (Xu & Chen, 2019).

Policy Implementation

Health workforce involvement

China's expansive network of community health workers and public health personnel forms the backbone of health promotion implementation, especially in rural and aging communities. These frontline staff are stationed in township health centers, village clinics, and urban community health stations, delivering a range of promotive and preventive services. Their responsibilities include health education, non-communicable disease screening, immunization, maternal and child health support, and care for the elderly. In remote or underserved areas, they often serve as the only accessible providers for essential public health functions.

The workforce also faces significant challenges. Many community health workers lack formal training in specialized areas such as behavioral counseling, digital health literacy, or culturally competent care for elderly populations. Compensation is often low, and difficult working conditions contribute to high turnover and low morale. Career development pathways are poorly defined, and opportunities for advancement or specialization remain limited. Addressing these issues will require a strategic investment in training, professional recognition, and incentive structures to support recruitment, retention, and upskilling, particularly in high-need regions (Wu et al., 2021) (X. Chen et al., 2021) (Zhang et al., 2021).

Incentives for Local Resource Engagement

Community engagement is a central pillar of China's health promotion strategy; however, its effectiveness varies significantly across different contexts. Local governments utilize public campaigns, volunteer networks, and grassroots mobilization strategies to promote health awareness and foster behavioral change. Neighborhood health committees, family doctor teams, and lay health workers are often involved in outreach. At the same time, campaigns such as National Fitness Day and the Healthy Lifestyle for All initiative aim to promote healthy behaviors. Older adults are targeted through senior clubs, peer support groups, and community workshops, which foster social connection alongside health education. Digital engagement is also increasing, particularly in urban areas, through platforms like WeChat and health-tracking apps. To strengthen engagement, long-term strategies should go beyond episodic campaigns to institutionalize community input into health planning, create participatory governance mechanisms, and build sustained partnerships with civil society organizations and local leaders (Li et al., 2022) (World Health Organization, 2023b).

Strategies for older adults

China has launched a range of initiatives to promote active aging, addressing not only health but also the broader social and psychological needs of older adults. Senior universities, wellness centers, lifelong learning programs, and neighborhood activity centers offer older individuals opportunities to stay cognitively stimulated, physically active, and socially engaged. These initiatives are aligned with Healthy China 2030's goals of improving HALE and delaying disability onset (Chen et al., 2022) (Feng et al., 2020). Some cities have introduced specialized programs in digital literacy, intergenerational mentoring, and elder entrepreneurship, reflecting a growing recognition of the contributions of older adults to society. Wellness centers often combine basic medical services with group exercise, dietary counseling, and support for self-management of chronic diseases. Urban residents benefit from better-funded, more diverse options, while rural elders often depend on sporadic outreach or informal networks. National support for scaling age-friendly infrastructure, subsidizing program participation, and integrating elder wellness into primary care will be crucial in addressing these disparities. Additionally, aligning these services with pension, transportation, and housing policies can enhance their impact and sustainability (Gong et al., 2022).

Monitoring and Performance

Standardized indicators

China has established a national framework for monitoring health promotion and healthy aging, anchored in a set of standardized indicators aligned with the goals of Healthy China 2030. These include Healthy Life Expectancy (HALE), the prevalence of key behavioral risk factors (e.g., tobacco use, physical inactivity, unhealthy diets), coverage of essential public health services, and population awareness of health issues. Indicators also track outcomes related to chronic disease management and the reach of educational campaigns (Feng et al., 2020). This data supports both national-level performance benchmarking and local policy adjustments. However, challenges persist in ensuring consistency in indicator application across provinces, reconciling regional data methodologies, and translating findings into timely policy actions. Local health authorities sometimes lack clarity on indicator definitions or face pressure to report inflated figures. Enhancing the utility of indicators will require stronger technical guidance, standardized protocols, and cross-provincial support mechanisms. (OECD, 2021)

Data and Monitoring Sources

China has invested heavily in health information technology, including electronic health records (EHRs), regional health data platforms, disease surveillance systems, and mobile health applications. These systems enable real-time monitoring of health service delivery, population risk trends, and user engagement with public health campaigns (Technology, 2021). In cities, integrated platforms can support granular tracking of community health indicators and facilitate predictive analytics. However, system coverage and reliability vary

significantly, especially in rural and less developed areas. Data entry may remain paper-based in these settings, and health workers may lack digital literacy or access to stable internet infrastructure. Moreover, the information systems used by different ministries and levels of government are not always interoperable, which hampers coordination. Closing these gaps will require investment in digital infrastructure and data governance, user training, cybersecurity, and interdepartmental interoperability standards (Liu & Hu, 2022).

Evaluation and feedback Loops

Routine evaluation mechanisms are embedded into the Healthy China 2030 governance model, but their application and influence on policy remain limited. National midterm reviews and health system reports are produced regularly, and local governments are encouraged to conduct assessments of program outcomes. Some provinces have developed scorecards and health report cards for public transparency. Nonetheless, evaluation practices often remain procedural rather than formative. There is little evidence that findings are systematically used to revise program design, target investments, or realign intersectoral responsibilities. Formal feedback loops—where community-level data, public opinion, and evaluation results inform strategic decisions—are underdeveloped. Participatory evaluation practices are rare, and performance-based budgeting remains in its early stages of development. To advance, China should institutionalize feedback mechanisms that link monitoring and evaluation (M&E) results to decision-making and budgeting processes, while promoting a culture of learning and continuous improvement (Krings et al., 2022; World Health Organization, 2022, 2023b).

3.4.3 Long-term care policies

Context

China's long-term care (LTC) system is undergoing profound transformation amid demographic pressures and shifting household dynamics. Chronic conditions such as cardiovascular disease, dementia, diabetes, and osteoporosis are becoming increasingly prevalent, resulting in a greater number of elderly individuals with complex and long-term support needs (Gong et al., 2022) (Zhang et al., 2021)Traditionally, elder care in China has been rooted in the Confucian ideal of filial piety, with multigenerational households and family members, particularly women, providing informal, unpaid care. However, this tradition is under strain. Rapid urbanization and internal migration have geographically separated younger generations from their aging parents. Young adults often move to urban centers for work, leaving behind elderly parents with little day-to-day support. In the absence of robust community or home-based services, many rural elderly face social isolation and inadequate care (Hu, 2013) (Zhan et al., 2012). One-child family structures, a legacy of past population policies, have created a "4-2-1" support model, where one working-age adult may support two parents and four grandparents (Feng et al., 2020). Additionally, increased female participation in the labor market has reduced the availability of full-time caregivers at home. These changes have created a widening care gap and exacerbated gender inequalities, as women continue to shoulder a disproportionate share of unpaid caregiving responsibilities (Zhu & Österle, 2019).

In response, grassroots and community-level initiatives have become increasingly important. In cities and some wealthier counties, local governments and NGOs have developed elder day-care centers, community dining halls, home visitation programs, and neighborhood support networks. These services provide social engagement, basic health monitoring, and limited personal care, helping to delay institutionalization and reduce family burden. However, such initiatives remain unevenly distributed, fragmented in governance, and financially unstable. Rural areas, in particular, continue to rely heavily on informal caregiving, with limited support and few institutional alternatives. The lack of a coherent national framework for community-based care, inconsistent funding, insufficient regulation, and poor integration with formal LTC and health services undermine their long-term sustainability (Jiang & Yang, 2023) (Gong et al., 2022).

In 2016, China launched LTC Insurance (LTCI) pilot programs in 15 cities to establish a formal LTC system that provides financial protection and structured service access to functionally dependent elderly individuals. These pilots have since expanded to 49 cities, covering a range of populations and geographies. The LTCI pilots vary in design, but most offer a mix of home-based care, daycare options, and institutional care. Eligibility is typically based on functional assessment, and benefits are capped annually, with co-payments required for many services. Financing mechanisms draw from government subsidies, reallocations from basic health insurance pools, and, in some cases, household contributions (Feng et al., 2020) (Zhu & Österle, 2019) (World Bank, 2019).

Timeline of Major Milestones (World Bank, 2019):

- **2016**: LTCI pilots launched in 15 cities, including Qingdao and Chengdu, focusing on home care for severely disabled seniors.
- **2017–2018**: Expanded to additional cities, with improvements in assessment tools, co-payment systems, and service contracts.
- **2019**: Healthy Aging Action Plan (2019–2022) formally integrates LTC into national aging policy.
- **2020**: COVID-19 pandemic highlights the vulnerabilities of institutional care and renews focus on home-based services.
- **2021–2025**: The 14th Five-Year Plan prioritizes LTC as a pillar of social protection reform and promotes medical-social integration.
- **Ongoing**: National legislation to institutionalize LTCI is under review; scaling up of best practices and pilot learnings is in progress.

China's LTC infrastructure is still in its infancy, and service availability and quality differ widely by region. While some urban centers have developed relatively advanced LTC systems—including licensed care institutions, home care agencies, and community-based service centers—rural and peri-urban areas face significant deficits. There is an insufficient number of care facilities, a shortage of trained care workers, and inadequate coordination among service providers. Many LTC institutions primarily function as custodial care facilities, offering room and board but minimal clinical or rehabilitative services (Feng et al., 2020) (Wu et al., 2021).

Community-based care is emphasized in policy documents, including the Healthy Aging Action Plan and the 14th Five-Year Plan, which promote the concepts of "aging in place" and "person-centered care." Despite this, institutional care absorbs a disproportionate share of public resources. The private sector, while growing, often caters to wealthier clients and operates with limited oversight. Integrated care models—combining health services with LTC—are being piloted in cities like Shanghai and Shenzhen. Most LTC providers lack electronic health records, data-sharing systems, or formal relationships with hospitals and primary care clinics (Linlin Hu, 2022) (Krings et al., 2022).

In addition to service fragmentation, regulatory oversight and quality assurance mechanisms remain weak. Accreditation processes are inconsistent, workforce qualifications are poorly defined, and no national benchmarks for service quality or outcomes. China should invest in a national LTC infrastructure strategy to address these issues, develop licensing and accreditation standards, and ensure that community-based and institutional care services are equitably accessible. Long-term sustainability will require financing reforms and policy frameworks that support care coordination, workforce training, and continuous quality improvement across service settings (Wu et al., 2021) (Feng et al., 2020).

Governance

Long-term care legislation and strategy

LTC development in China is steered by high-level strategies—most notably the National Medium- and Long-term Plan for Actively Responding to Population Aging and the 14th Five-Year Plan—which envision a multi-tiered system that promotes aging in place,

strengthens community- and home-based care, and advances integration of health and social services(Feng et al., 2020) (Wu et al., 2021). Since 2016, LTCI pilots in dozens of cities have served as test beds for financing models, eligibility assessment, and medical–social integration to inform future scale-up (Feng et al., 2020) (Chang et al., 2020) (S. Chen et al., 2021) (Li et al., 2022). However, without a legal framework defining roles, responsibilities, entitlements, and standards, implementation remains aspirational and vulnerable to regional disparities and bureaucratic inertia (Feng et al., 2020) (Wu et al., 2021).

Governance structure

Responsibilities are spread across multiple ministries and levels. The Ministry of Civil Affairs (MoCA) leads social care (facility regulation, community centers, caregiver support), the National Health Commission (NHC) oversees medical and public-health services (rehabilitation, chronic disease, and geriatric policy), and in some pilots, the Ministry of Human Resources and Social Security (MoHRSS) regulates LTCI financing. This tripartite arrangement often yields siloed planning, inconsistent standards, overlapping mandates, and fragmented budgets. Cross-ministerial working groups exist but typically lack legal authority, dedicated staffing, and pooled resources to drive integration (Feng et al., 2020) (Wu et al., 2021).

Administrative fragmentation across the health, social affairs, and social security sectors complicates LTC financing governance. Each industry operates its own data systems, eligibility rules, and claims processes. In many cities, LTCI operates as a standalone program, disconnected from broader health insurance or pension systems. This creates redundancies, increases administrative costs, and confuses beneficiaries (Wu et al., 2021). Furthermore, digital infrastructure is unevenly developed. Many localities lack centralized beneficiary databases, interoperable platforms, or real-time claims monitoring tools. Workforce shortages in financial management and information technology also hinder program efficiency and oversight. To overcome these challenges, China may invest in digital integration, data interoperability, and the development of administrative capacity across all levels of government (Technology, 2021).

Decentralization grants municipalities and counties broad discretion to set regulations, service standards, and reimbursement rules. Wealthier cities—such as Shanghai, Beijing, and Hangzhou—have developed more advanced LTC ecosystems (coordinated home care, age-friendly housing, digital case management). At the same time, poorer areas struggle to maintain basic services and rely heavily on family caregivers and volunteers. Limited intergovernmental transfers and the absence of nationwide benchmarks impede diffusion of best practices, and local incentives often prioritize higher-profile investments over LTC (Zhu & Österle, 2019) (Gong et al., 2022). A coherent national framework for service quality, workforce qualifications, and accountability is still lacking.

Financing

China's LTC financing system remains underdeveloped, characterized by regional variation, limited public investment, and inadequate household financial protection. The launch of LTCI pilots across 49 cities since 2016 represents a significant step toward institutionalizing LTC financing mechanisms. These pilots test models of eligibility determination, benefit design, revenue sources, and purchasing arrangements.

Expenditure

Public expenditure on LTC accounted for approximately 0.1% of China's GDP in 2021, which is significantly lower than the levels observed in OECD countries with more mature LTC systems. Projections suggest that this figure may reach 0.2% by 2050, but even this anticipated increase is unlikely to address the full scope of needs in an aging society (Maisonneuve & Martins, 2014). Because national LTC-specific out-of-pocket (OOP) statistics are scarce in China, empirical studies rely on CHARLS to estimate household burdens—typically constructing OOPE ratios or the newer "catastrophic health and long-term care expenditures (CHLTCE)" metric that explicitly includes formal and informal care; when LTC OOP isn't directly collected, costs are imputed from care hours × average wages (Chen et al., 2022) (Liu et al., 2025). Quasi-experimental evaluations of the LTCI pilots show measurable financial protection: difference-in-differences analyses find significant reductions in OOPE ratios and an average drop of about CNY 314 per month in outpatient OOP (M. Li et al., 2024) (Liu et al., 2025). Complementing this, early pilot reports cite roughly CNY 9,200 in average annual LTCI benefits per beneficiary, implying substitution away from private spending (Hu & Zhang, 2023).

Revenue raising and pooling resources

Funding for LTCI is derived from social health insurance transfers, individual payroll contributions (ranging from 0.1% to 0.2% of the salary), and subsidies from central and local governments. However, these funds are pooled at the municipal or district level, resulting in disparities in per capita funding and benefit generosity. Illustratively, five pilot cities finance LTCI, relying heavily on the Urban Employee Basic Medical Insurance (UEBMI) pooled funds; two (Guangzhou and Qiqihar) use fixed per-capita transfers, while Shanghai, Chengdu, and Chengde use payroll-based rates (as a percentage of the UEBMI premium base). Employer contributions are rare but notable in Shanghai (1% of the UEBMI premium base, post-pilot). (Chen et al., 2024; Huang, 2019)

Purchasing goods and services

Purchasing under most LTCI pilots is managed by local authorities using traditional fee-for-service models, which do not reward quality or efficiency. Few cities have implemented bundled payments, capitation, or pay-for-performance contracts (Chen et al., 2022).

Moreover, the dominance of public providers limits market competition, innovation, and responsiveness. Public providers continue to dominate China's LTCI purchasing because the policy and market architecture has long tilted in their favorThese dynamics are reinforced by China's broader hospital-centric public system, which spills over into long-term care delivery. (*Options for Aged Care in China*, 2018) (Huang, 2019). Encouraging private sector participation and expanding the role of not-for-profit providers could diversify supply and improve user choice. Strategic purchasing mechanisms—where public funds are used to buy high-quality, person-centered services—will require the development of performance indicators, accreditation standards, and robust regulatory oversight (Gong et al., 2022).

Workforce

Existing workforce

China's LTC system depends heavily on informal caregiving arrangements. Families—especially women—continue to serve as the primary providers of elder care, often without training, financial support, or institutional recognition. Cultural norms rooted in filial piety and intergenerational obligation shape this reliance on household caregivers, yet demographic and social transformations have eroded these traditional support systems (Zhan et al., 2012). The migration of younger family members to urban centers, shrinking family sizes, and increased participation of women in the formal labor force have all contributed to a reduction in the availability of family-based care. In rural areas, where aging is most pronounced, caregiving often falls to elderly spouses or daughters-in-law with limited education and resources (Hu, 2013).

In parallel, some community-based support has emerged, including neighborhood watch groups, volunteer-led elder care programs, and informal networks. These groups provide basic health monitoring, social engagement, and occasional respite care. However, without formal training, regulation, or integration into the broader LTC system, these informal providers operate with limited effectiveness and carry risks of caregiver burnout, neglect, or unintentional harm.

Capacity-building and Professionalization

Chinese authorities have launched initiatives to formalize the LTC workforce development, addressing workforce shortages and variability in care quality. The Ministry of Civil Affairs and the Ministry of Human Resources and Social Security have introduced national standards for caregiver training, focusing on essential competencies such as elder rights, mobility assistance, hygiene, nutrition, basic medical support, and dementia care. Certification programs have been introduced in vocational schools and adult training centers; however, their availability and uptake remain limited, particularly in rural and underserved areas (Chen et al., 2022).

Barriers to widespread professionalization include low wages, stigma associated with care work, minimal public awareness of training opportunities, and the absence of meaningful

career pathways. Many potential caregivers view LTC work as low-status and physically demanding, with little room for advancement. Moreover, training quality is inconsistent across institutions, and supervision is often weak. Graduates of caregiver programs may struggle to find employment in formal care settings due to limited demand or insufficient integration with regulated employers. Clinical placements and hands-on training opportunities remain scarce, particularly in less developed provinces (World Health Organization, 2022).

The LTC sector in China lacks defined career ladders for frontline workers, contributing to low retention and morale. Caregivers are often hired on short-term contracts, which frequently provide limited job security, social insurance coverage, and retirement benefits. Opportunities to specialize in palliative care, rehabilitation, or dementia care are rare, and few institutions offer promotion pathways to supervisory or managerial roles. As a result, LTC positions are often viewed as dead-end jobs, filled by middle-aged women reentering the workforce or migrant workers seeking temporary employment (Krings et al., 2022).

High turnover and workforce instability are especially problematic in institutional care settings, where continuity of care and relationship-building are critical. Reliance on precarious labor arrangements and the absence of performance-based incentives undermine the quality of care. These conditions deter young people from entering the sector, leading to a cycle of workforce shortages, overburdened staff, and reduced service standards (Gong et al., 2022).

Service Delivery

Eligibility and gatekeeping

Eligibility for LTC services under China's LTCI pilots is primarily based on age and functional status, with most programs targeting adults aged 60 and older with moderate to severe physical or cognitive impairments. However, the assessment process used to determine eligibility varies significantly across localities. Some pilot cities have adopted multi-dimensional assessment tools administered by trained professionals, which measure physical limitations, cognitive capacity, and self-care ability. Other areas rely on simpler evaluations, such as physician referrals or self-reporting mechanisms, which can lead to inconsistency and bias (Feng et al., 2020) (Chang et al., 2020). (Li et al., 2022)

In response, some jurisdictions are experimenting with digital eligibility platforms and AI-based scoring algorithms to enhance consistency, minimize human error, and reduce wait times. However, digital solutions are still in the early stages, and adoption remains uneven, particularly in rural areas that lack digital infrastructure or trained assessors. Establishing a nationally standardized, evidence-based assessment framework will be essential to ensure equitable access and portability of benefits across regions (Gong et al., 2022) (Wu et al., 2021).

Settings for public LTC support

China's LTCI system places a strong policy emphasis on home- and community-based services (HCBS), which aligns with the broader national goal of aging in place. HCBS encompasses a range of diverse interventions, including home nursing visits, personal care assistance, adult day care, and meal delivery programs. These services aim to delay institutionalization, reduce hospital readmissions, and improve the quality of life for older adults (Feng et al., 2020) (Wu et al., 2021).

Urban areas have benefited from greater investment in HCBS infrastructure, including community health stations, neighborhood elder care hubs, and day-service centers. These settings provide access to health, social, and rehabilitative care. However, rural regions often lack the necessary infrastructure, staffing, and funding to deliver these services on a large scale. In many remote counties, HCBS are delivered sporadically through basic health outposts or volunteers, with limited coordination (Li et al., 2022).

Institutional care remains underdeveloped, and when available, it is often utilized as a last resort due to cost, stigma, or family preference. Facilities frequently operate under resource constraints and may lack specialized staff or medical equipment. While some urban LTC institutions have introduced integrated medical and residential models, these innovations remain limited to wealthier areas. Addressing service setting disparities will require significant investment in rural infrastructure, stronger local planning, and support for family caregivers as a bridge to formal care (S. Chen et al., 2021). (Linlin Hu, 2022).

Service provided

The scope of services available under LTCI varies widely, depending on the policy design and fiscal capacity of the pilot site. Most LTCI programs offer a basic package that covers assistance with daily living (ADL) activities, such as dressing, bathing, toileting, and feeding. Some sites also provide limited rehabilitation services, nursing care, mental health support, and caregiver training. Despite this diversity, the depth and frequency of care remain limited. Typically, beneficiaries receive between two and eight hours of weekly care, which is insufficient to address the needs of those with significant impairments fully (Feng et al., 2020) (Gong et al., 2022).

The narrow scope of coverage forces families to supplement care through out-of-pocket expenditures or unpaid labor, perpetuating the informal caregiving burden. Eligibility thresholds often exclude individuals with mild or moderate functional limitations, delaying access to services until conditions worsen. Furthermore, few LTCI pilots offer comprehensive care planning, 24-hour care, or case management support. Developing tiered benefit packages that align with varying levels of need and expanding coverage to include preventative and transitional services will be key to enhancing the effectiveness of LTCI (Wu et al., 2021).

Integrated care and person-centered care pathways

Integration between LTC and the broader health and social care systems remains uneven. In many cities, LTC operates in parallel with health and welfare services, with little coordination in funding, staffing, or data sharing. However, there are promising examples of progress. Selected pilot sites have introduced interdisciplinary care teams that involve physicians, nurses, social workers, and rehabilitation specialists, who collaboratively develop care plans. Co-located elder care centers and community health stations have emerged in cities such as Shanghai and Nanjing, facilitating referrals and real-time communication (Zhang et al., 2021) (Feng et al., 2020).

China's Integrated Medical and Social Care Policy (IMSCP)—rolled out in selected pilot cities in 2016, in alignment with the WHO's ICOPE framework—seeks to integrate medical and social care through multidisciplinary teams, clearer referral pathways, and, in some locales, co-located services. A recent nationwide quasi-experimental study using CLHLS 2014–2018 (difference-in-differences) found the IMSCP was associated with lower odds of functional dependency (OR 0.72; 95% CI 0.58–0.89) and, among those already dependent, fewer care deficits (OR 0.62; 95% CI 0.41–0.95) (Zhou et al., 2025).

Electronic health record (EHR) integration and shared digital platforms are under development; however, data interoperability between LTC providers, hospitals, and insurers remains limited. Institutional resistance, misaligned incentives, and administrative silos are common barriers. More consistent policies mandating cross-sector planning, shared performance indicators, and joint financing mechanisms will be necessary to create integrated LTC systems that support complex care trajectories (Krings et al., 2022) (Wu et al., 2021).

Quality assurance

Quality monitoring in China's LTC system is still in its early stages. Since 2018, pilot cities have begun implementing quality assurance frameworks, including facility inspections, user satisfaction surveys, and performance evaluations. However, the scope, frequency, and enforcement of these efforts remain inconsistent. National standards for service quality and care outcomes are lacking, and facility accreditation remains voluntary or region-specific (Wu et al., 2021) (S. Chen et al., 2021).

User feedback mechanisms, such as hotlines or grievance redress systems, are underutilized, and data on adverse events, staff-to-patient ratios, and care outcomes are rarely published. Some cities are piloting public quality dashboards and real-time monitoring systems; however, these initiatives are fragmented and lack legal backing. China will need to adopt a national LTC quality framework to strengthen trust and accountability, including mandatory accreditation, regular inspections, and standardized outcome reporting. Establishing independent oversight bodies and integrating user voice into evaluation processes can enhance transparency and responsiveness.

Performance of long-term care service delivery

Coverage under the LTCI pilots is generally targeted at individuals with severe functional impairments, based on standardized or semi-standardized assessments of their needs. Most pilots offer basic home care services, nursing, and limited institutional care, but benefit caps—typically around ¥6,000 to ¥12,000 per year—often fall short of actual care costs. Institutional care is subject to higher copayments and stricter eligibility criteria to discourage its use. A few cities offer supplementary services, such as respite care, daycare, and psychological support.

Evidence on performance is starting to accumulate, but routine, comparable monitoring remains scarce. A recent nationwide quasi-experimental study of China's Integrated Medical and Social Care Policy (IMSCP) found meaningful reductions in functional dependency and, among those already dependent, fewer care deficits, with effects persisting in longer-run analyses for some groups. This early signal integrated, person-centered models can improve outcomes at scale (Zhou et al., 2025). Complementary evaluations report improvements in health-related quality of life and city-level gains in mortality/physical function after LTCI roll-outs. However, results are heterogeneous across pilots and study designs. At the same time, policy reviews note that most pilots still rely on fee-for-service or per-diem payments and have limited, fragmented outcome reporting, which constrains systematic performance management (Huang, 2019; Liu et al., 2025).

Several groups have proposed indicator frameworks for China's LTCI that cover access, quality, outcomes, experience, and efficiency, and new quality indicators for home- and community-based eldercare are emerging. Yet, adoption is uneven, and national standards for case-mix, data definitions, and public reporting are still developing. In practice, many cities track process measures (e.g., service hours, staffing) more than outcomes (e.g., ADL change, avoidable hospitalizations), and public benchmarking remains rare. Building a core indicator set aligned to IMSCP and WHO ICOPE which is implemented via shared digital platforms across LTC providers, hospitals, and insurers would enable fair comparison and strategic purchasing (Wang et al., 2025) (Q. Li et al., 2024) (Du et al., 2025).

3.4.4 Conclusion

China plays a pivotal role in responding to the dual imperatives of promoting population health and establishing a comprehensive, LTC system. The country's aging trajectory—characterized by rising longevity, declining fertility, and an increasing burden of chronic disease—requires a reorientation of its health and social systems toward prevention, integration, and equity. Over the past decade, significant policy momentum has emerged through the "Healthy China 2030" strategy and the introduction of LTCI pilots in 49 cities. Together, these initiatives recognize that healthy aging should be pursued across the health promotion and care delivery continuum (Feng et al., 2020) (Chen et al., 2022).

On the health promotion front, China has embedded behavioral risk factor reduction, health literacy, and community mobilization into national planning. The emphasis on prevention and the life-course approach—starting from childhood and extending into older age—has improved awareness and participation in population health initiatives. Programs such as "Healthy Lifestyle for All" and the Basic Public Health Services Package have implemented preventive screenings, increased physical activity, and improved dietary habits. However,

implementation gaps remain. Urban-rural disparities, limited workforce capacity in primary care, and fragmented data systems continue to hinder the reach and sustainability of these initiatives. Further integration of health promotion into intersectoral development, expansion of financing, and robust evaluation mechanisms will be key to sustaining gains in Healthy Life Expectancy (HALE) (Feng et al., 2020) (Chen et al., 2022).

Simultaneously, LTC reform is gradually taking shape. The LTCI pilots have helped define foundational eligibility, financing, service delivery, and quality assurance mechanisms. Progress has been made in shifting from institution-based to home- and community-based models, with pilots offering modest but vital services such as assistance with activities of daily living, rehabilitation, and home visits. However, critical challenges persist. Governance between health and social care agencies remains fragmented. Financing is inadequate and unevenly distributed across regions. Professional care workers are few, often underpaid, and undertrained. Services are usually limited in scope and disconnected from broader healthcare systems. Quality and performance monitoring are still at a nascent stage (Wu et al., 2021) (OECD, 2020).

To consolidate these early advances and transition from pilots to a national system, China should enact a LTC law that defines entitlements, assigns responsibilities, and standardizes benefit design. Coordinated national leadership will be required to align institutions, scale innovations, and harmonize service delivery. Health promotion can be better integrated into the LTC continuum, recognizing that healthy aging also depends on reducing the onset and progression of disability. Financing mechanisms may combine pooled risk-sharing, progressive contributions, and strategic purchasing to ensure long-term sustainability. Workforce investment—particularly in rural areas—should support training, accreditation, and career development. Furthermore, quality should be anchored in transparent standards, user-centered evaluation, and independent oversight (Krings et al., 2022) (Gong et al., 2022).

Ultimately, the success of China's dual-track reform—promoting healthy aging and delivering responsive long-term care—will rest on its ability to bridge policy ambition with implementation reality. With sustained investment, governance reform, and a commitment to equity, China can build an integrated, people-centered system that ensures older adults not only live longer but also do so with dignity, independence, and well-being.

References

- Bank, W. (2019). *UNDERSTANDING CHINA'S LONG-TERM CARE INSURANCE PILOTS: WHAT IS GOING ON? DO THEY WORK? AND WHERE TO GO NEXT?* https://documents1.worldbank.org/curated/en/496061563801421452/Technical-Note.docx

- Brief, C. D. (2020, 18 Oct 2020). *Chinese National Committee on Aging tackles the issue of senior citizens accessing the internet and smartphones* https://chinadevelopmentbrief.org/reports/chinese-national-committee-on-aging-tackles-the-issue-of-senior-citizens-accessing-the-internet-and-smartphones/

- Chang, S., Yang, W., & Deguchi, H. (2020). Care providers, access to care, and the Long-term Care Nursing Insurance in China: An agent-based simulation. *Social Science & Medicine*, *244*, 112667. https://doi.org/https://doi.org/10.1016/j.socscimed.2019.112667

- Chen, S., Li, L., Yang, J., Jiao, L., Golden, T., Wang, Z., Liu, H., Wu, P., Bärnighausen, T., Geldsetzer, P., & Wang, C. (2021). The impact of long-term care insurance in China on beneficiaries and caregivers: A systematic review. *J Glob Health Econ Policy*, *1*. https://doi.org/10.52872/001c.29559

- Chen, X., Giles, J., Yao, Y., Yip, W., Meng, Q., Berkman, L., Chen, H., Chen, X., Feng, J., Feng, Z., Glinskaya, E., Gong, J., Hu, P., Kan, H., Lei, X., Liu, X., Steptoe, A., Wang, G., Wang, H.,…Zhao, Y. (2022). The path to healthy ageing in China: a Peking University–Lancet Commission. *The Lancet*, *400*(10367), 1967-2006. https://doi.org/https://doi.org/10.1016/S0140-6736(22)01546-X

- Chen, X., Tang, L., Liu, L., Bai, Z., & Chen, R. (2021). Factors related to turnover intention among staff of elderly caring social organizations in Anhui Province, China: a cross-sectional study. *BMC Health Services Research*, *21*(1), 1265. https://doi.org/10.1186/s12913-021-07284-5

- China, N. H. C. o. t. P. s. R. o. (2018). *Department of Ageing and Health*. China Retrieved from http://en.nhc.gov.cn/2018-10/22/c_74496.htm

- ESCAP, U. (2015). *Long-term care for older persons in China* (Long-term care for older persons in Asia and the Pacific, Issue. https://www.unescap.org/sites/default/files/Long%20Term%20Care%20for%20older%20persons%20in%20China.pdf

- Fang, H. (2020). *China*. https://www.commonwealthfund.org/international-health-policy-center/countries/china

- Feng, Z., Glinskaya, E., Chen, H., Gong, S., Qiu, Y., Xu, J., & Yip, W. (2020). Long-term care system for older adults in China: policy landscape, challenges, and future

prospects. *The Lancet*, *396*(10259), 1362-1372. https://doi.org/https://doi.org/10.1016/S0140-6736(20)32136-X

- Glass, A. P., Gao, Y., & Luo, J. (2013). China: Facing a long-term care challenge on an unprecedented scale. *Global Public Health*, *8*(6), 725-738. https://doi.org/10.1080/17441692.2013.782060

- Gong, J., Wang, G., Wang, Y., Chen, X., Chen, Y., Meng, Q., Yang, P., Yao, Y., & Zhao, Y. (2022). Nowcasting and forecasting the care needs of the older population in China: analysis of data from the China Health and Retirement Longitudinal Study (CHARLS). *The Lancet Public Health*, *7*(12), e1005-e1013. https://doi.org/10.1016/S2468-2667(22)00203-1

- Hu, A. (2013). The Distinctive Transition of China's Five-Year Plans. *Modern China*, *39*(6), 629-639. http://www.jstor.org/stable/24574696

- Jiang, W., & Yang, H. (2023). Health spillover studies of long-term care insurance in China: evidence from spousal caregivers from disabled families. *International Journal for Equity in Health*, *22*(1), 191. https://doi.org/10.1186/s12939-023-02001-6

- Krings, M. F., van Wijngaarden, J. D. H., Yuan, S., & Huijsman, R. (2022). China's Elder Care Policies 1994-2020: A Narrative Document Analysis. *Int J Environ Res Public Health*, *19*(10). https://doi.org/10.3390/ijerph19106141

- Li, Q., Wang, Y., & Zhao, Y. (2018). The Impact of China's New Rural Pension Program on Elderly Labor, Grandchild Care, and Old-Age Support. *Feminist Economics*, *24*(2), 265-287. https://doi.org/10.1080/13545701.2017.1421768

- Li, Q., Zhang, L., & Jian, W. (2023). The impact of integrated urban and rural resident basic medical insurance on health service equity: Evidence from China. *Front Public Health*, *11*, 1106166. https://doi.org/10.3389/fpubh.2023.1106166

- Li, X., Li, C., & Huang, Y. (2022). Spatial-temporal analysis of urban-rural differences in the development of elderly care institutions in China [Original Research]. *Frontiers in Public Health*, *10*. https://doi.org/10.3389/fpubh.2022.1086388

- Linlin Hu, Y. F. W. G. (2022). What's Next - Integrating Health and Care for the Elderly in China under Healthy China 2030. *International Journal of Integrated Care*, *22*, 118. https://doi.org/10.5334/ijic.ICIC21065

- Liu, H., & Hu, T. (2022). Evaluating the long-term care insurance policy from medical expenses and health security equity perspective: evidence from China. *Archives of Public Health*, *80*(1), 3. https://doi.org/10.1186/s13690-021-00761-7

- Maisonneuve, C. d. l., & Martins, J. O. (2014). The future of health and long-term care spending. https://doi.org/doi:https://doi.org/10.1787/eco_studies-2014-5jz0v44s66nw

- OECD. (2020). *Ageing and Fiscal Challenges across Levels of Government* (OECD Fiscal Federalism Studies, Issue. https://www.oecd-ilibrary.org/governance/ageing-and-fiscal-challenges-across-levels-of-government_2bbfbda8-en

- OECD. (2021). *Health at a Glance 2021: OECD Indicators*. https://www.oecd-ilibrary.org/sites/cb584fa2-en/index.html?itemId=/content/component/cb584fa2-en

- Organization, W. H. (2022). *Ageing and health*. https://www.who.int/news-room/fact-sheets/detail/ageing-and-health

- Organization, W. H. (2023). *Healthy China* (Health Promotion, Issue. https://www.who.int/teams/health-promotion/enhanced-wellbeing/ninth-global-conference/healthy-china

- Province, T. P. s. G. o. F. (2021). *Outline of the 14th Five-Year Plan (2021-2025) for National Economic and Social Development and Vision 2035 of the People's Republic of China*. China Retrieved from https://www.fujian.gov.cn/english/news/202108/t20210809_5665713.htm#C45

- Tan, X., Liu, X., & Shao, H. (2017). Healthy China 2030: A Vision for Health Care. *Value Health Reg Issues*, *12*, 112-114. https://doi.org/10.1016/j.vhri.2017.04.001

- Technology, C. f. S. a. E. (2021). Outline of the People's Republic of China 14th Five-Year Plan for National Economic and Social Development and Long-Range Objectives for 2035. https://cset.georgetown.edu/publication/china-14th-five-year-plan/

- Wu, B., Cohen, M. A., Cong, Z., Kim, K., & Peng, C. (2021). Improving Care for Older Adults in China: Development of Long-Term Care Policy and System. *Research on Aging*, *43*(3-4), 123-126. https://doi.org/10.1177/0164027521990829

- Xu, X., & Chen, L. (2019). Projection of Long-Term Care Costs in China, 2020–2050: Based on the Bayesian Quantile Regression Method. *Sustainability*, *11*(13), 3530. https://www.mdpi.com/2071-1050/11/13/3530

- Yong, C., & Yuan, C. (2014). PENSION REFORM IN CHINA: CHALLENGES AND OPPORTUNITIES: PENSION REFORM IN CHINA. *Journal of economic surveys*, *28*, 636-651. https://doi.org/10.1111/joes.12082

- Zhan, H. J., Luo, B., & Chen, Z. (2012). Institutional elder care in China. *Aging in China: Implications to social policy of a changing economic state*, 221-235. https://link.springer.com/book/10.1007/978-1-4419-8351-0

- Zhang, A., & Imai, K. S. (2024). Do public pension programmes reduce elderly poverty in China? *Review of Development Economics*, *28*(1), 3-33. https://doi.org/https://doi.org/10.1111/rode.13016

- Zhang, Z., Wang, S., Miao, C., Su, M., Chen, T., & Yao, N. (2021). Substantial Differences in Turnover Intention Between Direct Care Workers in Chinese Hospitals and Long-Term Care Facilities. *Journal of the American Medical Directors Association*, *22*(3), 696-700.e691. https://doi.org/https://doi.org/10.1016/j.jamda.2020.09.006

- Zhu, Y., & Österle, A. (2019). China's policy experimentation on long-term care insurance: Implications for access. *The International Journal of Health Planning and Management*, *34*(4), e1661-e1674. https://doi.org/https://doi.org/10.1002/hpm.2879

3.5 Sri Lanka

3.5.1 Introduction

Sri Lanka, a lower-middle-income country is entering a pivotal phase in responding to the health implications of rapid population ageing. Having achieved near-universal healthcare coverage and remarkable progress in maternal and child health, the country now confronts an epidemiological transition marked by a growing burden of non-communicable diseases (NCDs) and an increasing proportion of older adults. These demographic and health shifts necessitate the development of comprehensive policies that promote healthy ageing and long-term care (LTC), while addressing the associated challenges of equity, sustainability, and intersectoral coordination.

This chapter examines Sri Lanka's policy responses to healthy ageing in health promotion and long-term care. Drawing on national policy documents, government strategies, and diagnostic studies, the analysis identifies strengths, gaps, and emerging opportunities in the country's efforts to support older populations. It offers insights for policymakers and stakeholders in the Asia-Pacific region who are grappling with similar demographic transitions and seeking to strengthen age-inclusive health systems.

3.5.2 Healthy ageing policies

Contexts

Sri Lanka is a lower-middle-income island nation of 21.4 million people with a rapidly ageing population – the share of those over 65 doubled from 3.7% in 1970 to 10.8% by 2019 (WHO, 2021).The country's health system has achieved near-universal access and strong maternal and child health outcomes, eliminating or controlling many infectious diseases. However, it is now in a late epidemiological transition facing a rising tide of non-communicable diseases (NCDs) such as cardiovascular disease, diabetes, and cancer. Over 90% of adults have at least one NCD risk factor (e.g. high blood glucose, high blood pressure, tobacco use), and roughly 18% have three to five risk factors (WHO, 2021). These trends, coupled with increasing life expectancy and ageing, have required Sri Lanka to shift from a treatment-centric model to one emphasizing health promotion and prevention across the life-course. The government explicitly recognizes health promotion as a "highly cost-effective strategy to foster a healthy nation," pursuing it a core responsibility not only of the health sector but of all parts of government and society (MoH, 2010). In 2010, Sri Lanka's Cabinet of Ministers endorsed the development of a National Health Promotion Policy and Action Plan, reflecting high-level political commitment to proactive healthy ageing policies. The following sections outline Sri Lanka's health promotion policy framework, its foundations and governance, and how it is being implemented and monitored – with a focus on practical insights for policymakers in the Asia-Pacific region.

Policy Foundations

Goal Setting

While life expectancy (LE) and healthy life expectancy (HALE) are tracked in both national and international health assessments, Sri Lanka does not explicitly position them as overarching goals within its national health promotion agenda or strategic policy documents (HPB, 2024; MoH, 2010). Based on a comprehensive review of Sri Lanka's national health promotion policies and strategic documents, there is no explicit statement that positions life expectancy (LE), health-adjusted life expectancy (HALE), or the gap between LE and HALE as overarching goals of the national health promotion agenda. For instance, the National Health Promotion Policy (2010) focuses on empowering individuals and communities to improve health, but it does not mention LE, HALE, or their gap as a targeted outcome (MoH, 2010). The National Health Promotion Strategic Plan 2024–2030 emphasizes reducing the burden of noncommunicable diseases (NCDs), improving health literacy, and enhancing equity in health, but again, without targeting LE or HALE directly (HPB, 2024). Also, WHO Sri Lanka Health System Review (2021) presents data on LE and HALE of Sri Lanka, but these are used descriptively (WHO, 2021). In conclusion, while LE and HALE are tracked indicators in national and international health system assessments, Sri Lanka does not explicitly frame them as overarching goals in its national health promotion agenda or strategic policy documents.

GEDSI (Gender, Equity, Diversity, and Social Inclusion)

Although the improvement of health outcomes among vulnerable populations is articulated as a key expected outcome in the National Health Promotion Strategic Plan 2024–2030, the plan lacks explicit integration of gender considerations. The document identifies "improved health and wellbeing of all people, especially more vulnerable populations" as one of its central objectives. However, it falls short of clearly defining which population groups are considered "more vulnerable," leaving the term open to broad interpretation and limiting the potential for targeted interventions. Notably, a gender-sensitive or gender-transformative lens is largely absent from both the strategic goals and implementation frameworks. While the plan does include the "Mother's Support Group" (MSG) as one of the six core settings in its settings-based approach—specifying that an active MSG should convene monthly meetings at least six times annually—this inclusion alone does not constitute a comprehensive gender strategy. Rather, it reflects a narrow, maternal health–oriented framing of gender, without addressing broader issues of gender equity, intersectionality, or the differentiated health needs and barriers experienced by women, men, and gender-diverse individuals across the life course. As such, the lack of an explicit gender perspective represents a critical gap in the strategic planning process and limits the plan's capacity to ensure equitable health promotion outcomes (HPB, 2024).

Life-Course Orientation

The Health Promotion Bureau (HPB) of Sri Lankan government implicitly incorporates elements of a life-course approach through its setting-based interventions, which target key stages of life such as early childhood (preschools and schools), maternal and reproductive health (through mothers' support groups), and working-age populations (via workplace programs). However, this framework lacks clearly defined, age-specific strategies that address the distinct health promotion needs of older adults. Despite the demographic significance and growing health burden associated with population ageing, there is limited evidence of systematic planning or targeted interventions aimed at promoting healthy ageing or fostering age-inclusive environments within the current strategic framework (HPB, 2024).

Shift to Prevention

The national healthcare system in Sri Lanka continues to be predominantly oriented toward curative services, with only limited and gradual progress made toward the establishment of a comprehensive preventive care model. Within this context, the Health Promotion Bureau (HPB), which is tasked with leading the development and implementation of national health promotion policies, operates under significant financial and human resource constraints (HPB, 2024).

Evidence-based Risk Factor Prioritization

As the national health promotion agenda in Sri Lanka remains in a relatively early stage of development, the overarching strategy has yet to be firmly grounded in empirical evidence or systematically aligned with the country's major health risk factors and burden of disease. While the current strategic framework adopts a settings-based approach—focusing on environments such as schools, workplaces, and villages—the associated key performance indicators are primarily activity-based. These indicators tend to emphasize the quantity of health promotion activities conducted (e.g., the number of meetings held or programs implemented) rather than measuring tangible health outcomes, such as reductions in modifiable risk factors or decreases in the burden of non-communicable diseases. This emphasis on process over impact limits the ability of the strategy to demonstrate effectiveness or inform evidence-based policy refinement. Strengthening the evidence base and shifting toward outcome-oriented evaluation metrics will be essential for enhancing the relevance and impact of national health promotion efforts (HPB, 2024).

Policy Alignment

The National Health Promotion Policy (NHPP) was formulated with the explicit objective of achieving coherence with other national health policies through a structured and systematic policy review process. This process aimed to align health promotion efforts with broader national health goals and ensure consistency across strategic frameworks. Specifically, the

NHPP was developed over a two-year period of multi-stakeholder consultations, beginning in 2010, and subsequently received cabinet approval in 2013. In an effort to promote policy coherence, the development of the NHPP was informed by a detailed analysis of existing health policy documents, including the National Health Policy (2016), the Policy on Health Care Delivery for Universal Health Coverage, and the National Multisectoral Action Plan for the Prevention and Control of Non-Communicable Diseases (NCDs). This review process involved identifying gaps in the implementation of existing policies, evaluating their alignment with emerging health priorities, and incorporating relevant elements into the health promotion policy framework. Since its endorsement, the NHPP has served as the foundation for the development of numerous annual action plans, each addressing specific priority areas outlined in the policy and reflecting evolving public health needs. This iterative planning process underscores the role of the NHPP as a dynamic policy instrument intended to guide long-term health promotion strategies in Sri Lanka (HPB, 2024).

Policy Governance and Funding Structure

Lead Institutions

While Sri Lanka does not have an independent, dedicated agency for health promotion, the Health Promotion Bureau (HPB) under the Ministry of Health has a designated lead for formulating and implementing its national-level health promotion agenda and policies. This designation gives the HPB both technical and operational authority for advancing health promotion efforts nationwide. The Health Promotion Board (HPB) is instrumental in raising public awareness about health promotion and encouraging healthy behavior changes through active involvement in large-scale health exhibitions, national awareness days, and local community events. Another key initiative led by the HPB is the development of health-promoting environments in homes and public spaces such as hospitals, schools, villages, and workplaces (HPB, 2024; WHO, 2021).

Multisectoral Collaboration (HiAP)

Sri Lanka seeking commitment to advancing multisectoral collaboration and fostering inter-ministerial coordination as integral components of its national health promotion strategy. This approach is firmly grounded in the principle of “Health in All Policies,” which serves not only as a guiding framework for the formulation of health-related policies but also as a practical mechanism for ensuring that health considerations are systematically integrated across diverse sectors and levels of governance. The Strategic Plan 2024–2030 for the National Health Promotion Program underscores the importance of collaboration as a central component. Among the eight key outcomes outlined, the first and fourth explicitly pertain to collaborative efforts: (1) the integration of health into all national policies; and (4) the development of sustainable, supportive environments for health across all geographies and populations through multisectoral collaboration (HPB, 2024).

Decentralization

The Sri Lankan healthcare system is partially decentralized. The Ministry of Health (MoH) retains authority over national health services, including policy formulation, legislation, and regulation of both public and private sectors. Local health ministries are tasked with implementing primary, secondary, and preventive care within their respective provinces. Although decentralization grants provinces the ability to establish their own statutes, decision-making remains predominantly centralized (WHO, 2021).

The health promotion sector reflects this structure. The Health Promotion Bureau, under the MoH, leads and coordinates the national health promotion agenda. While local health ministries are involved in planning and implementing health promotion activities, these efforts are aligned with and operate within the framework of the national plan (HPB, 2024; WHO, 2021)

Funding Mechanisms

In Sri Lanka preventive and promotive health care remains underfunded compared to curative services. General taxation is the primary source of funding for Sri Lanka's health promotion; however, the sustainability of this funding has long been a concern. For decades, the government, particularly the Health Promotion Bureau, has recognized the need for more sustainable financing mechanisms for health promotion. Several key reports have emphasized the necessity of increasing government budget allocations and diversifying funding sources (HPB, 2024; MoH, 2010).

Despite these recommendations, non-earmarked government budgets remain the primary source of health promotion funding, with limited contributions from international donors. In 2019, the Government of Sri Lanka provided 81% of total funding, while agencies such as the United Nations Population Fund (UNFPA), the World Bank (WB), and the World Health Organization (WHO) contributed the remainder (Siraj Mohamed, 2023).

Policy Implementation

Health Workforce Involvement

Public officers affiliated with the Health Promotion Bureau under the Ministry of Health bear the primary responsibility for the formulation, coordination, and implementation of national health promotion policies and strategies. Although community health workers may contribute to the delivery and facilitation of certain health promotion activities at the grassroots level, their roles and responsibilities in this context are not clearly defined or systematically articulated in official government policy documents or strategic frameworks (HPB, 2024; MoH, 2010; WHO, 2021).

Incentives for Local Resource Engagement

At the community level, the promotion of public awareness to foster healthy behavioral changes represents a distinctive and long-standing initiative led by the Health Promotion Bureau (HPB). This service has been widely acknowledged and valued across various sectors, reflecting its integral role in advancing population health. Community engagement in health promotion efforts is largely driven by non-financial incentives, with an emphasis on fostering a sense of social recognition, ownership, and collective responsibility. Rather than relying on monetary rewards, the HPB has prioritized strategies that encourage voluntary participation through community mobilization, peer support, and the cultivation of local leadership in health-promoting activities (HPB, 2024).

Strategies for Older Adults

Indicators and programs specifically designed to address the needs of older adults remain largely underdeveloped within the current health promotion framework. As a result, it is difficult to identify a clear participatory approach that actively involves older adults in the design, implementation, or evaluation of health promotion activities. Although the national strategic plan for health promotion acknowledges the importance of this demographic by identifying "healthy ageing within age-inclusive communities" as one of its anticipated key outcomes, this recognition is largely nominal. The plan falls short of articulating concrete strategies, targeted interventions, or implementation mechanisms tailored specifically to older populations. Consequently, the alignment of health promotion efforts with the unique health and social needs of older adults remains limited and underexplored (HPB, 2024).

Monitoring & Performance

Standardized Indicators

Sri Lanka adopts a settings-based approach as the central strategy for its national health promotion efforts, incorporating elements of the life-course perspective. Six key community and institutional settings have been identified to guide intervention implementation: villages, preschools, schools, workplaces, hospitals, and mothers' support groups.

To assess progress within these target areas, a total of six key performance indicators (KPIs) have been established, spanning diverse population groups: from preschool-aged children to the working population. However, the development and operationalization of these indicators appear to remain at a relatively nascent stage, with limited evidence of systematic outcome evaluation. For example, in the case of the "Happy Village" setting, the indicator specifies that each Medical Officer of Health (MOH) area should establish and sustain at least two new Happy Village settings per year. A "functional" Happy Village is further defined by three core criteria: (1) the presence of an active village committee that convenes at least once a month; (2) the maintenance of proper records and submission of routine reports, which must be available for review during field supervision; and (3) the implementation of activities recommended by the Health Promotion Bureau (HPB). While these guidelines provide a

basic operational framework, the extent to which they translate into sustained community-level health outcomes remains to be systematically evaluated (HPB, 2024).

Data and Monitoring Sources

Unfortunately, the outcomes associated with the key performance indicators (KPIs) developed by the Health Promotion Bureau (HPB) are not yet publicly available. This lack of transparency may be attributed, in part, to the absence of standardized data formats and centralized systems for monitoring and evaluation, which limit the ability to retrieve and analyze performance data efficiently.

A contributing factor to this challenge is the relatively limited integration and utilization of Information and Communication Technologies (ICT) within the HPB's planning, monitoring, and reporting processes. As a result, systematic data collection, aggregation, and dissemination remain underdeveloped, hindering efforts to assess the effectiveness of health promotion interventions in a timely and evidence-based manner (Siraj Mohamed, 2023).

Evaluation and Feedback Loops

No formal mechanisms for periodic feedback or evaluation loops are currently in place.

In 2010, the Sri Lankan government formally emphasized the critical importance of monitoring and evaluation (M&E) in its National Health Promotion Policy (MoH, 2010), recognizing it as a foundational element for ensuring the effectiveness and accountability of health promotion interventions. However, more than a decade later, the operationalization of M&E remains an unfulfilled component of the national health promotion agenda. In the most recent strategic plan, M&E continues to be listed as one of the key strategic objectives, yet implementation progress appears limited. The Health Promotion Bureau (HPB) has acknowledged that monitoring and evaluation constitute an integral part of any successful plan or program, underscoring their role in evidence-based planning and continuous improvement. Nevertheless, the current strategy concedes that adequate tools and systems for M&E in health promotion are still lacking, and explicitly sets a target to develop and institutionalize these tools no later than 2026 (HPB, 2024). This timeline reflects both the recognition of existing gaps and the urgency of strengthening accountability mechanisms within the health promotion system.

There could be many potential reasons for underdevelopment of M&E process in health promotion sector. Siraj Mohamed (2023) pointed out that the Health Promotion Bureau (HPB) currently lacks qualified and competent personnel dedicated to monitoring and evaluation (M&E) functions. There is no officially designated individual or unit responsible for systematically carrying out M&E duties, resulting in a significant institutional gap. Moreover, among existing officers, M&E is often perceived as a fault-finding exercise rather than a constructive tool for learning and program improvement. This perception further hinders the establishment of a robust evaluation culture. In addition to these challenges, the absence of adequate budgetary support is a well-recognized constraint. Furthermore, the lack

of formal training in M&E methodologies, insufficient allocation of dedicated staff, and limited institutional emphasis on reflective policy learning collectively contribute to the current deficiency in conducting regular performance reviews and evidence-informed policy revisions. These structural and cultural barriers must be addressed if M&E is to be fully integrated into the health promotion system as a mechanism for accountability and continuous improvement.

3.5.3 Long-term care policies

Contexts

Sri Lanka is experiencing a demographic transition marked by rapid population ageing, with increasing demands for long-term care (LTC) services. In 1970, the country's total fertility rate was 4.39 and life expectancy stood at 64.4 years, contributing to a predominantly young population structure. By 2023, however, the fertility rate had declined to 1.97—below the replacement level—while life expectancy had risen markedly to 77.5 years (UNDESA, 2024). As a result, the proportion of the population aged 65 years or older, which was 10.8% in 2019, is projected to increase significantly to 15.4% by 2030 (UNDESA, 2019).

Traditionally, older adults in Sri Lanka have been cared for within the households of their adult children. However, this customary arrangement is increasingly being challenged by evolving socio-economic conditions (Watt et al., 2014). However, the country does not yet have a formal LTC system. Care provision remains predominantly informal, relying on family members—especially women—within a context of shifting socioeconomic conditions that increasingly strain traditional caregiving models.

While existing support includes NGO-led programs, private in-home services, and eldercare homes, these efforts are fragmented, unregulated, and insufficient in scope. Policy instruments such as the National Elderly Health Policy (2017) and the Protection of the Rights of Elders Act (2011) reflect emerging recognition of ageing-related challenges but fall short of establishing a coordinated LTC framework.

The absence of centralized governance, standardized eligibility criteria, trained workforce, and sustainable financing mechanisms highlights the urgency of comprehensive policy reform. Strengthening institutional capacity is essential to meet the evolving care needs of Sri Lanka's ageing population in an equitable and sustainable manner.

Governance

Long-term care legislation and strategy

As previously noted, older adults in Sri Lanka have traditionally been cared for within the households of their adult children, but this customary caregiving model is increasingly under strain due to shifting socio-economic dynamics (Watt et al., 2014). At present, however, Sri Lanka does not currently maintain an officially recognized national definition of long-term care (LTC), nor does it possess a comprehensive or institutionalized LTC system.

Existing services for older adults are fragmented and limited in scope, falling short of constituting a formal or integrated LTC framework. Moreover, the country lacks dedicated legislation or a unified national strategy explicitly focused on long-term care. Nonetheless, certain policy instruments and legal provisions offer indirect support and regulatory guidance in this domain. Notably, the Protection of the Rights of Elders (Amendment) Act 2011

outlines general principles for safeguarding the welfare of older persons, while the National Elderly Health Policy of Sri Lanka 2017 aims to promote healthy ageing and improve access to healthcare for the elderly. Although these frameworks reflect a growing awareness of the needs of the ageing population, they do not collectively amount to a coordinated LTC policy infrastructure and remain insufficient for meeting the complex and long-term support requirements of older adults in a systematic manner (ADB, 2021).

In addition, the existing legislation and policies do not strengthen the government's role in the care of older adults. Rather, they reaffirm the responsibility of family members to provide such care. For instance, the Protection of the Rights of Elders (Amendment) Act, No. 05 of 2011 explicitly states that it is the "duty and responsibility of children to provide care for, and to look into the needs of their parents." The role of the state is limited to providing shelter only for "destitute elders who are without children or are abandoned by their children." Furthermore, the Act includes provisions prohibiting children from willfully neglecting their duty of care toward their parents. In cases of such neglect, the Act authorizes the appointment of a Board to adjudicate matters concerning the maintenance and support of parents by their children (ILO, 2023).

Governance structure

The governance structure for long-term care (LTC) in Sri Lanka is characterized by fragmentation, with responsibilities dispersed across multiple government departments and agencies. In general, the Ministry of Health (MoH), in collaboration with the State Ministry of Primary Health Care, Epidemics, and COVID Disease Control, holds responsibility for policymaking and the formulation of LTC services for older adults. The National Secretariat for Elders (NSE), operating under the State Ministry, is tasked with coordinating these services, alongside the Youth, Elderly, Disabled and Displaced (YEDD) unit within the MOH. Additionally, the MOH is responsible for delivering medical and nursing care to older adults (ADB, 2021).

Financing

Expenditure

Comprehensive and disaggregated information on government financial flows directed toward the long-term care (LTC) sector in Sri Lanka remains largely unavailable, posing significant challenges to assessing public investment in this domain. Existing budgetary data do not isolate LTC-related expenditures from broader health or social welfare allocations, thereby limiting transparency and impeding informed policy planning. In parallel, there is a notable absence of systematic data collection regarding household-level expenditures on LTC services, including out-of-pocket payments, informal care costs, and caregiving burdens. This lack of financial visibility at both the institutional and household levels constrains the ability to evaluate the economic sustainability, equity implications, and fiscal efficiency of LTC provision, and ultimately hinders the formulation of evidence-based resource allocation strategies (ADB, 2021).

Revenue raising

In the absence of a formal long-term care (LTC) financing mechanism or comprehensive public support system, care for older adults in Sri Lanka is predominantly funded through out-of-pocket payments made by family members. This reliance on familial financial contributions reflects the country's strong cultural expectations around filial responsibility but also exposes households to considerable economic strain, particularly in cases involving prolonged or intensive care needs (ADB, 2021). Public funding for LTC institutions remains limited and is widely considered inadequate to meet even the basic requirements of residents, thereby compelling facilities to rely heavily on internally generated revenue and charitable donations (ILO, 2023). The lack of publicly funded LTC subsidies, insurance schemes, or safety nets places a disproportionate burden on families, often resulting in inequities in access to care and adverse financial consequences for caregivers. This informal and household-centered financing model underscores the urgent need for policy interventions to enhance affordability, reduce care-related impoverishment, and promote more equitable and sustainable LTC funding arrangements (ADB, 2021).

Pooling resources

Pooling mechanisms for long-term care (LTC) financing in Sri Lanka remain extremely limited, primarily due to the underdevelopment nature of the country's LTC system. In the absence of a formal LTC policy framework and dedicated financial infrastructure, there are no structured arrangements—such as social insurance, risk pooling, or dedicated budget lines—to systematically mobilize and allocate resources for the care of older adults. This lack of financial pooling not only impedes the redistribution of risk and cost across the population but also exacerbates inequalities in access to services, as care provision continues to rely heavily on individual or familial capacity to pay. The underutilization of pooling mechanisms reflects broader structural weaknesses in the institutional design of LTC and signals an urgent need for strategic reforms to ensure more equitable, sustainable, and efficient financing (ADB, 2021).

Purchasing goods and services

Sri Lanka currently lacks a dedicated public purchasing mechanism for long-term care (LTC) services. In the absence of a formalized system for the public procurement or commissioning of LTC, individuals are largely responsible for directly arranging and financing care through private market channels. Non-governmental organizations (NGOs) and charitable institutions have emerged as the principal providers of LTC services, often operating in a decentralized and resource-constrained environment. While these organizations play a crucial role in filling service gaps, the reliance on market-based procurement and non-state actors results in variable quality, uneven geographic distribution, and limited regulatory oversight. The absence of public purchasing not only restricts the government's capacity to influence service standards and equity in access but also highlights the need for institutional mechanisms that

can formalize and scale LTC provision in a more coordinated and sustainable manner (ADB, 2021).

Workforce

Existing Workforce

In Sri Lanka, the provision of long-term care (LTC) for older adults is predominantly undertaken by informal family caregivers and domestic workers, in the absence of a structured formal care system. The principal caregiver within the household is typically a female relative, reflecting deeply rooted gender norms and cultural expectations regarding caregiving responsibilities. This gendered caregiving burden often imposes significant physical, emotional, and economic strain on women, particularly in multi-generational households with limited external support. In parallel, domestic workers play a growing role in meeting LTC needs, with their qualifications and services varying widely. While some are untrained and hired primarily for their affordability, others possess basic to advanced training and provide more specialized nursing or personal care (ADB, 2021). Many facilities are staffed by underpaid employees who often lack the necessary skills and training, leading to persistently poor quality of care in a significant number of these homes (ILO, 2023). The largely unregulated nature of this informal care labor market raises concerns about the quality of care, the protection of both care recipients and workers, and the broader implications for equity and sustainability in the LTC sector. The reliance on informal and market-based caregiving arrangements underscores the urgent need for policies that support and professionalize the LTC workforce while addressing gender disparities in caregiving roles (ADB, 2021).

Capacity-building and professionalization

Sri Lanka currently lacks formal certification standards or nationally mandated training requirements for individuals providing long-term care (LTC), particularly in home-based settings. As a result, the regulation and professionalization of the LTC workforce remain minimal. Most in-home care agencies operate in an unregulated space, either offering limited, ad hoc training to new recruits or preferentially hiring individuals with prior caregiving experience, often acquired informally. This absence of standardized qualifications contributes to significant variability in the quality of care delivered and undermines efforts to ensure accountability and safety in service provision. Furthermore, without formal recognition or credentialing pathways, caregivers face precarious employment conditions and limited opportunities for career development. The establishment of a structured training and certification framework is therefore critical to enhancing service quality, protecting vulnerable care recipients, and building a competent and sustainable LTC workforce (ADB, 2021).

Likewise, there are currently no officially established mechanisms in Sri Lanka to support continuous learning, professional development, or career progression for personal care workers engaged in long-term care (LTC). In the absence of structured training pathways,

accreditation systems, or institutional support for skill enhancement, care workers have limited opportunities to upgrade their competencies or transition into more specialized roles within the health and social care sectors. This lack of investment in workforce development not only affects the quality and consistency of care provided to older adults but also contributes to the marginalization and devaluation of caregiving as a profession. The absence of clear career trajectories further discourages long-term workforce retention and undermines efforts to build a sustainable, skilled, and motivated LTC workforce (ADB, 2021).

Service Delivery

Eligibility and gatekeeping

Eligibility criteria and gatekeeping mechanisms for access to long-term care (LTC) services are not currently applicable in Sri Lanka, as the country has yet to establish a formal LTC system. In the absence of a structured framework, there are no standardized procedures—such as needs assessments, eligibility thresholds, or case management protocols—to determine who qualifies for services or to regulate the allocation of resources. Neither universal entitlement nor means-tested approaches have been institutionalized to guide access to care. As a result, access to existing LTC services, which are primarily informal or NGO-provided, depends largely on individual initiative, family capacity, and the availability of local resources. The lack of formal gatekeeping not only limits equity and efficiency in service delivery but also hinders the development of a coherent system of needs-based care provision. Establishing eligibility and gatekeeping structures would be a critical step in moving toward a more accountable, transparent, and equitable LTC system in Sri Lanka (ADB, 2021). Similarly, criteria for targeted coverage have not been institutionalized in the absence of formal LTC system. No official eligibility parameters or assessment tools exist to identify and triage vulnerable older adults. As a result, the delivery of care remains heavily reliant on informal networks and unregulated civil society support. The lack of systematic targeting mechanisms limits the state's capacity to direct limited resources toward high-need populations and highlights the urgency of incorporating equitable eligibility criteria into the architecture of any future LTC policy (ADB, 2021). Given this context, formal needs assessment and gatekeeping mechanisms remain not applicable in Sri Lanka. Their future development will be essential to enabling a scalable, just, and sustainable long-term care system.

Settings for public LTC support

Sri Lanka currently lacks a formal long-term care (LTC) system, and the available services are both limited in scope and institutionally fragmented. While comprehensive home-based care services are largely absent, a number of residential facilities for older persons are operated by the government; however, these institutions predominantly serve a sheltering function rather than providing structured LTC. Broadly, two types of residential facilities exist in Sri Lanka: the first offers basic accommodation for older individuals without adequate housing, and the second is intended to deliver long-term and nursing care. In practice, the vast majority of public facilities belong to the former category, emphasizing

custodial support over clinical or rehabilitative services. At present, only six elder care institutions are operated by the state nationwide. By contrast, the private sector is estimated to run approximately 20 residential care homes, which, unlike their public counterparts, are primarily oriented toward providing LTC and nursing services. Notably, these private facilities receive no financial assistance from the government, further reinforcing the fragmented and inequitable nature of the LTC landscape in Sri Lanka (ILO, 2023).

In addition to institutional care, a number of community-based and volunteer-led initiatives aim to support older persons. For example, HelpAge Sri Lanka implements peer-support programs that train older adults to assist one another. Privately delivered in-home nursing services are also available, though they vary significantly in both quality and cost depending on caregiver qualifications and regulatory oversight. Day-care centers providing social and recreational activities are supported by the National Secretariat for Elders (NSE) and non-governmental organizations (NGOs). Furthermore, many eldercare homes offer shelter but lack the capacity to deliver comprehensive medical or LTC services (ADB, 2021).

Despite the presence of these various initiatives, they remain largely uncoordinated and unregulated. Critically, Sri Lanka does not have an institutionalized framework for integrated or person-centered care. There is minimal coordination across the health, social welfare, and long-term care sectors, and key mechanisms such as multidisciplinary care planning or interoperable data-sharing systems have not been developed. Consequently, service provision is often fragmented and inadequate in addressing the complex, evolving needs of older adults in a holistic and sustainable manner (ADB, 2021).

Quality assurance

Home care providers that do not offer clinical services are not subject to official regulation. In contrast, in-home nursing care services are regulated by the Private Health Services Regulatory Council (PHSRC), which enforces compliance during registration renewals. Eldercare homes are required to obtain certification from the Sri Lanka Standards Institute (SLSI), which conducts routine inspections; however, registration has been suspended since 2015, and the implementation of revised standards remains uncertain (ADB, 2021).

Performance of long-term care service delivery

The performance of long-term care (LTC) service delivery in Sri Lanka remains difficult to assess due to the absence of a formal LTC system and the lack of systematically collected data. Nevertheless, available evidence and contextual indicators suggest that the current landscape is characterized by significant gaps in service coverage, quality assurance, and institutional accountability. Notably, there is no financial protection mechanism in place for LTC, meaning that individuals and families must absorb the full cost of care—typically through out-of-pocket payments or informal arrangements. This places a considerable economic burden on households, particularly those with limited resources. Moreover, a high level of unmet care needs is strongly anticipated, especially among older adults with chronic illnesses, functional impairments, or those lacking adequate family support. However, the

absence of national surveys, administrative databases, or epidemiological studies on LTC utilization and demand constrains the ability to quantify these gaps or to design targeted policy interventions. This data void also hinders efforts to monitor equity in access, assess the adequacy of informal caregiving arrangements, and evaluate outcomes for care recipients. Strengthening the evidence base and establishing performance indicators will be essential steps in developing an effective, equitable, and sustainable LTC system in Sri Lanka (ADB, 2021).

3.5.4 Conclusion

Sri Lanka's policy environment reflects an increasing recognition of the importance of promoting healthy ageing, yet both the health promotion and long-term care systems remain underdeveloped relative to the pace of demographic change. On the health promotion front, while the country has laid foundational strategies and demonstrated political commitment through settings-based approaches and intersectoral collaboration, significant gaps persist in the integration of gender, life-course orientation, and evidence-based performance monitoring—particularly with respect to older adults.

Similarly, Sri Lanka lacks a formal long-term care system, with existing arrangements largely informal, fragmented, and dependent on families—especially women. The absence of dedicated legislation, financing mechanisms, and workforce development structures poses critical challenges to equitable and sustainable care provision. Although civil society organizations and some policy instruments offer partial support, a coordinated national LTC framework remains urgently needed.

Moving forward, the development of integrated policies that bridge health promotion and long-term care, grounded in equity, accountability, and inclusion, will be essential to supporting Sri Lanka’s ageing population. Building institutional capacity, improving data systems, and fostering stakeholder collaboration will be key to translating demographic pressures into policy opportunities for healthy and dignified ageing.

References

- ADB. (2021). Country Diagnostic study on Long-term Care in Sri Lanka.
- HPB. (2024). The National Health Promotion Programme Sri Lanka - Strategic Plan 2024–2030.
- ILO. (2023). The care economy and decent work in Sri Lanka: Opportunities, challenges and future trends.
- MoH. (2010). National Health Promotion Policy.
- Siraj Mohamed, I. (2023). A Case Study on an Evaluation of the Annual Activity Plan 2019 of Health Promotion Bureau Sri Lanka. International Journal of Research and Review, 10(12), 35-443. https://doi.org/https://doi.org/10.52403/ijrr.20231248
- UNDESA. (2019). World Population Ageing 2019.
- UNDESA. (2024). World Population Prospects 2024, Online Edition. https://population.un.org/wpp/downloads?folder=Standard%20Projections&group=Most%20used
- Watt, M. H., Perera, B., Østbye, T., Ranabahu, S., Rajapakse, H., & Maselko, J. (2014). Care-giving expectations and challenges among elders and their adult children in Southern Sri Lanka. Ageing & Society, 34(5), 838-858.
- WHO. (2021). Sri Lanka Health System Review.

3.6 Vietnam

3.6.1 Introduction

Vietnam stands at a pivotal juncture in the development of its health system. A confluence of demographic, epidemiological, and socio-economic transformations is reshaping the nation's health needs and service delivery imperatives. The country is experiencing a rapid demographic shift toward an aging society—projected to become an "aged" society by the 20.30s (The World Bank, 2021)—which, combined with urbanization, industrialization, and lifestyle changes, has led to a steady rise in non-communicable diseases (NCDs) such as diabetes, hypertension, cardiovascular diseases, and cancers (Sang Minh Lê, 2024) (Quan & Taylor-Robinson, 2023). These emerging challenges necessitate a fundamental reevaluation of how Vietnam promotes health and provides care throughout the life course, particularly in the domains of preventive health and long-term care (LTC).

Recognizing the need to adapt to this shifting context, the Vietnamese government has set out a forward-looking agenda through initiatives such as the Vietnam Health Programme (2018–2030) (MOH Vietnam, 2018). This program embodies a comprehensive national commitment to enhancing the health of the population by prioritizing disease prevention, health promotion, environmental health, nutrition, physical activity, and mental health (UNDP) (Minh et al., 2016). The program also emphasizes the importance of intersectoral action, recognizing that health outcomes are influenced not only by clinical services but also by education, housing, transportation, labor, and social welfare systems (UNDP) (WHO WPR, 2018). This vision reflects global policy trends emphasizing the importance of social determinants of health and the growing recognition that health equity and population well-being are essential components of sustainable development.

However, turning this ambitious vision into reality remains a work in progress. The health promotion system in Vietnam faces several enduring limitations. Service delivery is often fragmented and under-resourced, particularly at the primary care level, where community-based and preventive services should ideally be most robust (The World Bank, 2019). There is also insufficient capacity for health education and behavioral change communication, which are critical for addressing modifiable risk factors such as tobacco use, alcohol consumption, poor diet, and physical inactivity (Minh et al., 2016) (Quan & Taylor-Robinson, 2023). Moreover, Vietnam's decentralized health governance system presents coordination challenges, as roles and responsibilities across central, provincial, and district levels remain blurred or inconsistent (UNDP) (Pardoel et al., 2023).

At the same time, the provision of LTC—defined broadly as a range of services to meet the personal and health-related needs of people who are dependent due to age, chronic illness, or disability—is still in its nascent stage in Vietnam. The country does not yet have a comprehensive or unified LTC policy or system (The World Bank, 2021). Care for older people is predominantly provided by families, particularly women, without formal support or training (Long & Pfau, 2009). This heavy reliance on informal care creates a double burden for working-age caregivers, particularly in urban areas where traditional family structures are changing (Giang, 2013). Institutional care services, such as nursing homes, remain limited in number and accessibility, with most concentrated in urban centers and primarily operated by private or religious organizations (Dung et al., 2020). Community-based models, including

day-care centers or home-based services, are emerging but remain scattered and underfunded (Pardoel et al., 2023) (The World Bank, 2021).

Financing also remains a critical constraint. Vietnam has made considerable progress in expanding health insurance coverage under the Social Health Insurance (SHI) scheme. Still, preventive services and long-term care are not systematically included in benefit packages (The World Bank, 2021). Public funding for health promotion is limited, and LTC receives minimal attention in both central and local budgets (The World Bank, 2019) (Quan & Taylor-Robinson, 2023). The lack of sustainable financing mechanisms hinders the development of professional LTC services and discourages investment in innovative, community-based models (The World Bank, 2021).

The health workforce, particularly in the area of LTC, is another key area of concern. Vietnam faces shortages of trained personnel, such as geriatricians, rehabilitation therapists, and care aides, with skills relevant to elder care and chronic disease management (Leong et al., 2021). There are few formal pathways for workforce development in this sector, and limited incentives to retain qualified personnel in rural or underserved areas (The World Bank, 2021). Furthermore, professional caregivers often face low pay, poor working conditions, and restricted social recognition, which further undermines the sector's growth. (U.S. Goverment, 2024)

To address these challenges and capitalize on the opportunities presented by current demographic trends, a systems-based and person-centered approach to health promotion and long-term care (LTC) is urgently needed. Vietnam should shift its focus from disease treatment models to an integrated strategy that prioritizes prevention, early intervention, and coordinated care (Quan & Taylor-Robinson, 2023). It should also invest in institutional and human capacity, ensure sustainable financing, and support innovations in service delivery that are culturally appropriate, locally adapted, and inclusive of vulnerable populations.

This report provides an in-depth analysis of Vietnam's health promotion and LTC systems. Using a structured policy framework, it examines six critical components: (1) policy foundations and strategic vision, (2) governance and institutional arrangements, (3) financing mechanisms and resource allocation, (4) workforce development and capacity, (5) service delivery models and infrastructure, and (6) monitoring, evaluation, and learning systems. Each section synthesizes current status, identifies key gaps and opportunities, and highlights relevant international examples that may offer policy insights for Vietnam.

3.6.2 Healthy ageing policies

Context

Vietnam's health system has achieved significant progress over the past several decades, marked by sustained improvements in life expectancy, maternal and child health, infectious disease control, and near-universal vaccination coverage. These accomplishments have been made possible through relatively modest public spending, strong political commitment to primary health care, and the effective rollout of Social Health Insurance (SHI), which now

covers the vast majority of the population (World Health Organization, 2021b) (Pardoel et al., 2023). As a result, Vietnam has outperformed many countries at comparable income levels in moving toward universal health coverage (UHC).

However, the health challenges facing Vietnam today are more complex and multifaceted than those of the past. The country is undergoing a rapid epidemiological transition, characterized by the increasing prevalence of NCDs, while experiencing significant demographic, socioeconomic, and environmental shifts. NCDs now account for approximately 77% of all deaths nationally, with cardiovascular diseases, cancer, diabetes, and chronic respiratory illnesses emerging as leading causes of morbidity and mortality (MOH Vietnam, 2018). These chronic conditions are increasingly linked to modifiable behavioral risk factors, such as tobacco and alcohol use, unhealthy diets, physical inactivity, and rising levels of overweight and obesity, particularly among working-age adults and urban populations (Leong et al., 2021).

Vietnam's health system, historically centered on infectious disease control and acute care, is not yet fully adapted to these long-term and preventive care needs. Preventive health services continue to receive a disproportionately small share of national health expenditures, and service delivery remains skewed toward curative, hospital-based models. As a result, population-level interventions for health promotion—such as behavior change communication, screening and early detection, and community-based risk reduction—are inconsistently implemented and often heavily reliant on external funding (Quan & Taylor-Robinson, 2023).

Compounding the epidemiological burden are emerging environmental and occupational health risks, including exposure to air pollution, food safety concerns, and climate-sensitive health threats such as dengue and zoonotic disease outbreaks. These risks are intensified by rapid urbanization and industrialization, which have outpaced the development of public infrastructure in many settings. The capacity of local health systems to detect, prevent, and respond to these challenges remains uneven, especially in disadvantaged or remote areas.

Simultaneously, Vietnam is undergoing deep sociodemographic and structural transformations. Urbanization, changing labor markets, and increasing female labor force participation have altered traditional household dynamics, with implications for health behaviors and access to care. Fertility decline and shifting family structures have also reduced the availability of informal support, increasing the need for formal and community-based health promotion strategies across the life course.

Although Vietnam is still a relatively young country demographically, its population is aging rapidly, which has implications for how health promotion must be designed and delivered. A growing share of older adults now live with multiple chronic conditions and functional limitations, requiring integrated preventive, medical, and social services. While the LTC system is still in its early stages, the importance of healthy aging, achieved through risk factor management, age-friendly environments, and lifelong health literacy, has become a strategic imperative for health promotion policy.

Vietnam has acknowledged many of these challenges in its national strategies, notably the Vietnam Health Programme (2018–2030) and the National Strategy for NCD *Prevention and Control*. These frameworks emphasize life-course health, reduction of behavioral risk factors, and intersectoral collaboration. However, implementation has been constrained by

fragmented governance, vertical programming, weak local health capacities, and insufficient integration of health promotion into the primary care system. Preventive services are often delivered as stand-alone campaigns rather than as institutionalized components of health service delivery. Moreover, they are inconsistently covered by SHI, which limits provider incentives to prioritize prevention over treatment.

Ultimately, effective health promotion in Vietnam will depend not only on the health sector but also on coordinated action across various sectors, including education, transportation, labor, housing, and agriculture. Risk factors for poor health are shaped by structural and social determinants that extend far beyond clinical settings. Yet inter-ministerial coordination mechanisms remain underdeveloped, and health-in-all-policies approaches are not systematically enforced at the provincial or district levels (Pardoel et al., 2023) (UNDP).

Policy Foundations

Vietnam's policy foundations for health promotion and long-term care (LTC) are grounded in a strategic commitment to prevention, life-course health, and social inclusion. National frameworks, such as the Vietnam Health Programme (2018–2030) and the National Action Program on Aging (2021–2030), reflect a growing consensus on the need to address health holistically across all life stages. However, despite strong normative intent, the realization of these policies is constrained by fragmented implementation, underinvestment, and weak cross-sectoral coordination.

Goal Setting

Vietnam has set national targets to increase healthy life expectancy, reduce behavioral risk factors, and improve population well-being. These goals are broadly aligned with the Sustainable Development Goals (SDGs) and reflect a multidimensional understanding of health. However, implementation frameworks often lack the necessary granularity to drive inclusive outcomes.

The National Action Program on Aging highlights the growing demands for care but does not specify measurable objectives for gender equity, caregiver burden, or geographic disparities (World Bank Group, 2024). The absence of disaggregated data systems and equity-linked performance indicators weakens accountability and limits the responsiveness of policy to vulnerable populations.

GEDSI (Gender, Equity, Diversity, and Social Inclusion)

Vietnam's healthy ageing agenda signals equity intentions in the Vietnam Health Programme (2018–2030) and elder care strategies, yet gaps persist in who benefits and how progress is measured. Women continue to shoulder the majority of unpaid and low-paid elder care, often with limited formal training and protection, thereby reinforcing gendered economic risks (UNFPA, 2021). Urban–rural and provincial disparities persist under decentralized delivery

and financing, with formal services concentrated in social protection centers and community pilots that are unevenly scaled (Pardoel et al., 2023). Legal recognition via the Elderly Law (2009) has not yet translated into standardized benefits, caregiver supports, or routine disaggregation of outcomes by gender, disability, ethnicity, or income (ILO, 2010). Community models—especially Intergenerational Self-Help Clubs—show promise for inclusive outreach, women's leadership, and home-based support but rely on project funding and remain outside core public financing (Pardoel et al., 2023).

Life-Course Orientation

Vietnam has formally embraced a life-course approach, recognizing that health and care needs evolve from early childhood to old age. The Vietnam Health Programme outlines age-specific interventions, ranging from school-based health education and adolescent risk reduction to adult NCD screening and support for older adults (MOH Vietnam, 2018; UNICEF, 2020). This approach positions Vietnam to address both demographic aging and the shifting burden of disease.

In practice, however, integration across age-specific services remains limited. Programs for older adults, for instance, are often delivered through social protection channels under MOLISA, disconnected from MOH-led preventive services. This institutional separation undermines continuity of care and misses opportunities for upstream interventions that could delay or reduce the need for LTC.

Shift to Prevention

Prevention is a central component of Vietnam's health strategy, with an emphasis on early detection, risk reduction, and community-based interventions. Screening initiatives for hypertension, diabetes, and certain cancers have been scaled up, and community health stations serve as key delivery platforms for preventive services.

However, these services remain underfunded and inconsistently integrated into routine health system operations. Prevention continues to receive a small share of the national health budget, and many programs are driven by short-term external funding. Challenges include workforce shortages, inadequate provider incentives, and weak data infrastructure at the local level (Quan & Taylor-Robinson, 2023).

Evidence-Based Risk Factor Prioritization

Vietnam's policy agenda is informed by national burden-of-disease (BOD) evidence, with tobacco, alcohol, poor nutrition, and physical inactivity identified as key modifiable risks. Tobacco control has seen the most substantial institutional response: the Law on Prevention and Control of Tobacco Harms (2013) established the Vietnam Tobacco Control Fund (VNTCF), funded by a 1% industry levy and used to finance national campaigns, research, and local initiatives (Minh et al., 2016) (World Health Organization, 2021b).

Other risk factors, however, lack comparable legal or financial backing. Alcohol control, dietary improvement, and promotion of physical activity remain fragmented and under-resourced. This creates gaps in Vietnam's ability to address the growing burden of NCDs and achieve a balanced approach to risk reduction.

Policy Alignment

Vietnam's health and aging strategies are conceptually well-aligned with national development plans and international frameworks, including the SDGs. The Vietnam Health Programme promotes inter-ministerial cooperation and advocates for collaboration across various sectors, including education, transport, housing, and labor.

Despite this high-level alignment, operational coordination is weak. Ministries operate within siloed mandates, with limited joint planning or pooled financing. At the local level, coordination is rare, often confined to externally funded pilot initiatives. Community-based models, such as the Intergenerational Self-Help Clubs (ISHCs), which provide integrated health, social, and financial services for older adults, demonstrate the potential of cross-sectoral approaches. However, ISHCs remain outside public systems and are heavily reliant on donor support (Pardoel et al., 2023) (World Bank Group, 2024).

Policy Governance and Funding Structure

Vietnam's health promotion system operates under a decentralized yet fragmented governance and funding architecture. While national leadership is in place through the Ministry of Health (MOH), and coordination efforts are referenced in key strategies, institutional silos, weak inter-ministerial integration, and uneven subnational capacity continue to limit the effectiveness and equity of health promotion delivery, especially as needs evolve with population aging.

Lead Institutions

The MOH serves as the lead institution for health promotion, primarily through its Department of Preventive Medicine and the General Department of Population and Family Planning. These agencies are responsible for establishing national standards, implementing health campaigns, and collaborating with provincial health departments. In parallel, the Ministry of Labour, Invalids, and Social Affairs (MOLISA) leads efforts in elder care and social assistance, often addressing the health needs of older adults from a social protection standpoint (UNDP) (UNFPA, 2021).

However, the lack of a unified governance framework for health promotion across the life course—and particularly for older persons—leads to siloed planning and delivery. While MOH manages NCD screening and health education, MOLISA implements home care and subsidy programs, often without shared data systems, performance metrics, or referral

mechanisms (Pardoel et al., 2023). This bifurcation impairs coordination and weakens the development of integrated, person-centered prevention strategies.

Multisectoral Collaboration

Vietnam's health policy frameworks, including the Vietnam Health Programme and the National Action Program on Aging, explicitly endorse intersectoral action, aligning with the Sustainable Development Goals (SDGs) and the Health in All Policies (HiAP) approach. These strategies highlight the contributions of non-health sectors, such as education, labor, housing, and transportation, in shaping health outcomes (UNDP) (WHO WPR, 2018).

In practice, multisectoral collaboration remains limited and inconsistent. Coordination across ministries is often ad hoc or donor-driven. Joint planning, budgeting, or implementation mechanisms are rare, particularly at the provincial and district levels where service delivery occurs. The absence of formal inter-ministerial bodies, pooled funding arrangements, and cross-sectoral indicators undermines implementation and accountability (Pardoel et al., 2023). Strengthening governance will require institutional mechanisms—such as steering committees and performance-linked incentives—to turn collaborative rhetoric into operational reality.

Decentralization

Vietnam's decentralized governance structure empowers provincial People's Committees to plan, budget, and deliver health promotion activities. This approach enables localized responses to community needs but has led to significant disparities in implementation capacity. Provinces with strong leadership or external funding have introduced innovative community-based prevention programs; others, particularly in rural or remote areas, struggle with workforce shortages, technical capacity gaps, and limited fiscal resources.

A notable community-led initiative is the Intergenerational Self-Help Clubs (ISHCs), supported by the Vietnam Association of the Elderly and development partners. These clubs provide health education, screenings, and home-based support while promoting elder empowerment and women's leadership (Pardoel et al., 2023) (World Bank Group, 2024). Although successful in some provinces, they are not integrated into the formal health system and rely heavily on NGO or donor financing, underscoring the risks of unsustainable and fragmented innovation.

Funding Mechanisms

Vietnam's health promotion financing is fragmented across central government allocations, provincial budgets, household out-of-pocket spending, and donor contributions. Preventive services receive a relatively small share of the MOH's budget and are often deprioritized in favor of curative care. Provinces are expected to co-finance activities, but outcomes vary widely depending on local fiscal capacity and leadership.

A rare example of sustained health promotion funding is the Vietnam Tobacco Control Fund (VNTCF), established through a 1% industry levy mandated under the 2013 Law on Tobacco Harms (Minh et al., 2016). The VNTCF finances anti-smoking campaigns, education programs, and surveillance, demonstrating the potential of earmarked, ring-fenced funding for public health.

Other priority areas, such as alcohol use, poor nutrition, and physical inactivity, lack similar financial backing. Preventive services are inconsistently covered by the Social Health Insurance (SHI) scheme, which limits provider incentives for early detection and counseling. As a result, many health promotion initiatives are implemented as one-off campaigns or donor-supported pilots, not as core health system functions.

Although Vietnam lacks a dedicated long-term care financing mechanism, the financing challenges in LTC offer important parallels for health promotion. Funding for elder care remains fragmented across modest public subsidies, NGO initiatives, and private household contributions (UNFPA, 2021) (Giang et al., 2019). As with preventive services, reliance on family caregiving, especially by women, is high, and formal service options are scarce.

This reinforces the need for upstream investment in healthy aging and prevention, including routine screenings, lifestyle interventions, and community support for older adults. A stronger financial foundation for health promotion could reduce future LTC costs and enable more equitable aging-in-place strategies.

Policy Implementation

Vietnam's health promotion and long-term care (LTC) systems incorporate a range of policy implementation mechanisms, emphasizing community-level engagement, local service delivery innovation, and the active participation of older adults. While national policies provide strategic direction, implementation relies heavily on provincial leadership, grassroots mobilization, and informal caregiving networks. Three key areas—health workforce involvement, local resource engagement, and older adult participation—illustrate how policy translates into practice, revealing both promising models and persistent operational gaps.

Health workforce involvement

Vietnam has taken steps to strengthen the role of primary health care (PHC) and community health workers in preventive services and elder care. National efforts include the development of service cost norms at the district and community levels to guide home-based and community-based health delivery (Leong et al., 2021) (The World Bank, 2019). This approach is designed to support the integration of preventive and long-term services into routine primary health care (PHC) functions, especially for vulnerable populations, such as the elderly.

In parallel, the Intergenerational Self-Help Clubs (ISHCs) represent an innovative model of community-based service delivery. Supported by local associations and international partners, ISHCs mobilize volunteers to provide basic home care, social support, legal assistance, and

health promotion activities (Pardoel et al., 2023). These clubs offer a complementary workforce that extends the reach of formal health services, particularly in settings with limited public health infrastructure. However, their long-term sustainability remains uncertain in the absence of formal recognition and public financing.

Incentives for local resource engagement

Vietnam has employed various strategies to engage local resources and promote community empowerment, particularly through the involvement of local governments and mass organizations. These actors have been central to health promotion campaigns and public hygiene initiatives. A key example is their role in creating demand for sanitation and clean water services through household-level education and awareness programs (UNICEF, 2020) (MOH Vietnam, 2018). These efforts have contributed to behavioral changes and improved health outcomes, particularly in rural and underserved areas.

This bottom-up approach underscores the importance of social mobilization in Vietnam's health strategy. By leveraging existing community structures, local authorities can deliver culturally appropriate messages and generate collective action around public health goals. However, such efforts are often project-dependent and not uniformly institutionalized across regions.

Strategies for older adults

A participatory approach is increasingly recognized as vital in the design and delivery of services for older adults in Vietnam. At the community level, planning processes often involve older persons directly, primarily through their engagement with ISHCs and local elder associations (Pardoel et al., 2023) (United Nations). These platforms give older adults a voice in shaping programs that affect their lives, including decisions on health promotion activities, caregiving support, and social participation initiatives.

Such participatory mechanisms not only strengthen service relevance but also promote active aging and social cohesion. Involving older adults in decision-making reinforces their roles as contributors to community resilience, rather than passive recipients of care. However, participatory approaches remain uneven in scope and scale, with limited formal integration into provincial planning frameworks or budget processes.

Monitoring and Performance

Vietnam's monitoring and performance systems for health promotion are evolving, with a growing reliance on routine health information systems, national surveys, and external evaluations. However, the system remains constrained by limited use of standardized indicators, fragmented data flows, and weak feedback mechanisms for policy learning and adaptation. Strengthening the alignment between data collection, performance review, and

decision-making remains a critical area for system improvement (MOH Vietnam, 2024) (The World Bank).

Standardized indicators

The Ministry of Health (MOH) publishes the *Vietnam Health Statistics Yearbook* annually as the country's primary source of national health data. While this publication consolidates a wide range of administrative health statistics, serving as a national reference, it often lacks a targeted focus on priority indicators. Key health promotion and LTC metrics—such as service coverage, risk factor trends, and aging-related indicators—are not consistently highlighted or disaggregated (MOH Vietnam, 2024). As a result, the Yearbook does not always facilitate strategic decision-making or timely policy adjustments.

Moreover, the absence of clearly defined and widely adopted core national performance indicators in areas such as elder health, preventive service uptake, and community-based care limits the ability of national and provincial authorities to track progress toward health system goals. Without a standardized, outcome-oriented performance framework, monitoring remains descriptive mainly and does not effectively guide planning, investment, or evaluation.

Data and monitoring sources

Vietnam's health data landscape draws on several institutional sources, including MOH-managed health information systems and national survey data coordinated by the General Statistics Office (GSO). These include routine administrative data from hospitals and health centers, as well as large-scale household surveys such as the Multiple Indicator Cluster Survey (MICS) and Vietnam Household Living Standards Survey (VHLSS) (UNICEF, 2020) (MOH Vietnam, 2024). These sources collectively provide a foundational basis for monitoring the health system.

However, data flows are often siloed, and integration across sectors remains weak. For example, health information systems typically do not incorporate social care or LTC data, making it difficult to obtain a comprehensive picture of elder care service coverage or quality. Additionally, discrepancies between administrative records and survey findings can complicate interpretation and reduce confidence in the reliability of the data (World Health Organization, 2021b). Investing in interoperable digital systems, capacity-building for data analysis, and stronger linkages between health and social sector databases may be critical to enhancing monitoring precision.

Evaluation and feedback loops

Vietnam benefits from periodic reviews of its health system performance through UN- and donor-supported mechanisms, including evaluations conducted in collaboration with agencies such as UNICEF and WHO. These reviews typically utilize Vietnam's own administrative

and household survey data, focusing on progress toward global targets, such as UHC, NCD prevention, and health equity (World Health Organization, 2021b) (MOH Vietnam, 2024).

While such external reviews provide valuable technical support and benchmarking, they are often conducted independently of internal ministry-led evaluation processes. Furthermore, there are limited formal mechanisms to ensure that insights from evaluations are effectively incorporated into policy revisions, budgeting, or program redesign. In many cases, policy responses to monitoring results are slow or fragmented, particularly at the subnational level, where the capacity to interpret and act on data may be lacking.

To improve accountability and system responsiveness, Vietnam will need to institutionalize feedback loops that link performance monitoring to actionable planning. This includes establishing regular review cycles, cross-sectoral learning platforms, and province-level reporting formats that translate data into clear operational guidance.

3.6.3 Long-term care policies

Context

Vietnam has achieved remarkable progress in improving population health over the past several decades. Since the *Doi Moi* reforms of the late 1980s, the country has transformed its health sector and dramatically improved health outcomes across multiple domains. Life expectancy increased steadily to reach 73.6 years by 2022, a testament to successful investments in public health infrastructure, infectious disease control, maternal and child health services, and the rapid expansion of social health insurance (World Health Organization, 2021b) (Leong et al., 2021). Infant and maternal mortality rates have declined, vaccination coverage is near-universal, and most of the population is now enrolled in the national Social Health Insurance (SHI) scheme. These achievements have enabled Vietnam to outperform many countries at similar income levels and to move closer to achieving universal health coverage (The World Bank).

However, these historical gains now face mounting pressure from a new set of demographic, epidemiological, and social challenges. A defining feature of Vietnam's current health transition is the rapid aging of its population. As of 2022, around 13% of the population was aged 60 or older. This proportion is projected to rise to over 20% by 2045, officially marking Vietnam's transition into an "aged" society (UNFPA, 2021) (United Nations). Unlike many high-income countries that experienced this shift over several decades, Vietnam's aging process is occurring at a much faster pace and lower income level—a phenomenon often described as "growing old before growing rich." This demographic shift will have profound implications for health, social protection, labor markets, and family dynamics (Giang et al., 2019).

As life expectancy increases, older adults are living longer with chronic conditions, functional limitations, and multimorbidity. Meeting their needs requires not just acute care but integrated systems that encompass prevention, rehabilitation, and long-term care (LTC), including home-, community-, and facility-based services (Help Age International) (The World Bank, 2019). However, Vietnam's current health and social systems are still primarily oriented toward acute, episodic care, and formal LTC services remain underdeveloped, underfunded, and unequally distributed (UNFPA, 2021) (World Health Organization, 2021b).

Vietnam also faces the double burden of disease, with persistent infectious diseases (e.g., tuberculosis, dengue, zoonotic outbreaks) coexisting with rising NCDs, which now account for approximately 77% of all deaths (MOH Vietnam, 2018). Key contributors include cardiovascular disease, cancer, diabetes, and chronic respiratory conditions. These require continuous, coordinated care, but existing systems are not well-equipped to provide it. Behavioral risk factors such as tobacco use, alcohol consumption, unhealthy diets, and physical inactivity further exacerbate the situation (MOH Vietnam, 2018) (Leong et al., 2021).

These health system pressures are compounded by profound socioeconomic and cultural shifts that are reshaping traditional caregiving arrangements. Declining fertility rates—now below replacement level—combined with smaller family sizes and growing rural-to-urban migration, are eroding the family's capacity to serve as the primary provider of elder care

(UNFPA, 2021). Urbanization has led to increased geographic separation between generations, weakening intergenerational support networks. Simultaneously, rising female labor force participation and increased household economic demands mean that women, who have traditionally borne the brunt of unpaid care work, are less available to provide full-time support to aging relatives. As a result, many older adults, particularly those in rural areas or from low-income households, are increasingly at risk of isolation, neglect, and unmet health and social needs (Pardoel et al., 2023).

The traditional reliance on informal caregiving is no longer sufficient to meet the complex and increasingly demanding needs of an aging population. Families face mounting pressures, and without formal LTC infrastructure, many are forced to shoulder the costs of home-based care, private services, or forgo employment opportunities (HelpAge International). In some cases, older adults rely on similarly aged spouses or community volunteers for care, further underscoring the fragility of existing systems.

These interlocking trends—demographic aging, epidemiological transition, and shifting family structures—necessitate a cohesive and forward-looking policy response. Vietnam's continued progress in health will depend on its ability to adapt its systems to meet new realities. This entails transitioning from a disease-focused, treatment-centric model to one that prioritizes prevention, health promotion, and person-centered care throughout the life course (World Health Organization, 2021b) (MOH Vietnam, 2018). It also means building a formal LTC system that is accessible, equitable, and sustainable, anchored in community-based models, supported by trained personnel, and adequately financed through public and insurance-based mechanisms (The World Bank) (Pardoel et al., 2023).

Effective LTC development also requires bridging the divide between health, social protection, and labor policies. The well-being of older adults is shaped not only by healthcare access but also by factors such as pension adequacy, housing, mobility, and social inclusion (UNFPA, 2021) (United Nations). Building an age-responsive system will require intersectoral governance, integrated data systems, and meaningful engagement of older persons in policy design (Pardoel et al., 2023) (HelpAge International).

The Vietnamese government has acknowledged many of these challenges through policy instruments, including the Vietnam Health Programme (2018–2030), the National Strategy on Prevention and Control of NCDs, and the National Action Program for the Elderly (MOH Vietnam, 2018) (MOH Vietnam, 2018). These frameworks lay the necessary groundwork for more inclusive, life-course-oriented planning. However, implementation is hindered by fragmented governance, insufficient financing, and limited provincial and local capacity (World Health Organization, 2021b). While community-based innovations, such as Intergenerational Self-Help Clubs (ISHCs), offer promising models, they are not yet integrated into national systems or supported at scale (Pardoel et al., 2023).

Governance

Vietnam's LTC system operates within a governance framework that is evolving but remains fragmented and underdeveloped. While recent policy efforts reflect a growing awareness of the needs of the aging population, the country still lacks a comprehensive legal and institutional framework to support the delivery of integrated, equitable, and sustainable LTC

services(Pardoel et al., 2023; World Health Organization, 2021b). Two critical components—legislative and strategic direction, and institutional governance structure—illustrate both the progress made and the challenges that persist.

Long-term care legislation and strategy

Vietnam currently lacks a dedicated law on long-term care, which creates uncertainty around institutional responsibilities, financing commitments, and service entitlements. Instead, the LTC policy environment is shaped by broader legal and policy frameworks. Chief among them is the Elderly Law (2009) (ILO, 2010), which formally recognizes the rights of older persons and defines the roles of families, communities, and the state in providing support for elder care. While this law marks a vital acknowledgment of aging as a social issue, it does not establish detailed provisions for formal care delivery, service standards, or financial protections (Long & Pfau, 2009; UNFPA, 2021).

In a more recent development, the government approved the National Strategy for the Elderly (2025–2035) in March 2025. This strategy represents a significant step forward, emphasizing the need to enhance employment opportunities, access to healthcare, and social welfare for Vietnam's aging population. The plan emphasizes cross-sectoral goals, including promoting healthy aging, expanding age-friendly environments, and supporting independent living (Pardoel et al., 2023). However, it remains aspirational mainly, offering broad objectives without clearly defined mechanisms for implementation, financing, or inter-ministerial coordination. As such, the absence of a legally binding LTC framework continues to limit the coherence and enforceability of elder care policies in Vietnam (World Health Organization, 2021b) (HelpAge International).

Governance structure

LTC governance is divided between the Ministry of Health (MOH) and the Ministry of Labour, Invalids and Social Affairs (MOLISA). The MOH oversees healthcare services, including prevention, NCD management, and rehabilitation, while MOLISA is responsible for social protection and public elder care facilities (MOH Vietnam, 2018). This sectoral split weakens policy coherence, undermines service integration, and creates accountability gaps.

There is no central coordinating body to align efforts across ministries. As a result, health and social services often operate in parallel, with little collaboration on planning, budgeting, or case management (Pardoel et al., 2023) (World Health Organization, 2021b). For example, while MOH may provide preventive screenings and medical follow-up, MOLISA may separately manage income support and residential care, without mechanisms for shared planning or joint case management.

At the subnational level, provincial and district authorities are responsible for implementing these measures. However, varying capacity, resource constraints, and fragmented reporting lines make coordination difficult ((Leong et al., 2021; Long & Pfau, 2009). Decentralization adds flexibility but also reinforces systemic fragmentation in the absence of national-level integration mechanisms.

Financing

Vietnam's long-term care (LTC) financing system remains underdeveloped, lacking a coherent structure to support the growing needs of an aging population. Current financing mechanisms rely heavily on general government revenues and informal caregiving, with limited financial protection for older adults or their families. The absence of a dedicated LTC insurance scheme, standardized benefit packages, and pooled funding structures contributes to regional disparities and underfunded services (Long & Pfau, 2009; UNFPA, 2021). This section examines five key financing dimensions: expenditure levels, benefit coverage, revenue generation, resource pooling, and purchasing arrangements.

Expenditure

Precise data on public and private LTC expenditures in Vietnam remain scarce. While total health expenditure reached approximately 4.6% of GDP in 2022, LTC-specific spending is not separately tracked in national health accounts or budget reports(World Health Organization, 2021b). Available estimates suggest that LTC services are severely underfunded, with average public expenditure amounting to only around USD 35 per person per month in limited pilot or institutional care settings (Pardoel et al., 2023). This level of investment is insufficient to cover comprehensive personal care, rehabilitation, or home-based services, particularly for individuals with multiple chronic conditions or functional limitations.

The lack of disaggregated financial data also makes it challenging to evaluate equity in spending across population groups, provinces, or service types. Without visibility into how resources are allocated and used, strategic planning for LTC expansion and quality improvement remains constrained.

Revenue raising

Vietnam's LTC financing is supported through a combination of general taxation, social health insurance contributions, and out-of-pocket payments by households. However, there is no dedicated LTC insurance scheme or earmarked public funding line for elder care. Social health insurance, while extensive in coverage for curative services, offers minimal reimbursement for preventive, rehabilitative, or long-term care services, leaving significant financial burdens on families (Long & Pfau, 2009) (Leong et al., 2021).

Because LTC funding competes with other health and welfare priorities, it is often underprioritized in national and local budgets. In practice, the majority of resources for elder care come either from charitable organizations or individual households, further exacerbating inequities for low-income or rural populations (HelpAge International).

Pooling resources

Vietnam operates a decentralized model of health and social service financing, with provincial governments responsible for managing budgets and allocating resources based on local priorities. While this allows for flexible implementation, it has led to substantial disparities in LTC availability and quality across regions (MOH Vietnam, 2018). Provinces with stronger revenue bases or donor engagement can fund more comprehensive care models, whereas poorer or remote areas struggle to sustain even basic institutional care.

There is no national-level pooling mechanism specifically for LTC funding that could promote redistribution or cross-subsidization across provinces. The absence of pooled risk-sharing or reallocation strategies hinders the development of a uniform national care system and leaves localities dependent on uneven financial capacities (Pardoel et al., 2023).

Purchasing goods and services

A mix of public and non-state providers delivers LTC services in Vietnam, including social protection centers, local NGOs, and community-based organizations. Public units receive direct financing from government budgets. At the same time, non-state actors typically operate with indirect support, such as subsidized facilities, grants, or donor funds, based on the services they provide (HelpAge International). For example, Intergenerational Self-Help Clubs (ISHCs) are financed through hybrid funding models, including grants from the Japan Social Development Fund and the World Bank, government support, membership fees, revolving loan schemes, community donations, and income-generating activities. These clubs are explicitly oriented toward supporting disadvantaged older adults and women caregivers, representing one of the few community-based models with a financing structure that integrates external and domestic resources (World Bank Group, 2024).

However, strategic purchasing arrangements are underdeveloped. There is no performance-based financing system or contractual mechanism that ties payments to care quality, outcomes, or client satisfaction. Most service providers are reimbursed through fixed-budget allocations or lump-sum grants, without incentives for innovation, efficiency, or person-centered care. Establishing results-based financing and quality-linked payment models would enhance service delivery and accountability, particularly as Vietnam explores scalable community-based care alternatives (Long & Pfau, 2009) (The World Bank, 2021).

Workforce

Vietnam's long-term care (LTC) workforce is characterized by informal caregiving, a limited presence of professional care workers (PCWs), and weak institutional support for training and career development. As the demand for elder care rises, these constraints pose significant barriers to scaling equitable and quality services. This section examines three key workforce dimensions: the existing caregiver landscape, capacity-building and training initiatives, and professional development pathways for care workers.

Existing workforce

Vietnam's LTC system remains heavily dependent on unpaid and informal care, primarily provided by family members and community volunteers. In most households, caregiving responsibilities fall disproportionately on women—daughters, daughters-in-law, or spouses, who often balance care duties with other work or family obligations (UNFPA, 2021). In rural areas, where institutional care options are scarce or absent, this reliance is even more pronounced.

Formal caregiving roles are limited, both in number and in institutional recognition. The current public health system lacks a professional cadre of long-term care workers, and social protection centers are consistently understaffed (Pardoel et al., 2023). As a result, care recipients may not receive sufficient support for activities of daily living, managing chronic conditions, or maintaining emotional well-being. This shortage of trained personnel reflects broader systemic underinvestment in LTC workforce planning and human resources (Long & Pfau, 2009).

Community-based initiatives, such as Intergenerational Self-Help Clubs (ISHCs), partially fill this gap by mobilizing older volunteers and neighbors to provide basic home-based services. While these efforts promote social cohesion and offer low-cost models of support, they are not substitutes for professionally trained caregivers capable of delivering complex or medical care. (HelpAge International)

Capacity-building and professionalization

Vietnam has seen modest progress in caregiver training, primarily driven by civil society organizations. Non-governmental actors such as HelpAge International have implemented basic training programs for community volunteers, focusing on essential caregiving skills, health monitoring, and elder-centered communication (HelpAge International). These programs contribute to capacity-building at the grassroots level and raise awareness of aging-related needs.

However, Vietnam lacks a standardized national certification system for caregivers. There is no regulatory framework or credentialing process to define core competencies, training hours, or continuing education requirements. As a result, both care quality and caregiver safety vary widely (Pardoel et al., 2023). Without standardized guidelines or formal recognition, trained individuals have limited professional status or mobility, and clients have no assurance of minimum service standards.

Efforts to professionalize the LTC workforce are further constrained by the absence of accredited training institutions, publicly funded training programs, or workforce registries. These gaps hinder workforce development, limit quality assurance, and obscure labor market needs in the care economy (Long & Pfau, 2009).

Long-term care in Vietnam offers limited formal career opportunities and advancement pathways for caregivers. Because caregiving is still widely perceived as unpaid domestic labor rather than a formal profession, there is little incentive for individuals to pursue LTC as a career (UNFPA, 2021). This lack of professional recognition discourages recruitment,

particularly among younger workers, and contributes to high turnover among those with caregiving responsibilities.

Caregivers who do receive training often lack clear progression routes, such as pathways to supervisory roles, further specialization, or integration into the health system (HelpAge International). Moreover, most care-related training remains informal and is not linked to broader workforce development or national employment strategies. Without structured pathways, caregivers often stay at the margins of the labor market, excluded from social protection and occupational benefits (Pardoel et al., 2023).

Service Delivery

Vietnam's long-term care (LTC) service delivery system remains fragmented and underdeveloped, shaped by resource constraints, institutional limitations, and a heavy reliance on informal care (UNFPA, 2021) (Pardoel et al., 2023). While there are efforts to provide support through social protection centers and community-based pilots, the system lacks standardized eligibility criteria, integrated care models, and consistent service packages. This section analyzes six dimensions of service delivery: eligibility and gatekeeping, service settings, types of care provided, integration and person-centeredness, quality assurance, and system performance.

Eligibility and gatekeeping

Access to formal LTC services in Vietnam is primarily means-tested, with eligibility focused on older adults who are poor, live alone, or lack family support (ADB, 2022) (UNFPA, 2021). There is no universal entitlement to care. Local authorities conduct assessments to determine eligibility; however, standardized tools and procedures are lacking, resulting in inconsistencies across provinces. Coverage criteria are applied unevenly across provinces, with some regional governments using informal or discretionary assessments to identify beneficiaries. This approach targets the most vulnerable, but excludes a large segment of the elderly population who may still face significant care needs but do not meet poverty-based thresholds (ADB, 2022). An exception is the Intergenerational Self-Help Clubs (ISHCs), which apply inclusive, community-based eligibility criteria—prioritizing vulnerable older adults without requiring formal means-testing (World Bank Group, 2024).

The absence of nationally standardized tools or processes for needs assessment further undermines the fairness and efficiency of service allocation (Pardoel et al., 2023). Local authorities conduct evaluations based on varying indicators and resource availability, often without formal training or institutional guidance. This results in inconsistencies in eligibility decisions and hinders the development of an equitable, rights-based care system.

Settings for public LTC support

Vietnam's LTC services are heavily concentrated in social protection centers, which are government-run facilities providing shelter, meals, and basic personal care for vulnerable older adults (UNFPA, 2021 {Long, 2009 #663). These centers serve as the default setting for public LTC, particularly for individuals without family support. However, their reach is limited, particularly in rural areas, and they often operate with inadequate staffing and limited infrastructure.

Home-based and community-based care remains scarce, with most services provided informally by family members or through NGO-supported pilot initiatives. In contrast, community-based services such as ISHCs give an alternative model: offering home visits, health screenings, mutual aid groups, and psychosocial support. ISHCs operate independently from the formal LTC system, combining support from local government, international donors, and member contributions (World Bank Group, 2024). Despite their promise, these community-based models have not been formally incorporated into public service systems, and their expansion depends on external funding and local initiative rather than national policy (Pardoel et al., 2023).

Services provided

There is no national service package or guideline outlining the scope and standards of LTC services in Vietnam. In some localities, older adults may receive basic personal care, periodic medical check-ups, rehabilitation support, and group-based activities through community organizations or development projects (Pardoel et al., 2023). However, there is no nationally standardized benefit package, and coverage is often determined by local discretion or project-based funding.

Critical services such as dementia support, palliative care, and respite services remain largely unavailable in public offerings. Furthermore, existing services often lack quality assurance, monitoring, and continuity, limiting their ability to address the complex and evolving needs of aging populations.

Integrated care and person-centered care pathways

Vietnam's LTC system currently lacks institutional mechanisms for coordinated, person-centered care. The split between the Ministry of Health (MOH), which oversees healthcare services, and the Ministry of Labour, Invalids and Social Affairs (MOLISA), which governs social protection and elder services, creates parallel systems with limited communication or planning integration. As a result, older adults requiring both medical and social care often encounter fragmented pathways, duplicated assessments, and service gaps.

Some pilot models, such as those led by HelpAge International or ISHCs, attempt informal coordination between local health stations and community volunteers. These initiatives represent important innovations but remain small-scale and lack institutional backing or formal governance support (Pardoel et al., 2023). Achieving proper integration will require

shared funding mechanisms, interoperable data systems, and cross-sector training to ensure continuity and personalization of care.

Quality assurance

Vietnam does not yet have a national certification system for caregivers, nor a regulatory framework in place to ensure quality in LTC service delivery. There are no unified standards for care provision, staff qualifications, facility performance, or user safety. Quality assurance is primarily limited to administrative audits of public facilities, which focus more on compliance than service outcomes or client satisfaction (Dung et al., 2020).

Without formal standards or monitoring tools, both public and community-based LTC services face significant variation in care quality. There are also no established channels for complaints, redress, or performance improvement, leaving older adults and their families without protection against neglect or inadequate service.

Performance of long-term care service delivery

LTC benefits in Vietnam are primarily available through social protection centers, which offer institutional care for the poor, the isolated, and those without family support. However, the range and quality of services provided vary significantly across locations, and there is no nationally standardized benefit package outlining eligible services, care intensity, or quality benchmarks (HelpAge International). As a result, access to LTC is inconsistent, with urban areas typically offering more options and better-equipped facilities than rural provinces.

Community-based care services, such as day programs or home visits, are mostly pilot-based or NGO-led and not formally integrated into the public benefits system. The lack of clear entitlements also contributes to a reliance on informal and unpaid caregiving, primarily by female family members, with limited state support (Pardoel et al., 2023) (UNFPA, 2021).

Overall, Vietnam's LTC service delivery system suffers from high levels of unmet need, particularly in rural and low-income areas. The absence of financial protection mechanisms means that most care is provided informally and unpaid by family members, predominantly women (Long & Pfau, 2009) (The World Bank, 2019) (The World Bank, 2021). This places a substantial burden on households and has adverse spillover effects on labor force participation, particularly among working-age caregivers.

Data on quality of life, caregiver burden, and service equity are scarce, making it challenging to fully assess the impact of current LTC arrangements. Available evidence suggests substantial disparities in access and care outcomes, both by region and socio-economic status

3.6.4 Conclusion

Vietnam stands at a critical crossroads in the evolution of its health system. While the country has made substantial strides in expanding healthcare access and improving population health, the dual challenges of rapid population aging and the rising burden of non-communicable diseases (NCDs) are placing unprecedented demands on the health and social care infrastructure. Meeting these challenges requires a paradigm shift—away from fragmented, curative-focused services and toward an integrated model of preventive, person-centered, and life-course-oriented care.

This report has illustrated that Vietnam's health promotion system, though anchored in strong policy intent—particularly through the *Vietnam Health Programme (2018–2030)*—continues to suffer from fragmented service delivery, limited intersectoral coordination, and insufficient prioritization of NCD prevention and health literacy. At the same time, the country's long-term care (LTC) system remains embryonic, heavily reliant on informal family caregiving, with underdeveloped public provision, limited financing mechanisms, and virtually no formal workforce infrastructure.

In both domains, governance remains a central barrier and opportunity. The current division of responsibilities between the Ministry of Health and the Ministry of Labour, Invalids and Social Affairs (MOLISA) contributes to policy fragmentation, duplication, and service gaps. Local implementation capacity is uneven, and innovative community-based initiatives, such as Intergenerational Self-Help Clubs, remain disconnected from formal policy frameworks and financing streams.

Financing structures, similarly, reflect profound asymmetries. Health promotion suffers from underinvestment and a lack of earmarked or insurance-based support. Long-term care lacks any coherent financing mechanism, leaving households, particularly women, to absorb the bulk of care costs in the absence of formal support. Without robust and equitable financing arrangements, both health promotion and LTC will struggle to expand coverage, ensure quality, or adapt to the country's demographic transformation.

Workforce challenges are acute in the LTC sector, where caregiving is often unregulated, unpaid, and underappreciated. Without formal training pathways, credentialing systems, or labor protections, Vietnam is ill-equipped to build the professional care workforce needed to support healthy aging. Similarly, capacity gaps at the primary care level constrain the delivery of preventive services and limit the effectiveness of health promotion campaigns.

Finally, service delivery models remain fragmented and inequitable. Preventive services are inconsistently integrated into primary care, and LTC provision is highly concentrated in institutional settings, with minimal support for home- or community-based alternatives. Care pathways are rarely coordinated, and person-centered models of care remain aspirational rather than operational.

Yet despite these gaps, Vietnam is uniquely positioned to act. The country's strong public health legacy, growing policy awareness, and dynamic civil society create a favorable environment for reform. International experience offers valuable lessons: countries that have successfully adapted to aging and NCD transitions have done so by investing in prevention, reconfiguring service delivery to emphasize continuity and coordination, and recognizing care work as a core component of social and economic policy.

Vietnam’s demographic window offers both a challenge and an opportunity. With decisive action and sustained political commitment, the country can transition toward a more resilient, inclusive, and future-ready health system—one that ensures not just more extended life, but healthier, more dignified lives for all its citizens.

References

- (WHO), W. H. O. (2021). *Vietnam country health data* https://data.who.int/countries/704
- ADB. (2022). Long-Term Care for Older People in Viet Nam: The Current Scenario,and Next Steps Toward a Healthy, Aging Population. *ADB BRIEF*, *218*.
- Bank, T. W. *STRENGTHENING GOVERNMENT STEWARDSHIP FOR A DIVERSIFIED*
- *AND RESILIENT AGED CARE SYSTEM IN VIETNAM*
- Dung, V., Thi Mai Lan, N., Thu Trang, V., Xuan Cu, T., Minh Thien, L., Sy Thu, N., Dinh Man, P., Minh Long, D., Trong Ngo, P., & Minh Nguyet, L. (2020). Quality of life of older adults in nursing homes in Vietnam. *Health Psychol Open*, *7*(2), 2055102920954710. https://doi.org/10.1177/2055102920954710
- Giang, L. T., Pham, T. H. T., & Phi, P. M. (2019). Productive activities of the older people in Vietnam. *Social Science & Medicine*, *229*, 32-40. https://doi.org/https://doi.org/10.1016/j.socscimed.2018.09.054
- Giang, T. L. (2013). Social protection for older people in vietnam: Role, challenges and reform options. *Malaysian journal of economic studies*, *50*(2), 207-219. http://snu-primo.hosted.exlibrisgroup.com/82SNU:TN_cdi_proquest_journals_1471984446
- Goverment, U. S. (2024). *Vietnam Country Commercial Guide*. Retrieved from https://www.trade.gov/country-commercial-guides/vietnam-healthcare
- Group, W. B. (2024). *How Intergenerational Self-Help Clubs Transform Elderly Care in Viet Nam*. https://www.worldbank.org/en/news/feature/2024/05/28/how-intergenerational-self-help-clubs-transform-elderly-care-in-viet-nam
- ILO. (2010). *Law on the Elderly (Law No. 39/2009/QH12)*.
- International, H. *Vietnam*.
- International, H. A. *Vietnam*. https://www.helpage.org/global-network/asia/south-east-asia/vietnam/
- Leong, S. L., Teoh, S. L., Fun, W. H., & Lee, S. W. H. (2021). Task shifting in primary care to tackle healthcare worker shortages: An umbrella review. *Eur J Gen Pract*, *27*(1), 198-210. https://doi.org/10.1080/13814788.2021.1954616

- Long, G. T., & Pfau, W. D. (2009). Ageing, Poverty and the Role of a Social Pension in Vietnam. *Development and Change*, *40*(2), 333-360. https://doi.org/https://doi.org/10.1111/j.1467-7660.2009.01517.x

- Minh, H. V., Ngan, T. T., Mai, V. Q., My, N. T., Chung le, H., Kien, V. D., Anh, T. T., Ngoc, N. B., Giap, V. V., Cuong, N. M., Manh, P. D., & Giang, K. B. (2016). Tobacco Control Policies in Vietnam: Review on MPOWER Implementation Progress and Challenges. *Asian Pac J Cancer Prev*, *17*(S1), 1-9. https://doi.org/10.7314/apjcp.2016.17.s1.1

- Nations, U. *Promoting Inclusive Sustainable Development to Improve the Well-being of Disadvantaged Groups in Vietnam*.

- Pardoel, Z. E., Reijneveld, S. A., Lensink, R., Postma, M., Thuy, T. B., Viet, N. C., Phuong, L. N. T., Koot, J. A. R., & Landsman, J. J. A. (2023). The implementation of community-based programs in Vietnam is promising in promoting health [Original Research]. *Frontiers in Public Health*, *Volume 11 - 2023*. https://doi.org/10.3389/fpubh.2023.1182947

- Quan, N. K., & Taylor-Robinson, A. W. (2023). Vietnam's Evolving Healthcare System: Notable Successes and Significant Challenges. *Cureus*, *15*(6), e40414. https://doi.org/10.7759/cureus.40414

- Sang Minh Lê, Q. H. T. (2024). *DIGITAL JOURNEY IN PRIMARY HEALTH CARE: EMPOWERING PATIENTS WITH NONCOMMUNICABLE DISEASES IN VIETNAM*.

- The World Bank, A. A., phcpi. (2019). *Vietnam National and Provincial Primary Health Care Scorecards*.

- The World Bank, J. (2021). *VIETNAM: ADAPTING TO AN AGING SOCIETY*.

- UNDP. *COUNTRY PROGRAMME* (Document for the Socialist Republic of Niet Nam (2022-2026), Issue.

- UNFPA. (2021). *Population Ageing and Older Persons in Viet Nam* (THE POPULATION AND HOUSING CENSUS 2019, Issue.

- UNICEF. (2020). *POLICY BRIEF*

- *WATER, SANITATION AND HYGIENE*

- *IN VIET NAM*.

- Vietnam, M. (2018). *National health programme to improve Vietnamese well-being and stature*. Retrieved from https://moh.gov.vn/web/ministry-of-health/top-news/-/asset_publisher/EPLuO8YEhk19/content/national-health-programme-to-improve-vietnamese-well-being-and-stature?inheritRedirect=false&utm_source=chatgpt.com

- Vietnam, M. (2024). *Vietnam Health Statistics Yearbook* (IHME, Issue.
- WPR, W. (2018). *UHC and SDG Country Profile 2018*
- *Viet Nam*.

3.7 Indonesia

3.7.1 Introduction

Indonesia is undergoing a profound demographic shift, with its population aging at an unprecedented pace. By 2050, the proportion of Indonesians aged 60 and above is projected to nearly triple, rising from 8% in 2015 to 23% of the total population. This rapid aging brings a dual imperative: to promote longer, healthier lives through preventive health strategies and to provide adequate long-term care (LTC) for those with chronic conditions or functional limitations. Health promotion and LTC policies form the backbone of a sustainable and equitable approach to healthy aging.

Despite impressive gains in life expectancy over recent decades, the quality of those additional years remains a significant concern. As of 2016, Indonesia's Healthy Life Expectancy (HALE) was 61.7 years, significantlywas 61.7 years, significantly lower than the global average of 63.3 years. Women in Indonesia enjoy a life expectancy at birth (HALE) of 63 years, compared to 60.4 years for men. In regional terms, Indonesia's HALE is near the bottom of the Southeast Asian rankings, outperforming only Laos, Myanmar, and Cambodia, and roughly on par with the Philippines. By contrast, Singapore leads the region with a HALE of 76.2 years (World Health Organization, 2023a) .

To address this challenge, Indonesia has incorporated health promotion as one of its strategic pillars under the Ministry of Health's Six Pillars of Health System Transformation. Programs such as the Clean and Healthy Living Behaviour (PHBS) and the Healthy Living Movement (GERMAS) aim to instill preventive practices across all age groups (Ministry of Health (n.d.)). These initiatives reflect a shift in policy toward upstream, behavioral health interventions. However, systemic constraints—including fragmented implementation, weak intersectoral collaboration, and low investment in promotive services—have limited their reach and impact.

At the same time, the demand for LTC is rising sharply, but Indonesia’s care infrastructure remains underdeveloped and fragmented. Most older adults, particularly women, continue to rely on family members for care, often without access to formal support or financial protection. Formal LTC systems—including residential care, home-based services, and caregiver support—are underdeveloped, inconsistently regulated, and unevenly distributed across the country. Efforts such as the National Strategy on Aging (Government of Indonesia, 2021)and the Care Economy Roadmap 2025–2045 (International Labour Organization, 2024a) (World Bank, 2024b) represent essential steps toward institutionalizing LTC. Yet implementation is hindered by workforce shortages, financing gaps, and a lack of integration between health and social services.

3.7.2 Healthy ageing policies

Context

Indonesia is undergoing a significant demographic transition that will shape its health and social policy landscape for decades. Life expectancy at birth has steadily increased to 69.4 years and is projected to rise further to 74.2 years by 2050. More strikingly, longevity among older Indonesians is also improving. At age 60, Indonesian men can expect to live an additional 15.4 years, while women can expect 18.1 more years. By 2050, these figures are projected to increase to 17.3 and 20.9 years, respectively (ADB, 2020). These gains reflect improvements in medical services, economic development, and public health infrastructure over the past four decades.

However, this demographic dividend presents serious policy challenges. Indonesia's older population is growing rapidly, in absolute numbers and as a proportion of the population. The number of people aged 60 and over is expected to rise from 20.9 million in 2015 to 61.7 million by 2050. The proportion of older adults will increase from 8% to 19% of the population during the same period. This shift will result in a more pronounced old-age dependency burden, with the dependency ratio projected to reach 31.5 by 2050. These figures imply that for every 100 working-age individuals, more than 30 older persons will require support through family caregiving, public welfare, or the health system (BAPPENAS, 2020).

Indonesia has made health promotion a strategic pillar in its public health agenda, especially in light of demographic aging. Although specific HALE targets are not explicitly outlined in the current National Medium-Term Development Plan, a five-year national development plan document (RPJMN 2020–2024), the government has demonstrated a strong commitment through the Ministry of Health's Health System Transformation Framework. Launched in 2022, the six-pillar reform strategy—comprising primary care, referral care, health resilience, human resources, health financing, and health technology—aims to build a more integrated and people-centered health system(World Health Organization, 2024).

Health promotion programs such as the Clean and Healthy Living Behaviour campaign (PHBS) and the Healthy Living Movement (GERMAS) are essential to this vision. These programs encourage preventive behaviors, such as regular physical activity, balanced diets, regular health check-ups, and tobacco reduction. The Ministry of Health initiated the PHBS campaign, focusing on promoting healthy habits in various settings, including households, workplaces, schools, and public spaces. PHBS encourages regular hand washing with soap, a nutritious diet, physical activity, non-smoking, and the use of clean water. GERMAS, launched in 2016, advocates fostering a culture of healthy living nationwide. GERMAS facilitates increased physical activity, improvements in dietary habits, health screenings, and environmental cleanliness. However, weak intersectoral coordination and insufficient investment in community-level outreach have often hampered implementation. Ministries outside the health sector frequently treat their health-related responsibilities as ancillary tasks, resulting in fragmented efforts.

The alignment between national development goals and health promotion remains conceptually strong, but it is practically underdeveloped. Most health spending in Indonesia is allocated to curative services under the national health insurance scheme (JKN), with

preventive and promotive spending accounting for only about 1% of total health expenditure. Consequently, community-based interventions often lack sustainable funding and workforce support. For example, many community health centers (puskesmas) operate without trained health promoters or rely heavily on unpaid volunteers (Asian Development Bank, 2021).

A future-oriented national health plan should integrate health promotion more deeply into Indonesia's broader development strategy. This includes setting measurable HALE goals, expanding funding for promotive services, clarifying interministerial responsibilities, and leveraging Indonesia's extensive community health infrastructure. With its ageing population and increasing burden of chronic diseases, Indonesia cannot afford to delay systemic action on healthy ageing.

Beyond demographic projections, these shifts raise essential implications for the structure of the labor force, pension systems, and long-term care infrastructure. As the proportion of older adults grows, Indonesia must consider how to support active and productive ageing. This includes policies that encourage longer workforce participation, age-friendly workplace environments, and retraining opportunities for older workers (International Labour Organization (ILO) & Ministry of Women's Empowerment and Child Protection (KPPPA), 2024). Moreover, retirement planning and social security systems must evolve in response to extended longevity to ensure financial protection throughout later life.

In addition to education, early-life nutrition and access to maternal and child health services also influence health trajectories. Nutritional deficits experienced during childhood can lead to chronic diseases later in life, such as hypertension, diabetes, and cardiovascular conditions. Historical food insecurity and periods of famine, coupled with limited access to healthcare, have compounded health disadvantages for today's older adults (UNICEF Indonesia, 2021).

Indonesia's progress in health promotion also depends on data systems, evaluation, and community participation. Strengthening the Health Management Information System (HMIS) and integrating community feedback mechanisms can improve responsiveness and accountability. Moreover, leveraging Indonesia's strong tradition of community volunteerism through initiatives such as Posyandu and community health workers (kaders) could significantly enhance the reach and sustainability of promotive programs. These grassroots actors are well-positioned to bridge the gap between national policies and local implementation, particularly in rural areas (Wachs, 2022).

Policy Foundations

Goal settings

Indonesia's national development plans emphasize health equity and gender inclusion. The National Medium-Term Development Plan (RPJMN) 2020–2024 outlines goals to improve women's access to education, employment, health services, and political participation. However, it does not establish explicit targets for Healthy Life Expectancy (HALE), which limits the ability to track the health span of the population 1,15 systematically. In 2015, Indonesia's HALE at birth was estimated at 62.1 years, significantly lower than the average life expectancy of 69.1 years. This 7-year gap reflects the substantial burden of morbidity in the population (Asian Development Bank, 2021). Moreover, women experience a slightly

greater loss in healthy life years than men—7.5 years versus 7.3 years—suggesting gendered disparities in health outcomes later in life.

Since 2022, the Ministry of Health has introduced six health transformation pillars—primary health care, referral care, health resilience, human resources, health financing, and health technology—which signal a structural commitment to system reform (World Health Organization, 2024). These pillars provide strategic direction but would benefit from being paired with measurable HALE and gender-based health equity indicators.

GEDSI (Gender, Equity, Diversity, and Social Inclusion)

Equity and inclusion have become more visible in Indonesia's health and care policy frameworks, though practical implementation remains uneven. Women remain the backbone of unpaid and low-paid care, a pattern reinforced by limited formal LTC infrastructure and the absence of caregiver protections (Asian Development Bank, 2021). Regional disparities persist under decentralization: urban areas offer more diverse health and social services, while rural and remote regions rely heavily on family caregivers and under-resourced puskesmas or posyandu lansia (World Health Organization, 2024). The National Strategy on Aging (2021) and the Indonesia Care Economy Roadmap 2025–2045 explicitly call for gender-responsive investment, redistribution of unpaid care, and community-based services (World Bank, 2024b). Yet, financing, workforce professionalization, and monitoring systems remain weak, and few programs disaggregate outcomes by gender, disability, or income level.

Life-course orientation

Indonesia's Strategic Health Plan, which encompasses an overall health development plan including UHC implementation and community welfare promotion, reflects a life-course approach, emphasizing age-specific interventions to promote health from infancy to old age (World Health Organization, 2024). Programs such as maternal and child health services, adolescent nutrition, adult workplace health, and elderly-friendly primary health centers (puskesmas santun lansia) are aligned with this framework. Despite policy-level endorsement, operationalization is uneven. Interventions focus on early-life or curative care for older people, with fewer programs targeting prevention and health maintenance in working-age or pre-frail older adults. Consequently, the life-course perspective often remains a conceptual ideal rather than an integrated service delivery model across all life stages.

Shift to prevention

Indonesia has made some strides toward prevention. In 2022, the government launched a nationwide free annual health screening program aimed at early disease detection and reducing premature mortality (Sujudi, 2017). This marks a significant shift toward preventive care. However, funding remains a major constraint. In 2024, approximately 1% of health spending was allocated to preventive and promotive services, with the majority directed toward curative care through public insurance (Fuady et al., 2024). This imbalance highlights

a structural barrier to scaling preventive programs, which remain undervalued in Indonesia's health financing priorities.

Evidence-based risk factor prioritization

Indonesia's health promotion agenda prioritizes behavioral and environmental risk factors associated with non-communicable diseases (NCDs). According to the 2019 burden of diseases in Indonesia, NCDs account for 72% of the overall burden. (Murray, 2020). The Ministry of Health, in partnership with the WHO, has focused on reducing tobacco use, promoting physical activity, encouraging healthier diets, and addressing indoor air pollution(World Bank, n.d.). Nevertheless, enforcement and follow-through remain inconsistent. National tobacco control policies vary across provinces, and efforts to regulate food environments or promote physical activity often lack continuity. While priority-setting is evidence-informed, sustainable implementation is necessary to effectively reduce the prevalence of risk factors nationwide.

Policy alignment

Health promotion policies, including PHBS and GERMAS, align with Indonesia's national health goals and international commitments, such as partnerships with WHO and the World Bank (World Bank, n.d.). Further initiatives include the Health System Transformation Agenda (HSTA) and Healthy Cities, which focus on strengthening the health system, promoting universal health coverage, and addressing specific health challenges such as stunting and infectious diseases. This alignment ensures that promotion efforts are not isolated from broader development agendas. However, practical integration remains limited.

Policy Governance and Funding Structure

Lead institutions

Indonesia's approach to health promotion governance reflects its broader administrative system, with the Ministry of Health (MoH) serving as the national authority for formulating health strategies and coordinating health initiatives. The MoH leads the design of health promotion policies, sets strategic priorities, and engages with global institutions such as the WHO and the World Bank to align domestic programs with international development agendas(Wachs, 2022) (World Health Organization, 2024). However, actual implementation responsibilities with subnational governments—provinces, regencies, and municipalities—lead to challenges in translating national priorities into consistent local action.

While MoH issues overarching frameworks such as the Health System Transformation Strategy launched in 2022, implementation gaps often emerge locally. Many puskesmas (community health centers) lack staff dedicated to health promotion, and there is no national requirement for local governments to allocate dedicated personnel or budgets for this function (Fuady et al., 2024).

Multisectoral collaboration

Indonesia has formally embraced the Health in All Policies (HiAP) concept, which promotes intersectoral collaboration to address social determinants of health. This has led to initiatives such as Health Promotion Schools, which involve coordination among the Ministry of Health, the Ministry of Education, and local education offices (World Health Organization, 2023a). National-level campaigns, such as the Clean and Healthy Living Behaviour program (Perilaku Hidup Bersih dan Sehat) and the Healthy Living Movement (Gerakan Masyarakat Hidup Sehat, or GERMAS), aim to instill healthier behaviors through community-based action.

Yet, despite these efforts, interministerial coordination remains weak. According to Fuady et al. (2025), ministries outside the health sector often consider their engagement with health promotion as secondary, leading to fragmented implementation. GERMAS, although broadly supported in principle, has been criticized for lacking long-term institutionalization at the local level, resulting in a series of one-off activities. Moreover, ministries and local governments operate with distinct performance indicators and budgets, further hindering cross-sectoral planning (Fuady et al., 2024).

Decentralization

Indonesia's decentralized governance system delegates substantial authority to subnational governments, including the planning and execution of health promotion. District and municipal governments manage community health outreach (e.g., Posyandu), hire frontline health workers, and budget for public health initiatives. Decentralization was initially intended to enhance responsiveness and innovation, but it has also led to disparities in service coverage and program quality (Wachs, 2022).

Wealthier districts can deliver integrated and comprehensive health promotion programs better, while poorer areas struggle with staff shortages and limited infrastructure(World Health Organization, 2024) . While local governments have the autonomy to design health promotion interventions, there are few mechanisms to enforce consistency with national goals. As Fuady et al. (2024) noted, HiAP is rarely operationalized at the district level, and interagency coordination bodies are either weak or absent in many jurisdictions.

Funding mechanisms

A significant limitation of Indonesia's health promotion system is the absence of a dedicated and sustainable financing model. Most health spending continues to be absorbed by curative care, primarily through Jaminan Kesehatan Nasional (JKN), the national health insurance scheme, which reimburses hospitals and clinics for treatment rather than prevention (Wachs, 2022),

As of 2024, only an estimated 1% of total health spending was allocated to promotive and preventive activities, far below the levels recommended for effective public health systems(Fuady et al., 2024). Funding for health promotion is often channeled through the Bantuan Operasional Kesehatan (BOK), a central government transfer to local governments, as well as through the sharing of tobacco tax revenue. However, these sources are not earmarked exclusively for health promotion and are often diverted to other uses (MoF, 2023).

Health promotion programs often operate separately from the UHC scheme, which primarily covers treatment services. As a result, preventive services are not consistently reimbursed or embedded within the JKN benefit package, creating disincentives for both providers and users (Fuady et al., 2024).

The fragmented nature of health promotion financing makes it challenging to monitor expenditures or assess efficiency. Ministries and agencies maintain independent budgets and reporting systems, which impede joint planning. This financial fragmentation is further exacerbated locally, where public health activities compete with infrastructure, education, and administrative spending in district budgets.

Recent research (Fuady et al., 2024) suggests that local governments frequently prioritize short-term financial needs over preventive health, resulting in underfunded programs and missed opportunities for upstream investment. Without pooled funding mechanisms or results-based financing, health promotion lacks the political and financial capital needed for scale-up.

Policy Implementation

Indonesia's health promotion system is built on a decentralized, community-driven model that leverages its vast network of primary health care centers and volunteer cadres. This model has proven crucial in expanding access to preventive services, especially in rural and underserved areas. However, the system continues to face challenges in workforce capacity, local resource mobilization, and integrating the needs of ageing populations into mainstream service delivery.

Health workforce involvement

Public community health centers, or puskesmas, serve as the primary gateways for implementing health promotion at the local level. These facilities provide numerous preventive and promotive services and are supported by thousands of community health workers, known as kaders. Kaders play a vital role in extending the reach of government programs, particularly in remote or densely populated areas. They are involved in immunization campaigns, maternal and child health services, nutritional outreach, and, increasingly, in supporting the management of non-communicable diseases (NCDs) management(World Health Organization, 2024).

Government programs, such as the BKL cadre (Elderly Family Development Program), provide skills training to over 31,000 cadres, reaching more than 625,000 recipients.

Meanwhile, LKS cadres and ASLUT cadres offer support services and cash disbursements to over 228,000 older adults. The Posyandu lansia volunteer health workers, estimated at around 417,000 individuals and without official training requirements, deliver a wide range of health promotion and screening services to approximately 2.5 million older adults (Wachs, 2022).

Health promotion activities are also supported by posyandu lansia, which provides volunteer-led health posts for older adults. Puskesmas operate day clinics in some areas for people with specific conditions, such as diabetes or hypertension, providing peer-based education, monitoring, and self-care support (Asian Development Bank, 2021) . These services offer a valuable first step for individuals at risk of functional decline. However, they are generally not equipped to serve those with moderate or severe levels of care dependency, especially individuals requiring complex or home-based care.

Community health volunteers (CHVs) face persistent structural challenges despite their importance. Their roles and responsibilities are poorly defined within the health system. Most kaders are unpaid, have no formal employment status, and receive limited training and supervision(Fuady et al., 2024). This undermines both service quality and volunteer motivation. Expert interviews conducted in 2023 revealed that only around 65% of Indonesia's 10,321 puskesmas had assigned staff for health promotion activities, suggesting widespread gaps in coverage even within public facilities (Fuady et al., 2024).

Incentives for local resource engagement

Indonesia has long relied on grassroots mobilization for health promotion, and posyandu networks play a central role in this model. Initially developed in the 1980s, posyandu have become key platforms for immunizations, child growth monitoring, and nutrition campaigns.

However, the sustainability of these programs depends on the community health volunteers (CHVs)' willingness to contribute unpaid labor. Without structured incentives, pathways for professional development, or recognition systems, many CHVs operate at the margins of the formal health system. When donor support or national campaigns wane, volunteer motivation tends to decline, leading to the erosion of local service delivery (Fuady et al., 2024). Moreover, inconsistencies in training and a lack of certification contribute to disparities in care quality between regions.

Strategies for older adults

Their expansion of posyandu to include older adults through posyandu lansia reflects the government's recognition of shifting demographic needs (UNICEF Indonesia, 2021).

Some participatory programs have emerged to engage older adults more actively in community health. One example is the Elderly Golden Age School (EGAS), which promotes active aging through group activities that support physical, mental, and social well-being (Hariastuti et al., 2024). These programs demonstrate a shift in how older people are viewed, from passive recipients of care to active contributors to public health and community resilience.

However, the reach of such programs remains limited. Local champions or NGOs often lead EGAS and similar initiatives, but they frequently lack secure funding and integration into national health strategies. This results in variability in implementation and uncertain long-term sustainability. Without formal inclusion in district-level health planning or budget frameworks, these programs remain pilot-level innovations rather than scalable models.

Monitoring & Performance

A robust monitoring and evaluation (M&E) system is fundamental for ensuring the effectiveness, equity, and adaptability of health promotion policies and programs. In recent decades, Indonesia has developed a variety of performance indicators and data platforms. Yet, implementation is hindered by challenges in data quality, reporting consistency, institutional coordination, and the limited application of evaluation results in policy revision. This section reviews the current state of performance measurement, monitoring infrastructure, and feedback mechanisms in the Indonesian context.

Standardized indicators

Indonesia has established a national set of core health indicators, many of which are collected through large-scale surveys, such as the Basic Health Research Survey (Riskesdas), the Indonesia Family Life Survey (IFLS), and the Indonesia Demographic and Health Survey (IDHS). These indicators help track key outcomes, including immunization coverage, maternal and child nutrition, disease burden, and service utilization rates.

Despite these systems, significant data gaps persist. Vital registration, including mortality reporting, is still incomplete in many provinces. As highlighted by Idaiani (2023) (Idaiani et al., 2023), Indonesia's civil registration and vital statistics system cannot reliably capture causes of death or health-related demographic transitions at scale. These limitations significantly reduce the reliability of health performance indicators, particularly at the subnational level where health promotion services are managed and delivered.

Data and monitoring sources

The Health Management Information System (HMIS) is the primary platform for routine health data collection across public health facilities, including puskesmas and hospitals. It supports reporting on various health service indicators and program metrics. However, challenges persist in data completeness, accuracy, and timeliness. In many rural or under-resourced areas, staff shortages and a lack of digital infrastructure result in delayed or incomplete reporting (Musadad et al., 2023) (Fuady et al., 2024). On the other hand, the Indonesia Longitudinal Aging Survey (ILAS/Indonesia Ageing Population Survey), conducted in cooperation with the Asian Development Bank, provides vital data on functional health, socioeconomic status, and care needs among older adults (Asian Development Bank, 2023).

Another persistent challenge is system fragmentation. Many disease-specific or donor-supported programs operate with their information systems, which are not interoperable with HMIS. This results in duplication of data entry, inconsistencies across datasets, and reduced utility for integrated health planning. Efforts are underway to harmonize digital health reporting through the Satu Sehat (One Health Data) initiative, but its full implementation will require extensive technical upgrades and inter-agency coordination.

Indonesia's current monitoring tools are often designed to fulfill administrative requirements rather than support strategic management. Many frontline workers view reporting as a bureaucratic obligation rather than a means to improve service. This affects data validity and undermines the potential of digital platforms to enable responsive and adaptive health promotion programming.

Evaluation and feedback loops

While periodic evaluations of national health programs occur, they tend to be ad hoc and fragmented. Ministries and local governments often conduct performance reviews to satisfy reporting requirements, but these rarely lead to evidence-informed policy adjustments or program redesign. A 2023 review by CISDI (Center for Indonesia's Strategic Development Initiatives) (CISDI, 2024) found that formal evaluations of health promotion initiatives are infrequent and lack transparency in methodology and outcomes.

Provincial governments have adopted annual health performance reviews, which include monitoring of puskesmas-level outputs and disease-specific interventions. However, these reviews often focus on curative services and fail to systematically evaluate the effectiveness and equity of health promotion efforts. Moreover, mechanisms for community or stakeholder feedback are underdeveloped. Without structured input from program beneficiaries, especially older adults and vulnerable groups, M&E processes remain top-down and disconnected from the realities on the ground.

A key gap is the lack of real-time feedback mechanisms to support adaptive learning. For example, data collected through *posyandu* activities or community outreach is rarely used for timely course corrections. Similarly, outcome monitoring is not systematically linked to budgeting or performance-based incentives, which limits its influence on resource allocation and policy design.

3.7.3 Long-term care policies

Context

Indonesia is at a critical juncture in developing its long-term care (LTC) system. As the population ages, the need for consistent and formalized care for older adults has become increasingly apparent. According to demographic projections, the proportion of Indonesians aged 60 and above is expected to rise sharply over the coming decades, with the absolute number of older adults projected to triple between 2015 and 2050. (Asian Development Bank, 2021; World Health Organization, 2023a) Despite this, formal LTC infrastructure remains underdeveloped, and the burden of care is still overwhelmingly shouldered by families, particularly women (International Labour Organization (ILO) & Ministry of Women's Empowerment and Child Protection (KPPPA), 2024) (Idaiani et al., 2023).

In most households, caregiving responsibilities are informal, unpaid, and carried out by female family members, whose contributions often go unrecognized in economic and policy terms. This caregiving arrangement imposes considerable opportunity costs on women, many of whom must exit the labor force or curtail educational and personal development opportunities to fulfill their caregiving roles (International Labour Organization, 2024b; UNICEF Indonesia, 2021). These dynamics contribute to broader gender inequities and raise concerns about the sustainability and equity of Indonesia's care system.

The absence of a comprehensive LTC policy framework until recently has contributed to fragmented and inconsistent care services. Access to formal care services is limited, especially in rural areas, with sparse institutional care options (World Bank, 2024b) (Asian Development Bank, 2021). Where they exist, long-term care services are typically provided by a mix of community-based programs, NGOs, religious institutions, and private actors, often with no clear standards or coordination (Ministry of Health, 2022) (International Labour Organization (ILO) & Ministry of Women's Empowerment and Child Protection (KPPPA), 2024).

Field-based insights from focus group discussions with staff in Depok and 20 other districts confirm these disparities. Health workers noted a growing demand for LTC services, particularly for bedridden individuals and those with chronic conditions. However, their understanding of LTC was limited, and terminology such as "long-term care" was unfamiliar (CISDI, 2024). Services such as posbindu lansia (integrated elderly health posts), home care, and family caregiver programs were frequently mentioned; however, these are fragmented and inconsistently available (Asian Development Bank, 2021) (Ministry of Health, 2022) .

Recognizing these growing challenges, Indonesia has begun formulating strategic responses to lay the groundwork for a national LTC system. A significant milestone was the issuance of Presidential Decree No. 88/2021, which introduced the National Strategy on Aging. This strategy addresses the need for a coordinated response to ageing, incorporating elements of healthcare access, social protection, and long-term care provision. It emphasizes the importance of supporting older adults to age in place and of building systems that empower communities to deliver local, person-centered care.

Complementing this is the Care Economy Roadmap 2025–2045 (World Bank, 2024b), which offers a long-term vision for strengthening Indonesia's care infrastructure, including LTC. The roadmap emphasizes community-based services, the formalization of the caregiving workforce, and support systems for unpaid caregivers. It also outlines how investments in the care economy can generate employment, especially for women, and enhance social protection (World Bank, 2024b) (International Labour Organization (ILO) & Ministry of Women's Empowerment and Child Protection (KPPPA), 2024) (International Labour Organization, 2024a).

Various institutional efforts support these high-level frameworks. The Ministry of Social Affairs (MOSA), for example, implements a three-pillar strategy to improve the welfare of older people: (i) the management of social institutions for the elderly, (ii) development of social welfare human resources, and (iii) service delivery to vulnerable groups, including older adults classified as People with Disadvantages in Social Welfare (PMKS).

Governance

Long-term care legislation and strategy

Indonesia has introduced several policies to guide its response to the ageing population and the growing need for long-term care (LTC). A foundational policy was the 1998 Law on Older Persons (Law No. 13/1998) (Government of Indonesia, 2021), which defined older persons as those aged 60 and above and emphasized the state's responsibility to ensure their welfare and social protection. However, this law and its associated regulations are now considered outdated, with ongoing revisions.

A more recent and comprehensive policy is Presidential Decree No. 88/2021 (Government of Indonesia, 2021), which introduced the National Strategy on Aging. This strategy identifies long-term care as a component of a broader ageing policy, including social protection, health services, caregiver support, and institutional care. The plan also includes objectives such as improving elderly-friendly environments, enhancing public awareness, and strengthening legal protections for older people.

In addition to strategy documents, Indonesia has enacted a series of laws and regulations relevant to LTC. These include (Government of Indonesia, 2021):

- Regulation No. 43 of 2004 on the implementation of social welfare services for older persons, emphasizing community coordination;
- Law No. 52/2009 on population dynamics and family development, encouraging families to care for older members;
- Regulation No. 79 of 2014 on geriatric services in hospitals, which has resulted in only 78 geriatric clinics across the country;
- Ministerial Regulation No. 4 of 2017 promoting age-friendly cities;
- Regulation No. 25 of 2016 outlining a national plan for elderly health.

Despite the numerous legal instruments, actual implementation has lagged. Many regulations are still under review, and their relevance to LTC is unclear. Long-term care has yet to be

clearly defined in legal terms, and most existing frameworks address only aspects of ageing without addressing integrated care needs.

Several local pilot programs have emerged to test community-based approaches to LTC. These initiatives often focus on home care services, day-care centers for older persons, and integrated service posts (*Posyandu Lansia*) that deliver basic health monitoring and social interaction opportunities. Although promising, such programs remain small-scale and reliant on donor or local government support. Their scalability and sustainability are uncertain without clear policy backing and long-term funding commitments.

The Care Economy Roadmap 2025–2045 supports the policy developments. It outlines a plan to develop the care sector with a focus on community— and home-based care models, emphasizing the roles of unpaid caregivers and reflecting a policy shift from institutional dependency to a more decentralized, community-centered model of care. The *Indonesia Care Economy Roadmap 2025–2045* is a strategic national framework launched on (Rohmah, 2022) 28 March 2024 by the Ministry of Women's Empowerment and Child Protection, with support from the International Labour Organization (ILO) (Basrowi et al., 2021). It aims to transform Indonesia's care ecosystem into a more inclusive, equitable, and gender-responsive system, aligning with the country's *Long-Term National Development Plan (RPJPN) 2025–2045*. Priorities of the roadmap are integrated into the *Medium-Term National Development Plan (RPJMN) 2025–2029*, emphasizing the government's commitment to investing in the care economy as a driver of economic growth and social equity (International Labour Organization (ILO) & Ministry of Women's Empowerment and Child Protection (KPPPA), 2024) (World Bank, 2024b). The roadmap also addresses the need to increase women's labor force participation to 70% by 2045, reduce stunting rates, and promote gender-transformative workplaces. It acknowledges the disproportionate burden of unpaid care work on women and aims to redistribute care responsibilities more equitably between genders (Basrowi et al., 2021). However, policy awareness of LTC remains limited among national and local stakeholders, and practical understanding of LTC still varies across institutions (International Labour Organization (ILO) & Ministry of Women's Empowerment and Child Protection (KPPPA), 2024) (World Bank, 2024b) (International Labour Organization, 2024a).

Governance structure

The governance of LTC in Indonesia is decentralized, with responsibilities split among multiple agencies, including the Ministry of Health (MOH), MOSA, and local governments (International Labour Organization (ILO) & Ministry of Women's Empowerment and Child Protection (KPPPA), 2024) (Ministry of Health, 2022) (Idaiani et al., 2023). While decentralization enables flexibility and responsiveness to local needs, it also leads to significant coordination problems. Ministries operate in silos, and responsibilities are often duplicated or poorly defined, making it difficult to establish a cohesive national LTC system (World Bank, 2024b) (Murray, 2020).

One of the institutional mechanisms intended to bridge this gap is the National Commission for Older Persons (NCOP), established in 2004. The NCOP was designed to provide input on national ageing policies and improve the welfare of older persons. Local commissions (Komisi Lansia Daerah) were later established in all 34 provinces to act as regional arms of the NCOP. However, these commissions report to the NCOP rather than directly to the

Ministry of Social Affairs or Health, leading to jurisdictional misalignments. The effectiveness of NCOP has been questioned due to its limited authority, lack of dedicated resources, and insufficient coordination mechanisms (CISDI, 2024) (Asian Development Bank, 2021). Stakeholder interviews also revealed concerns that the NCOP lacks sufficient power and a clear mandate to promote inter-ministerial cooperation. There is no established monitoring or evaluation mechanism to assess the effectiveness of these commissions, and no consolidated data exists on the number or functionality of Komisi Lansia Daerah.

Puskesmas (community health centers) and Social Protection Centers are the leading providers of LTC services in terms of service delivery. However, access and quality vary widely (Asian Development Bank, 2021). In some areas, puskesmas offer regular health check-ups, home visits, and limited rehabilitation services for older persons. In others, such services are nonexistent or dependent on local NGO support. Integration between health and social services is minimal, and comprehensive case management is rare (Fuady et al., 2024) (World Bank, n.d.).

Moreover, there is currently no dedicated financing mechanism for LTC under Indonesia's universal health insurance system (JKN). This leaves families to bear the brunt of care-related expenses, which can be catastrophic for low-income households (World Bank, 2024b) (International Labour Organization, 2024a) . The lack of insurance coverage for LTC services has also limited the development of a professional care workforce and discouraged private sector participation.

Governance responsibilities for LTC are shared among multiple actors. The Ministry of Health (MOH) handles health-related services, including rehabilitation and preventive care for older people. At the same time, the Ministry of Social Affairs (MOSA) is responsible for social protection programs and the management of care facilities. Local governments are tasked with implementing and financing many LTC-related services on the ground, but the distribution of roles and coordination mechanisms remains unclear.

Community involvement is a vital asset in Indonesia's LTC landscape. Programs like Posyandu Lansia rely on community health volunteers and family caregivers to deliver services. Expanding such models will require training, supervision, and material support for caregivers, as well as formal recognition of their contributions. Integrating eldercare into broader social protection and local development frameworks will also ensure that aging populations receive comprehensive, person-centered support.

Service providers and local implementation

Most LTC services are delivered through Community Health Centers (Puskesmas) and Social Protection Centers, although their capacity varies widely. Puskesmas provide basic health monitoring, chronic disease management, and limited rehabilitation for older adults. Some are designated as Puskesmas Santun Lansia (Ministry of Health, 2022) under a 2015 regulation, which promotes polite and respectful services for older persons. By 2016, approximately 25% (World Health Organization, 2023) of primary care facilities had adopted this designation; however, implementation remains uneven (Government of Indonesia, 2015).

Meanwhile, social care services such as home visits, day centers, and institutional care are often administered under MOSA. Means-tested programs like ASLUT and BANTU LU provide limited cash assistance to disadvantaged older persons. These services typically reach a small fraction of the older population, with support dependent on local government resources and capacity.

Financing

Expenditure

Indonesia has no dedicated or coordinated public expenditure system for long-term care (LTC). LTC spending is not systematically tracked under the National Health Accounts, and there are no comprehensive datasets that capture government, household, or private-sector expenditures related explicitly to LTC services. The absence of an official LTC category in national health or welfare accounting frameworks reflects the broader policy invisibility of LTC as a distinct investment area.

Estimates suggest that families typically pay most LTC-related costs privately, mainly out of pocket. While total health expenditure in Indonesia reached approximately 3.71% of GDP in 2021 (Asian Development Bank, 2023), this includes all forms of health spending. Within this total, spending directly attributable to older adult care or LTC is obscured by the lack of clear budget lines or classifications. Even within public programs managed by the Ministry of Health (MOH) and the Ministry of Social Affairs (MOSA), expenditures that could qualify as LTC—such as institutional services for vulnerable older persons or community care pilots—are not labeled as such, making it difficult to assess the government's actual level of commitment to the sector.

Revenue Raising

Indonesia has historically relied on a combination of general taxation and social health insurance contributions to fund its health and social protection systems. However, LTC has no dedicated revenue stream, and existing health insurance mechanisms, such as JKN (under BPJS Kesehatan), do not formally recognize LTC as a covered service category. While some medical rehabilitation services and assistive devices are included under JKN, they represent only a fraction of what would be required for comprehensive LTC.

Village funds (Dana Desa) have occasionally been used to support basic elder care activities at the community level, but such expenditures are ad hoc and discretionary. Financing remains fragmented and inadequate, and the political prioritization of LTC financing has been limited by competing policy focuses, particularly poverty reduction and child development programs.

Pooling Resources

Indonesia's resource allocation for health and social services is highly decentralized, resulting in significant variation in how LTC- related funds are managed and allocated. Provincial and district governments control many aspects of service delivery and resource distribution. However, the lack of standardized protocols or joint funding mechanisms means that risk pooling is limited and fragmented, often resulting in inequitable access to services across regions.

This decentralization has led to a patchwork of pilot programs and services that are not coordinated or scaled nationally. It also exacerbates inefficiencies in budgeting and planning, as health and social sectors operate under separate ministries with different objectives and financial systems.

Purchasing Goods and Services

Without a strong public provision system, most LTC services in Indonesia are purchased privately by households, with little regulation or quality control. Families often hire informal or domestic caregivers, many of whom lack formal training. Others rely on unpaid care provided by female family members—especially daughters or daughters-in-law—who take on significant emotional, physical, and economic burdens (Asian Development Bank, 2021) (Berkman et al., 2011).

Cost estimates for LTC are significant relative to household incomes. Government data suggest that home-based care services—including two weekly visits and basic supplies—can cost Rp1.1 million per year per person (International Labour Organization (ILO) & Ministry of Women's Empowerment and Child Protection (KPPPA), 2024), while private residential care in pantis can reach Rp1.5 million per month (World Bank, n.d.). Middle-class families hiring private caregivers may spend up to Rp4 million per month, excluding medical expenses.

Despite some community-based services and small-scale day centers for older people, these are generally offered by NGOs or religious organizations and are limited in scope and capacity. The government has not yet implemented large-scale purchasing or contracting models for LTC services, nor does it provide vouchers or subsidies for families purchasing care.

Indonesia's long-term care financing system is currently underdeveloped, fragmented, and largely informal. There is no national funding mechanism; formal service coverage is patchy at best. Most care is delivered within households and funded privately, with considerable social and economic burdens placed on women (Asian Development Bank, 2021) (OECD Development Pathways, 2019).

Although recent policy initiatives, such as the National Strategy on Aging and the Care Economy Roadmap, signal growing government awareness of LTC needs, financing structures remain inadequate. Strengthening public investment, formalizing caregiver support, and developing data systems to monitor LTC spending will be critical first steps in establishing a sustainable and equitable care system in the country.

Workforce

Existing workforce

Indonesia's long-term care (LTC) system remains heavily reliant on informal, family-based caregiving. Most older adults receive care from biological children—especially daughters—and spouses, with significant input from other family members such as grandchildren and daughters-in-law. According to the Indonesia Family Life Survey, nearly half of older care recipients identified their children as their primary caregivers. This firm reliance on familial networks remains the backbone of the LTC system but poses substantial challenges, particularly as family sizes decline and migration distances increase.

Outside the family, community-based cadres—such as LKS Lansia volunteers, posyandu lansia health workers, and cadres from the Elderly Family Development Program (BKL)—make significant contributions to basic outreach and health promotion for older people. These cadres, however, often lack formal training, standardized job descriptions, and legal protection. Services typically include companionship, facilitation of physical activity, and basic health monitoring, rather than hands-on care.

The formal LTC workforce remains small and concentrated in urban areas. Private-sector home-based care providers, such as Insan Medika, employ trained caregivers and nurses but reach only a limited portion of the population, primarily middle—and upper-income clients in major cities. Monthly caregiver fees can range between Rp2.2 million and Rp7 million (Asian Development Bank, 2021), depending on the service intensity and whether care is contracted directly or through agencies. By contrast, public care services are limited in reach and scope, and home-based personal care is not widely included in existing government programs.

Capacity building and professionalization

Training for LTC workers in Indonesia lacks national coordination. There is no universal certification system for caregivers, and current programs are fragmented. Training for volunteers and care cadres ranges from brief (Asian Development Bank, 2021) 2-day modules at posyandu lansia to slightly longer 40- to 50-hour introductory courses. These programs focus on basic geriatric care, communication, vital sign monitoring, and nutrition, but do not equip workers for advanced caregiving needs such as dementia support or end-of-life care.

Recent efforts have aimed to standardize care training within a multi-level framework, coordinated by MOSA and the Ministry of Health. The framework defines six levels of certification based on education, training hours, and work experience. However, implementation remains limited, with few accredited institutions and most training conducted ad hoc. The 2017 draft outlined training pathways, ranging from 50-hour introductory modules for volunteers to a Caregiver Certificate at level 5 for professionals with a Diploma 3 (D3) education working in residential care or hospices (World Bank, n.d.).

Social workers trained and employed under the Ministry of Social Affairs also contribute to care coordination and support for older adults. However, as of 2016, only 2,176 social

workers worked nationally under MOSA standards, and just 665 were certified (Asian Development Bank, 2021). These workers often act as facilitators or mediators rather than direct care providers, and staffing shortfalls remain a significant constraint on service expansion.

In the public health system, doctors and nurses at puskesmas are the frontline providers for older people with complex needs. Yet workforce shortages persist. More than 30% of puskesmas lack nutritionists (Wachs, 2022), and nearly half do not have laboratory technicians. Only 341 nurses are formally trained in geriatrics, and Indonesia has just 50 registered geriatricians. This shortage of qualified personnel limits the effectiveness of facility-based care and hampers the integration of health and social support.

A considerable weakness in Indonesia's LTC workforce is the absence of a structured career ladder. Most caregivers—both formal and informal—remain in entry-level roles for an indefinite period. There are limited opportunities for advancement or salary progression, and no clear systems exist for transitioning from volunteer work to professional employment. Cadres and home-based workers lack formal recognition, and supervisory or managerial roles are poorly defined or absent.

The limited career infrastructure contributes to workforce attrition and emigration. Indonesia exports many care workers, particularly to Japan, Hong Kong, Malaysia, and Singapore. Estimates suggest that approximately 540,000 Indonesians are employed abroad as personal care workers, with better salaries and job stability serving as key factors attracting them. Although Japan's Economic Partnership Agreement (EPA) program has offered training and qualification routes for Indonesian workers, few returnees reintegrate into the domestic care workforce. Instead, they often shift to unrelated sectors or migrate again, reflecting the limited demand for skilled caregivers within their communities.

Incentives for retention are also minimal. Salaries for domestic workers and caregivers remain low, ranging from Rp 1.5 million to Rp 4 million per month (World Bank, n.d.), and benefits such as health insurance, paid leave, or pensions are virtually nonexistent. These conditions diminish the appeal of care work and hinder professional development efforts.

Service Delivery

Eligibility and gatekeeping

Indonesia's long-term care (LTC) system predominantly relies on a means-tested model, where public services are targeted toward individuals who are poor, socially isolated, or without family caregivers. Programs such as ASLUT (Social Assistance for Older People) provide a small monthly transfer to those aged 70 and above who are bedridden and classified as neglected. However, this assistance functions more as income support than direct care provision, and it is not guaranteed to lead to access to long-term services.

Admission to publicly managed residential facilities—such as panti, panti werdha, or panti sasana tresna werdha—is not based on assessed need for LTC but on the individual's social status. Entry is determined by whether the person is not neglected, neglected due to limited

interaction and support, or discarded due to family estrangement. These criteria prioritize social vulnerability over functional impairments or clinical diagnoses.

Needs assessment processes exist, but are fragmented. Local governments and service providers may utilize tools such as the Activities of Daily Living (ADL) scale, the Abbreviated Mental Test, the Geriatric Depression Scale, or the Mini Nutritional Assessment; however, these are not systematically implemented. There is no unified or mandatory assessment protocol to ensure equitable gatekeeping or service allocation.

Settings for public LTC support

LTC services are delivered across residential, home-based, and community-based settings, though the quality and reach vary significantly. Residential care is provided by an estimated 277 panti nationwide, which offer approximately 18,100 beds (UNICEF Indonesia, 2021). Of these, only three are operated by the central government, while local or nonprofit organizations manage the rest. Most homes serve as social shelters and cannot consistently assist with daily living. Only about 20 percent of residents are estimated to receive some form of care support (Indrawati, 2023) .

Home and community-based services remain limited in scale and structure. Programs such as PUSAKA in Jakarta provide light assistance like feeding and bathing, often carried out by family members or local volunteers. MOSA-supported LKS Lansia facilities serve over 170,000 older persons, primarily through social visits or the provision of material aid. These services rarely include structured personal care, rehabilitation, or monitoring for chronic conditions.

The most widely distributed public outreach mechanism is the Posyandu Lansia network, operating under the Puskesmas system. These community health posts serve more than 2.5 million older adults with basic health screenings, nutrition education, and wellness activities (Asian Development Bank, 2021) (World Bank, n.d.). While integral to community engagement, Posyandu Lansia is not equipped to deliver long-term care and focuses primarily on health promotion and early detection.

Services provided

The types of services available vary by location and provider, and no standardized care package has been implemented nationally. According to MOSA guidelines, home care services should include companionship, assistance with activities of daily living (ADLs) and instrumental activities of daily living (IADLs), personal hygiene, medication reminders, and basic health-related services for individuals who are disabled or bedridden. However, delivery is inconsistent, and many services rely on unpaid family caregivers or volunteers.

Day care and social interaction centers for older people are uncommon. A few facilities in Jakarta and its surrounding areas offer structured activities, cognitive exercises, and physical therapy to small groups of older adults. Still, fees for these services are prohibitive for most

families. Similarly, medical home visits, occasionally available through puskesmas or NGO initiatives, are not widespread and depend heavily on local pilot programs.

Integrated care and person-centered care pathways

Indonesia's efforts to implement person-centered and integrated care pathways are still in their early stages. One example is the Puskesmas Santun Lansia model, launched in 2000, which categorizes older people based on their functional ability and prescribes different levels of support. Mildly dependent older persons are encouraged to participate in health promotion activities, while those with moderate or severe impairments are referred for home-based care or hospitalization. Yet, as of 2018, only 48.4 percent of puskesmas (World Bank, 2024b) had implemented this model, with significant regional disparities due to financial and staffing limitations (Government of Indonesia, 2015) (Asian Development Bank, 2021).

Only 88 out of 2,813 hospitals (Asian Development Bank, 2021) offer integrated geriatric services, and just 10 hospitals (Fuady, 2023) deliver fully integrated care across outpatient, inpatient, day care, and hospice settings. These hospitals are located in major cities and employ multidisciplinary teams that include geriatricians, trained nurses, rehabilitation therapists, nutritionists, and pharmacists. For those without access to these facilities, continuity of care remains a significant challenge.

Some residential facilities and NGOs apply informal coordination approaches. In a few pantis, social workers use case conferencing to address complex care needs, occasionally involving medical professionals or psychologists. However, such practices are rare and not institutionalized across the LTC system.

Quality assurance

Quality assurance mechanisms for LTC are underdeveloped. There is no formal caregiver certification system; most training programs are short-term and localized. While MOSA and the Ministry of Health have issued minimum service standards and general protocols, their implementation is often voluntary and lacks effective enforcement mechanisms.

Service provider accreditation is limited. As of 2017, only 120 LKS Lansia organizations had been accredited, mostly located in Jakarta (Asian Development Bank, 2021). Quality monitoring is primarily conducted through administrative audits and financial reviews, rather than performance evaluations or service outcome assessments. There is no national registry for providers or a database for tracking adherence to care standards.

Performance of long-term care service delivery

Indonesia has a narrow and inconsistent framework for benefit coverage of long-term care services. Public LTC services are primarily directed at low-income or disadvantaged older adults through social welfare schemes such as the People with Disabilities in Social Welfare

(PMKS) program. These are means-tested programs, and eligibility is usually restricted to individuals without family support or income.

Service coverage varies significantly by region. In areas where local governments or donor-funded pilots are active, older adults may have access to home visits, basic health checkups, or day-care services through puskesmas or local NGOs. In other regions, formal LTC services may be absent. Puskesmas and Social Protection Centers serve as the principal access points for services. Still, the type and quality of care delivered are mainly dependent on local budget allocations, staffing, and infrastructure.

Despite multiple programs aimed at older adults—including ASLUT and BANTU LU—Indonesia's formal LTC workforce remains under-resourced. Programs under MOSA reach tens of thousands of older adults with cash or in-kind support, but generally do not include personal or home-based care services. For example, ASLUT supports 30,000 older individuals (Wachs, 2022), while LKS Lansia centers provide material assistance and basic monitoring to over 170,000 (Wachs, 2022). Yet most of these programs fail to deliver daily support for ADLs, and hands-on care is largely absent.

In 2019, only 852 LKS Lansia institutions were recognized by MOSA as providing any form of elder care, despite an estimated need from over 30,000 older persons in urban centers alone (Wachs, 2022). While social volunteers and community programs have expanded coverage, they remain heavily dependent on local funding, and many lack sustainable financing mechanisms or government oversight.

The system lacks adequate integration between formal medical providers and the social care workforce. Doctors and nurses at puskesmas often work independently from MOSA cadres or volunteers, leading to gaps in follow-up care and inconsistent care quality. The absence of case management roles or team-based approaches further fragments the care delivery process.

Official data on unmet need and the financial protection level are limited. Publicly supported LTC services are largely lacking in Indonesia, and approximately 10.2% of older Indonesians who need care rely on family member support (Asian Development Bank, 2021). Many older people, particularly those in rural and remote areas, have no access to public services or trained caregivers. Families, particularly female relatives, bear the majority of care responsibilities without compensation or respite support.

Without an insurance mechanism for LTC, all expenses are covered out-of-pocket or absorbed as unpaid labor. Lost income and reduced workforce participation, especially among women, compound the economic burden on families. Few social or policy supports are available to alleviate this burden or compensate informal caregivers. Official data on the informal caregiving burden, including lost income due to informal caregiving, do not exist (Asian Development Bank, 2021), which highlights the need for such data collection in future national surveys.

Respondents also cited numerous barriers to service delivery, including limited staffing, inadequate infrastructure, insufficient training, and unclear regulations. Some local governments have attempted to respond by developing elderly-friendly initiatives and caregiver training programs, but these efforts remain isolated and lack national coordination.

Monitoring data on user experience, care quality, or functional outcomes is sparse. Although some indicators have been developed through the Ministry of Health's minimum service standards, they are not widely applied, and performance reviews tend to focus on input and budget compliance rather than health or well-being outcomes. Disparities in access and quality persist between regions, with urban and wealthier areas generally better served than rural or poorer districts.

3.7.4 Conclusion

Indonesia is entering a decisive era in its demographic transition. With the proportion of older adults projected to rise sharply over the coming decades, the imperative to promote healthy aging and build a robust long-term care (LTC) system has never been more urgent. While gains in life expectancy are commendable, the persistent gap between life expectancy and healthy life expectancy (HALE) signals a critical need to invest in living longer and better.

The country has made promising strides in health promotion. Initiatives such as PHBS and GERMAS demonstrate a strong political commitment to preventive health, supported by strategic frameworks like the Ministry of Health's Six Pillars of Health System Transformation. Yet these programs often fail to be implemented due to insufficient investment, weak intersectoral coordination, and overreliance on unpaid community labor. Likewise, while Indonesia formally embraces a life-course and equity-oriented vision, these principles remain unevenly operationalized across regions and age groups.

Indonesia's policy landscape has undergone significant shifts in the realm of long-term care. The National Strategy on the Care Economy Roadmap 2025–2045 provides much-needed strategic direction. However, formal LTC services remain sparse, fragmented, and heavily dependent on local initiatives and unpaid family caregivers, particularly women. The lack of transparent governance, sustainable financing mechanisms, and a trained care workforce continues to limit coverage and quality. Despite a rich tradition of community volunteerism and recent pilots in home-based care, the absence of national standards and dedicated funding means most older adults must navigate aging with minimal formal support(International Labour Organization, 2024a) (International Labour Organization (ILO) & Ministry of Women's Empowerment and Child Protection (KPPPA), 2024) (World Bank, 2024b).

Systemic reforms are now essential. For health promotion, this means institutionalizing measurable HALE targets, integrating preventive services into the JKN benefit package, and scaling up investments in community-based outreach through a well-supported workforce. For long-term care, Indonesia must move beyond fragmented pilots toward a unified and equitable system with clear eligibility pathways, standardized care models, and protection for informal caregivers. Financing reforms are critical—LTC must be recognized as a distinct area of investment, tracked in national health accounts, and supported through pooled funding and insurance coverage.

The challenges are considerable, but the foundation is in place. Indonesia's decentralized health system, vast cadre of community health workers, and increasing interministerial awareness offer strategic advantages. With deliberate reforms that integrate health promotion and LTC under a coherent aging policy framework, Indonesia can seize the demographic

opportunity to deliver not just longer lives. Still, lives lived with dignity, autonomy, and well-being.

References

- Organization. WH. Global Health Estimates. 2023.
- Organization WH. Indonesia continuity and change. 2024.
- Health Mo. Healthy Living Community Movement. (n.d.)https://kemkes.go.id/eng/layanan/healthy-living-community-movement.
- Indonesia. Go. National Strategy on Aging. 2021
- Organization IL. Launch of the Indonesia Care Economy Roadmap. 2024a.
- (KPPPA) ILOIMoWsEaCP. Indonesia Care Economy Roadmap 2025–2045. 2024.
- Bank W. Indonesia Care Economy Roadmap 2025–2045. 2024.
- Bank AD. Indonesia Longitudinal Aging Survey (ILAS). Country Dataset on Ageing. 2023.
- Pathways OD. Social Protection System Review of Indonesia. 2019.
- Indonesia B-S. Profile of Indonesia Population (Result of SUPAS 2015). 2016https://www.bps.go.id/en/publication/2016/11/30/63daa471092bb2cb7c1fada6/profil-penduduk-indonesia-hasil-supas-2015.html.
- Berkman ND, Sheridan SL, Donahue KE, Halpern DJ, Crotty K. Low health literacy and health outcomes: an updated systematic review. Ann Intern Med. 2011;155(2):97-107.
- Fuady A, Anindhita M, Haniifah M, Ahsan A, Sugiharto A, Haya MAN, et al. Bridging the gap: financing health promotion and disease prevention in Indonesia. Health Res Policy Syst. 2024;22(1):146.
- Bank AD. Country Diagnostic Study on Long-Term Care: Indonesia. 2021.
- Indonesia U. Delivering essential nutrition services through community action in Indonesia. 2021.
- Wachs D. Long-term Care Assessment Toolkit: Application to Indonesia. World Bank Social Protection and Jobs Global Practice; 2022.
- Murray CJL, et al. Global burden of 87 risk factors in 204 countries and territories. The Lancet. 2020;396(10258):1223–49.
- Bank W. Supporting Health Programs in Indonesia. n.d.
- Hariastuti I, Dawam M, Sugiharti S, Suratmi T, Kurniasih DE, Budiningsari D, et al. Elderly Golden Age School (EGAS): a strategy to promote health and prosperity elderly in Indonesia. Humanities and Social Sciences Communications. 2024;11(1):1098.
- Idaiani S, Hendarwan H, Herawati MH. Disparities of Health Program Information Systems in Indonesia: A Cross-Sectional Indonesian Health Facility Research 2019. Int J Environ Res Public Health. 2023;20(5).
- Musadad DA, Angkasawati TJ, Usman Y, Kelly M, Rao C. Implementation research for developing Civil Registration and Vital Statistics (CRVS) Systems: lessons from Indonesia. BMJ Glob Health. 2023;8(7).
- CISDI. White Paper on Indonesia's Health Sector Development (2024–2034). 2024.
- Organizationv IL. Indonesia launches its Road Map for the Care Economy. 2024b.
- Health Mo. Six Pillars of Health System Transformation. Government of Indonesia. 2022.
- Rohmah NH. PHBS and Stunting Prevention. Public Health Insights. 2022;2(1).
- Basrowi RW, Rahayu EM, Khoe LC, Wasito E, Sundjaya T. The Road to Healthy Ageing: What Has Indonesia Achieved So Far? Nutrients. 2021;13(10).
- Indonesia Go. Guidelines for Elderly-Friendly Community Health Centers

(Puskesmas Santun Lansia). 2015.
- Indrawati I, et al. Family Clean and Healthy Living Behavior. 2023.
- Fuady A, et al. Factors Influencing Participation in the Healthy Living Movement. International Journal of Environmental Research and Public Health. 2023;20(5).

3.8 Fiji

3.8.1 Introduction

Fiji, a Pacific Island nation with a population of approximately 900,000, is undergoing a slow but notable demographic transition, marked by increased life expectancy and a gradual rise in the proportion of older adults. Despite this emerging trend, the policy and institutional response to population ageing remains nascent. While Fiji has made progress in advancing health promotion through multisectoral wellness frameworks, it lacks a dedicated, coherent policy infrastructure to address the specific needs of its older population.

Historically, the Fijian health system has focused primarily on maternal and child health and infectious disease control. In recent years, however, there has been a gradual pivot toward non-communicable disease (NCD) prevention and health promotion, exemplified by the 2015 National Wellness Policy. Yet, these developments have not been translated into comprehensive strategies that systematically incorporate ageing-related concerns. Key components such as a life-course approach, tailored interventions for older adults, and integrated care pathways remain largely absent. Moreover, the long-term care (LTC) system in Fiji is severely underdeveloped, characterized by the absence of formal policies, financing mechanisms, and workforce capacity. Care for older persons continues to rely almost entirely on informal family support, with minimal institutional provision or state support.

Several structural and contextual challenges further impede the development of a robust healthy ageing framework. These include limited fiscal space, political instability, a fragmented governance structure, and cultural norms that prioritize family-based elder care but lack corresponding state supports. The demographic profile of the country—with only 5.6% of the population aged 65 and older as of 2023—may also delay policy urgency in this domain. Nonetheless, as Fiji continues to experience demographic shifts and rising burdens of chronic illness, the need to prepare for an ageing society becomes increasingly critical.

This section provides an overview of Fiji's health promotion and long-term care policy environment from the perspective of healthy ageing. It highlights existing initiatives, identifies major policy and implementation gaps, and situates Fiji's response within the broader context of Asia-Pacific trends. Drawing upon national policy documents, international assessments, and comparative insights from countries such as Japan and Korea, this review aims to inform the development of a more inclusive, coordinated, and anticipatory approach to healthy ageing in Fiji.

3.8.2 Healthy ageing policies

Contexts

Fiji's national health promotion framework has evolved over the past two decades in response to rising burdens of non-communicable diseases, demographic shifts, and growing recognition of the social determinants of health. Guided primarily by the National Wellness Policy (2015), health promotion in Fiji is structured around a multisectoral, settings-based model that emphasizes the collective responsibility of all sectors in advancing population wellness. However, despite these commendable aspirations, key policy design and implementation features remain underdeveloped or inconsistently articulated. This review examines the strategic underpinnings, governance structures, and operational challenges of Fiji's health promotion system. It evaluates the degree to which core principles—such as evidence-based planning, gender equity, life-course orientation, and participatory governance—are reflected in actual frameworks and implementation practices. This assessment highlights both strengths in Fiji's shift toward prevention and inclusive conceptions of wellness, and weaknesses related to fragmented monitoring systems, insufficient financing, and limited strategies targeting specific population groups, particularly older adults.

Policy foundations

Goal setting

Fiji's current health promotion initiatives do not explicitly articulate goals focused on enhancing overall life expectancy or healthy life expectancy (HALE). Instead, the stated objectives remain relatively broad, abstract, and descriptive, lacking specific, measurable, and outcome-oriented targets. For instance, Goal 1 of the National Wellness Policy (2015), which serves as the principal guiding framework for health promotion activities in Fiji, is expressed as an aspiration "to build the understanding that all sectors of society are equally responsible for population health." This formulation emphasizes awareness and shared responsibility across various societal domains but does not provide concrete benchmarks or direct interventions aimed at quantitatively improving health outcomes or extending longevity within the population (MHMS, 2015).

GEDSI (Gender, Equity, Diversity, and Social Inclusion)

As a guiding policy principle, Fiji underscores the importance of applying a gender-sensitive lens to its health promotion and wellness initiatives, thereby striving to ensure that the distinct needs and experiences of men, women, boys, and girls are equitably acknowledged and addressed across all facets of policy development and implementation. This commitment reflects an awareness of the critical role gender plays in shaping health outcomes and access to services. However, despite this stated principle, there remains a notable absence of a clearly articulated implementation plan that operationalizes gender equity across sectors.

Without such a framework, the practical translation of this commitment into actionable strategies, measurable indicators, and sustained outcomes remains limited (MHMS, 2015).

Life-Course Orientation

While there may be areas of conceptual overlap, Fiji's national health promotion policy predominantly adopts a 'settings-based' approach, as opposed to a comprehensive life-course perspective. This approach emphasizes the importance of implementing health promotion strategies within specific physical and social environments where people live, work, and interact on a daily basis. The key settings identified include schools, workplaces, and urban communities such as towns and cities. By targeting these environments, the policy seeks to create supportive conditions that facilitate healthier behaviors and outcomes within defined contexts. However, unlike the life-course approach, which systematically addresses health needs and risks across different stages of life from infancy to old age, the settings-based model in Fiji does not explicitly integrate the temporal and developmental dimensions of health. As a result, the policy may lack continuity in addressing the evolving health needs of individuals across the lifespan (MHMS, 2015).

Shift to Prevention

Although Fiji's healthcare system has traditionally prioritized the delivery of clinical and curative services, recent strategic developments indicate a gradual shift toward a more preventive orientation. This transition is exemplified by the establishment of the National Wellness Centre, a specialized unit dedicated to the promotion of health and wellness across the population. The creation of this center reflects a growing recognition among policymakers that early intervention and preventive measures are not only more effective in improving population health outcomes but also more cost-efficient in the long term compared to delayed, treatment-focused responses. By investing in upstream interventions, Fiji aims to reduce the burden of non-communicable diseases and other preventable conditions, ultimately enhancing the sustainability and resilience of its healthcare system (MHMS, 2015; WHO, 2011; World Bank, 2024a)

Evidence-based Risk Factor Prioritization

Rather than limiting its focus to traditional biomedical risk factors for disease, Fiji's health promotion strategy adopts a more holistic and multidimensional framework. Central to this approach is the emphasis on seven interrelated dimensions of wellness: social, spiritual, environmental, occupational, psychological, physical, and financial. This broadened perspective reflects an understanding that health is shaped by a wide range of social determinants and that well-being extends beyond the mere absence of illness. By integrating these diverse dimensions into its health promotion efforts, Fiji aims to foster a more comprehensive and inclusive conception of wellness that aligns with individuals' lived experiences and the complex realities of their social (MHMS, 2015)

Policy Alignment

The National Wellness Policy for Fiji (2015) affirms that the country's health promotion policy is strategically aligned with a range of complementary health-related frameworks and legislative instruments (MHMS, 2015). Notably, this includes coherence with the provisions outlined in the Public Health Act. Such alignment is intended to ensure policy consistency, facilitate intersectoral coordination, and strengthen the institutional foundation for implementing health promotion initiatives across multiple levels of governance. This integrated policy approach reflects an effort to embed health promotion within the broader legal and strategic architecture of the national health system.

Policy Governance and Funding Structure

Lead Institutions

Fiji does not currently maintain an independent, standalone health promotion agency. Instead, the coordination and implementation of national health promotion activities are primarily the responsibility of the National Wellness Centre (NWC), which functions as a dedicated unit within the Ministry of Health and Medical Services (MHMS). As an integral part of the Ministry's organizational structure, the NWC is tasked with advancing health and wellness initiatives across the country. However, its embedded position within the broader health system may limit its institutional autonomy and capacity to operate with the independence typically associated with specialized health promotion agencies in other contexts (MHMS, 2015).

Multisectoral Collaboration (HiAP)

The *National Wellness Policy for Fiji* positions itself as a comprehensive, national-level, multi-sectoral framework designed to promote population wellness through the coordinated engagement of both health and non-health sectors. Central to its strategic orientation is the adoption of a Health in All Policies (HiAP) approach, which emphasizes the integration of health considerations into policymaking across diverse sectors such as education, agriculture, transport, and urban planning. By encouraging cross-sectoral collaboration and shared accountability, the policy aims to address the broader social determinants of health and foster an enabling environment for sustained improvements in national well-being. This approach reflects an understanding that health outcomes are influenced by a wide range of policy domains and that meaningful progress in public health requires a whole-of-government and whole-of-society response (MHMS, 2015).

Decentralization

In Fiji, the functions of local government are relatively limited and remain largely centralized under the authority of the national government. This centralized governance structure significantly constrains the autonomy and capacity of local authorities to initiate or lead

public health initiatives. As a result, no explicit roles or responsibilities have been formally assigned to local governments in the planning or implementation of health promotion activities (MHMS, 2015; WHO, 2011). The absence of clearly defined local-level mandates in health promotion represents a missed opportunity for place-based and community-driven interventions, which are often critical for addressing context-specific health needs and fostering grassroots participation.

Funding Mechanisms

A dedicated and clearly defined funding source for health promotion has not yet been established in Fiji. Although certain components of the national government budget are directed toward health promotion activities, these allocations are embedded within broader health expenditure categories and do not appear as a distinct budget line. Consequently, there is no separate or protected financial allocation specifically earmarked for health promotion initiatives, the operational activities of the National Wellness Centre, or the implementation of wellness programs (MHMS, 2015, 2024). This lack of financial delineation may hinder the strategic planning, sustainability, and scalability of health promotion efforts, as it limits transparency, prioritization, and long-term resource commitment.

Policy Implementation

Health Workforce Involvement

Detailed and clearly defined operational roles specific to health promotion have not yet been formally institutionalized within Fiji's health system. In the absence of dedicated health promotion personnel, the implementation of wellness-related activities largely depends on the existing general health workforce. At the community level, frontline health personnel—referred to as zone nurses—play a pivotal role in monitoring wellness indicators, engaging with local populations, and reporting health trends and concerns to divisional medical officers. These nurses serve as the primary link between the health system and the communities they serve, despite limited specialization in health promotion. In the longer term, it is anticipated that Community Health Workers (CHWs) will be trained and mobilized to provide additional support for these functions. However, the extent of formal training, role clarity, and integration of CHWs into the wellness framework remains a work in progress, pointing to the need for a more structured and sustainable human resource strategy for health promotion (MHMS, 2015; WHO, 2011).

Incentives for Local Resource Engagement

Local institutions, including schools, workplaces, and other community-based settings, are actively encouraged to designate Wellness Champions—individuals tasked with promoting health and wellness within their respective environments. These champions receive training, guidance, and periodic support from the National Wellness Centre (NWC), which aims to build local leadership capacity and strengthen community-level engagement in health

promotion activities. By embedding wellness advocates within everyday institutional settings, this initiative seeks to foster a culture of health ownership and peer-driven behavioral change. However, the sustainability and scalability of this model may be constrained by the limited availability of financial incentives or formal recognition mechanisms for Wellness Champions, potentially affecting motivation and long-term retention (MHMS, 2015).

Strategies for Older Adults

Fiji lacks a dedicated strategy that specifically addresses the health and wellness needs of older adults, despite their growing significance in national health planning. Moreover, the current policy framework does not incorporate a participatory approach that actively involves older adults in the development process. It also lacks clearly defined mechanisms to facilitate meaningful engagement of older persons and other community stakeholders in the design, implementation, and evaluation of wellness initiatives. This omission reflects a critical gap in inclusive policy development and raises concerns about the extent to which the wellness agenda represents the diverse needs and perspectives of Fiji's ageing population (MHMS, 2015).

Monitoring & Performance

Standardized Indicators

National-level indicators specifically designed to monitor and evaluate health promotion efforts under the *National Health (Wellness) Policy* have not yet been formally established. This gap in the policy framework limits the ability to systematically assess progress toward wellness objectives or to ensure accountability in implementation. However, the *Non-Communicable Diseases (NCD) Strategic Plan 2015–2019*, which functions as a supplementary and more targeted policy instrument focused on the prevention and control of NCDs, does propose a set of illustrative indicators. These include, for example, the prevalence of overweight and obesity, as well as patterns of tobacco and alcohol consumption (MHMS, 2015; MHMS & Australian Aid, 2015). Despite these proposed metrics, the extent to which they have been formally adopted, integrated into national monitoring systems, or operationalized in practice remains unclear. This lack of clarity raises concerns about the robustness of the current monitoring and evaluation framework for health promotion in Fiji.

Data and Monitoring Sources

The National Wellness Centre (NWC) is anticipated to leverage existing institutional pathways established under the Strategic Framework for Coordinating Change Office (SFCCO) to facilitate the integration of wellness-related indicators into ministerial reporting processes. The SFCCO, as a central coordinating body, was established to enhance intersectoral collaboration by monitoring and evaluating government programs outlined in annual corporate plans and by aligning overlapping responsibilities among various ministries and stakeholders. In this context, the NWC is positioned to benefit from SFCCO's mechanisms to embed wellness metrics across sectors, thereby advancing a whole-of-government approach to health promotion. However, despite this intended alignment, the current operational status, effectiveness, and level of utilization of these interministerial coordination mechanisms remain unclear. This uncertainty poses challenges for ensuring the systematic

incorporation of wellness indicators into national monitoring frameworks and for realizing the full potential of intersectoral policy implementation (MHMS, 2015; WHO, 2011).

Evaluation and Feedback Loops

Monitoring and Evaluation (M&E) activities are intended to be led by the National Wellness Centre (NWC), with each program assessed individually and national health statistics used to evaluate the overall impact of the wellness approach. However, the current functionality and implementation of these M&E mechanisms remain unclear, raising concerns about their effectiveness in guiding evidence-based decision-making and policy improvement (MHMS, 2015).

3.8.3 Long-term care policies

Contexts

The public long-term care (LTC) system in Fiji remains underdeveloped, with no comprehensive policy framework, legislative foundation, or dedicated governmental body responsible for the formulation and implementation of LTC policy. To date, there exists neither a national LTC strategy nor an institutional mechanism to coordinate or monitor the development of such services across the country. Although facility-based LTC services are not entirely absent, the public provision is extremely limited in scope and scale. Currently, only a small number of older adults, approximately 100 individuals, can be accommodated in government-supported residential facilities, such as the Samabula, Labasa, and Natabua Senior Citizens Homes. These institutions are funded and staffed by the government, covering operational costs but providing only minimal coverage relative to the growing need. A small number of privately operated aged-care homes also exist, yet the capacity remains severely restricted, and access is often contingent upon the ability to pay (MHMS, 2024; WHO, 2011; World Bank, 2024a).

The limited development of the LTC"syst'm In Fiji is often interpreted through the lens of cultural and familial values. As noted by the WHO (2011), older adults in Fijian society are traditionally revered and cared for within the family unit. The notion of relocating elderly individuals from their homes or communities into institutional care is considered culturally inappropriate and potentially detrimental to their dignity and well-being. Consequently, care for older people, including those with disabilities or chronic illnesses, continues to rely heavily on unpaid family caregivers in informal home settings.

However, cultural explanations alone may not sufficiently account for the lack of LTC development. Two additional structural factors—demographic composition and political-economic instability—may be more fundamental in explaining the current status of (lack of) LTC system in Fiji.

First, Fiji's demographic profile does not yet exert the kind of pressure on policymakers that is observed in more rapidly ageing societies. The country maintains a relatively youthful population structure, with a life expectancy of 67.3 years and a median age of just 27.7 years as of 2023 (UNDESA, 2024). This stands in stark contrast to countries such as Viet Nam (median age 32.4), Sri Lanka (32.8), and China (39.1), as well as to highly aged societies like South Korea (44.5) and Japan (49.0). The share of the population aged 65 years or older in Fiji is only 5.6%, significantly lower than in Sri Lanka (10.8%) and South Korea (24.7%) (UNDESA, 2019). Given this demographic reality, there is limited political impetus or public demand to develop a targeted policy framework for elderly care. The relatively small proportion of older adults also implies limited political representation or advocacy power to influence national policymaking in favor of LTC development.

Second, Fiji's history of political instability and economic fragility further constrains its capacity to develop a robust LTC infrastructure. The country has undergone three military coups within a span of two decades—in 1987, 2000, and 2006—each reflecting unresolved ethnic tensions and a governance system ill-equipped to mediate them (Collins & Fraenkel, 2012). These episodes of instability have disrupted long-term policy continuity and

diminished the state's institutional capacity. In parallel, Fiji has faced persistent fiscal deficits (ADB, 2014), limiting the availability of domestic resources to expand public social services. As a small island developing state, Fiji has relied on foreign aid to finance sectors such as education, healthcare, and infrastructure. Since the 1987 coups, many international donors have redirected aid flows away from the state and toward civil society organizations (CSOs), in part to bypass weak state structures and concerns over governance. This shift has had two major consequences: the state's role in resource allocation for service delivery has diminished, and it no longer maintains full control over the scope, equity, or quality of services being delivered. This fragmentation has weakened efforts to develop coordinated and state-led LTC systems (Chand & Naidu, 2010).

In conclusion, the underdevelopment of Fiji's public LTC system can be attributed to an interplay of cultural, demographic, and political-economic factors. While cultural norms around filial responsibility remain a strong influence, demographic youthfulness reduces the immediacy of policy demand, and historical political instability coupled with chronic fiscal constraints weakens the state's ability to respond systemically. The cumulative effect of these conditions may continue to hinder the establishment of a formal, government-led LTC system unless targeted reforms and investments are made in anticipation of future demographic transitions.

In addition, significant information gaps persist in the long-term care (LTC) landscape. Specifically, there is a lack of systematically collected data on the number of older individuals in need of LTC services. This absence of epidemiological and service utilization data impedes evidence-based policymaking and the effective allocation of resources. Moreover, the scope and scale of family or informal caregiving remain not documented. No official registries, surveys, or administrative data are available to estimate the number of informal caregivers who provide essential day-to-day support to older adults living with chronic illness, disability, or functional decline. Furthermore, informal caregiving—although culturally normative and indispensable within the Fijian context—receives no formal recognition or financial support from the state. There are no structured financial assistance schemes, caregiver allowances, or respite care provisions to alleviate the economic and emotional burdens shouldered by informal carers. This lack of institutional support may exacerbate caregiver burnout and contribute to inequities in access to care for vulnerable older populations. The cumulative effect of these gaps points to an urgent need for improved data systems, policy development, and caregiver support mechanisms within Fij''s evolving health and social care framework (WHO, 2011; World Bank, 2024a).

Governance

Long-term care legislation and strategy

As noted earlier, Fiji currently lacks a formal long-term care (LTC) system, and as a result, there is no comprehensive legislative framework or national strategy specifically aimed at guiding the development, regulation, or delivery of LTC services (WHO, 2011; World Bank, 2024a). The absence of policy infrastructure significantly hampers the establishment of coordinated, equitable, and quality-controlled care for the ageing population. Without a formalized legal or strategic foundation, long-term care remains a largely informal domain,

heavily reliant on familial caregiving without the support of institutional mechanisms or regulatory oversight.

Governance structure

Although the Fijian government supports a small number of residential aged-care facilities—most notably the Samabula, Labasa, and Natabua Senior Citizens Homes—which collectively accommodate approximately 100 older adults, these services represent only a minimal and isolated component of the care landscape. Crucially, there is no centralized or dedicated governmental body, agency, or inter-ministerial committee tasked with the development, implementation, or coordination of long-term care policies and programs. This institutional vacuum reflects a broader governance gap, whereby long-term care responsibilities are neither clearly assigned nor systematically integrated within the national health or social welfare governance architecture. In the absence of a formal governance structure, policy development remains ad hoc, uncoordinated, and inadequately resourced—constraining Fij''s ability to respond proactively to the evolving needs of its ageing population (WHO, 2011; World Bank, 2024a).

Financing

Expenditure

The share of public long-term care (LTC) expenditure as a proportion of gross domestic product (GDP) in Fiji remains unknown and is not applicable (N/A), primarily due to the absence of a formalized LTC system. While the government operates a small number of residential aged-care facilities, the associated expenditure is presumed to be negligible in relation to overall GDP. Furthermore, in the absence of a nationally coordinated LTC policy framework, there are no consolidated expenditure data or standardized budgetary classifications that would enable a reliable estimation of public spending on LTC. The current financing landscape is thus characterized by minimal public investment and a lack of dedicated financial monitoring mechanisms specific to long-term care (WHO, 2011; World Bank, 2024a).

Revenue raising

There is presently no dedicated revenue-raising mechanism for long-term care services in Fiji. Given the absence of a formal LTC policy and institutional structure, the government does not levy taxes, insurance contributions, or earmarked funds specifically for the purpose of financing long-term care. Consequently, LTC-related activities, to the extent they exist, are either absorbed within broader social welfare or health budgets or supported through external donor assistance on an ad hoc basis (WHO, 2011; World Bank, 2024a).

Pooling resources

Resource pooling mechanisms for long-term care are also non-existent in the Fijian context. Without a formal LTC financing system, there is no collective risk-sharing arrangement that could ensure equitable and sustainable access to care for older adults. This gap contributes to significant financial uncertainty for families and individuals who may need to rely on out-of-pocket payments or informal arrangements in the absence of state support (WHO, 2011; World Bank, 2024a).

Purchasing goods and services

Similarly, there is no formal public purchasing mechanism for LTC goods and services in Fiji. Public procurement is limited to the operational support of a few government-run aged-care homes, and even this is not governed by a sector-specific purchasing strategy. As such, there is no institutionalized framework for contracting, quality assurance, or performance-based purchasing in the LTC sector (WHO, 2011; World Bank, 2024a).

Workforce

Existing Workforce

Fiji currently lacks a formally recognized long-term care (LTC) workforce. In the absence of an established LTC system, there is no designated personal care workers (PCWs) or other trained professionals whose primary role is to provide assistance with activities of daily living (ADLs) for older adults. Care provision is instead carried out informally, primarily by family members or domestic helpers, often without any formal training, supervision, or remuneration. Consequently, no official data exist regarding the size, distribution, or qualifications of individuals performing caregiving functions in home or institutional settings (WHO, 2011; World Bank, 2024a).

Capacity-building and professionalization

There are no national standards, regulatory frameworks, or institutional pathways for the certification or training of personal care workers in Fiji. The lack of formal requirements for caregiving roles reflects the broader absence of workforce planning in the LTC sector. As such, individuals providing care—whether in private homes or the few existing residential facilities—typically do so without formal preparation in geriatric care or nursing assistance. This situation raises concerns about the quality and safety of care for older adults, particularly those with complex health or functional needs (WHO, 2011; World Bank, 2024a).

Likewise, given the absence of a recognized professional role for personal care workers within Fij'’s health or social care system, there are no structured career development opportunities available for individuals in this field. There are no established pathways for skills advancement, specialization, or progression to supervisory or managerial roles within

the caregiving sector. The lack of institutional recognition and professional incentives may further disincentivize potential entrants into the care workforce and perpetuate the informal and under-resourced nature of caregiving in the country (WHO, 2011; World Bank, 2024a).

Service Delivery

Eligibility and Gatekeeping

This section is intended to outline the general eligibility framework for long-term care (LTC), including whether access is universal or means-tested, the specific criteria used to determine eligibility when coverage is not universal, and the presence of gatekeeping mechanisms such as formal needs assessments. However, as previously noted, these considerations are not applicable in the context of Fiji, as the country has not yet established a formal LTC system. In the absence of a structured policy or programmatic framework, there are no standardized eligibility criteria, targeting mechanisms, or institutionalized processes to assess or regulate access to LTC services (WHO, 2011; World Bank, 2024a).

Settings for Public LTC Support

The public sector provides minimal institutional LTC support, primarily through a handful of senior citizens homes (e.g., Samabula, Labasa, Natabua). These facilities are publicly funded and staffed, but their capacity is limited, accommodating only around 100 older adults nationwide. There is no publicly funded home-based or community-based LTC support available at present (WHO, 2011).

Services Provided

In the limited institutional settings that exist in Fiji, it is assumed that basic custodial care—such as accommodation, meals, and assistance with activities of daily living (ADLs)—is provided. However, there is a lack of publicly available documentation specifying the exact scope, nature, or quality of services delivered within these facilities. This information gap hinders a comprehensive understanding of the current level of institutional care and impedes efforts to evaluate or improve service provision (WHO, 2011; World Bank, 2024a).

Integrated and Person-Centered Care Pathways

Fiji lacks both policy and infrastructure for integrated care models or person-centered LTC pathways. There are no established mechanisms to facilitate coordination across health, welfare, and social care sectors (WHO, 2011; World Bank, 2024a).

Quality Assurance

There are no formal quality assurance mechanisms, regulatory standards, or provider certification requirements specific to long-term care in Fiji. The small number of existing institutional care settings operate without sector-specific oversight bodies or accreditation procedures. As such, there is no systematic monitoring of care quality, no penalties for malpractice or neglect, and no established performance metrics to ensure accountability (WHO, 2011; World Bank, 2024a).

Performance of LTC Service Delivery

In the absence of a formal long-term care (LTC) system and a reliable data infrastructure, the performance of LTC services in Fiji cannot be meaningfully assessed using conventional indicators such as coverage, quality, financial protection, or user outcomes. Nonetheless, several challenges are evident. First, financial protection is virtually nonexistent. Without public funding or insurance schemes for LTC, families are left to bear the full cost of care, often through out-of-pocket expenditures, which can lead to significant financial hardship. Third, the burden of care falls overwhelmingly on informal caregivers who often lack access to training, respite services, or financial support. This contributes to considerable physical, emotional, and economic strain within households. Second, access to the limited services that do exist is shaped by socioeconomic and geographic disparities, leading to inequities in care provision (WHO, 2011; World Bank, 2024a).

3.8.4 Conclusion

Fiji's response to population ageing remains in a formative stage, with notable efforts made in health promotion but critical gaps in policy coherence, long-term care infrastructure, and institutional preparedness. The National Wellness Policy has laid the groundwork for a multisectoral and preventive approach to health, yet it lacks a life-course perspective and does not explicitly address the unique needs of older adults. While cultural norms emphasize familial responsibility for elder care, the absence of formal support structures, workforce development, and financial assistance places a disproportionate burden on informal caregivers and perpetuates inequalities in access to care.

Compared to countries such as Japan and Korea, where ageing is a central pillar of national policy with dedicated LTC systems, professionalized care workforces, and robust financing mechanisms, Fiji's institutional capacity remains limited. The country's relatively youthful demographic profile, coupled with historical political instability and fiscal constraints, has contributed to the deferral of ageing-related reforms. However, the trajectory of demographic change suggests that population ageing will become a more salient issue in the near future, especially as non-communicable diseases and functional limitations among older adults continue to rise.

To move toward a comprehensive healthy ageing policy, Fiji must begin laying the institutional foundations for integrated, person-centred care. This includes developing a national LTC strategy, improving data systems on ageing and caregiving, establishing formal

caregiver support mechanisms, and embedding ageing considerations across health and social policies. Strategic investment and anticipatory planning, informed by international models and adapted to Fiji's sociocultural context, will be essential to ensure that the country's ageing population can live with dignity, security, and wellbeing.

References

- ADB. (2014). Fiji: Update 2014.
- Chand, A., & Naidu, S. (2010). The role of the state and Fiji Council of Social Services (FCOSS) in service delivery in Fiji. International NGO Journal, 5(8), 185-193.
- Collins, C., & Fraenkel, J. (2012). Conflict prevention in the commonwealth: The 2000 Fiji Coup. International Negotiation, 17(3), 449-484.
- MHMS. (2015). National Wellness Policy for Fiji.
- MHMS. (2024). Fiji Health Accounts National Health Expenditure 2016-2021.
- MHMS, & Australian Aid. (2015). Non-Communicable Diseases Strategic Plan 2015 - 2019.
- UNDESA. (2019). World Population Ageing 2019.
- UNDESA. (2024). World Population Prospects 2024, Online Edition. https://population.un.org/wpp/downloads?folder=Standard%20Projections&group=Most%20used
- WHO. (2011). Fiji Health System Review. In.
- World Bank. (2024). Fiji Health Sector Review 2024 - Investing in People.

3.9 Uzbekistan

3.9.1 Introduction

Uzbekistan is undergoing a demographic transition characterized by gradual population ageing, increased life expectancy, and a growing prevalence of chronic diseases. As of 2024, individuals aged 65 and older account for 7.1% of the total population (WHO, 2024a), and the old-age dependency ratio has reached 9.0, signaling rising pressure on the working-age population (World Bank, 2024). Although these figures remain relatively low compared to countries with more advanced ageing, the rapid pace of demographic change indicates that the window for strategic policy response is narrowing.

Life expectancy in Uzbekistan has also shown notable improvement. The national average has risen to 72.2 years—70.2 years for men and 74.1 years for women—indicating progress in survival rates (WHO, 2024b). However, healthy life expectancy (HALE) remains significantly lower at just 63.4 years, resulting in a nine-year gap between expected lifespan and years lived in good health. This disparity suggests that many older adults are spending prolonged periods in later life with illness or disability, pointing to a concerning trend of expansion of morbidity (UNDP, 2023).

This gap between life expectancy and healthy life expectancy is closely linked to the rising burden of non-communicable diseases (NCDs). Chronic conditions such as cardiovascular disease, liver cirrhosis, diabetes, stroke, and Alzheimer's disease now dominate the disease profile in Uzbekistan (WHO, 2024c). As the country enters an epidemiological transition dominated by NCDs, the health system is increasingly strained by the complex and long-term care needs of an ageing population. This underscores the need to shift beyond a curative model and prioritize health promotion strategies alongside the institutionalization of long-term care (LTC) services.

However, the institutional foundations needed to support this transition remain underdeveloped. Uzbekistan's health system continues to follow the legacy structure of the Soviet-era Semashko model, with centralized authority over planning and regulation concentrated in the Ministry of Health (WHO, 2021). The country does not yet operate a universal health insurance scheme, and public spending on health remains low—just 2% of GDP as of 2018, compared to the WHO European regional average of 4.9%. Consequently, out-of-pocket payments account for as much as 60.3% of total health expenditure, presenting significant financial barriers to care access (WHO, 2021).

These structural constraints make it even more difficult to meet the growing healthcare and care needs of the elderly population. Uzbekistan lacks a formal LTC system, and much of the care burden falls informally on women within households. Public LTC infrastructure is extremely limited and lacks sufficient financial support (UNDP, 2023). As a result, older adults who have lost functional independence but are unable to access appropriate community-based care may resort to prolonged hospital stays—a phenomenon referred to as“"social admission”" This not only undermines the core purpose of hospitals, which is to provide acute care, but also places additional strain on already limited healthcare resources.

In an effort to address care gaps, Uzbekistan established a legal foundation for the provision of social services through the 2016 Law on Social Services for the Elderly, Persons with Disabilities, and Other Socially Vulnerable Categories of the Population, which was amended in 2022. This law outlines a broad set of services intended to ensure a dignified standard of living for vulnerable groups. The defined services include domestic assistance such as laundry, cooking, and cleaning; support with daily living activities like bathing, eating, and hygiene; outpatient care assistance; psychological support and legal counseling; rehabilitation and social integration assistance; temporary housing through shelters or rehabilitation centers; and transportation support and fuel provision.

Despite this legislative framework, the implementation of social services remains highly uneven across regions. Eligibility determination is largely discretionary, as the law does not mandate standardized, function-based assessments. As such, the system's effectiveness remains limited.

To address these challenges, the government of Uzbekistan launched the "Concept of Health System Development for 2019–2025" in 2018 and the "Uzbekistan Strategy 2030" in 2023 as part of a broader reform agenda across health care, social protection, and elderly welfare. These strategies prioritize the strengthening of primary health care, improving access to medical services, and establishing a solid policy foundation to respond to population ageing. In particular, they emphasize expanding preventive approaches to health promotion and developing a sustainable long-term care (LTC) system supported by public financing.

Nonetheless, Uzbekistan continues to face significant challenges in responding to the structural demands of population ageing. To ensure greater sustainability and equity, the country must establish standardized tools to assess functional care needs, address regional disparities in service delivery, and invest in the expansion of LTC infrastructure financed through public resources. By building an integrated LTC system alongside preventive health policies, Uzbekistan can improve the quality of life for its ageing population while promoting a virtuous cycle of reduced long-term social costs.

3.9.2 Healthy ageing policies

Contexts

Health promotion activities in Uzbekistan are being pursued as part of broader health system reforms and multi-sectoral development strategies. A key policy milestone is the *Concept on Health System Development of the Republic of Uzbekistan for 2019–2025*, adopted through Presidential Decree No. 5590 in 2018. This concept outlines national priorities such as increasing life expectancy, improving the quality of primary health care services, and strengthening the health workforce system (WHO, 2021).

Health promotion is also highlighted as a core policy direction in the *Uzbekistan Strategy 2030*, established in 2023. Although not a dedicated health promotion strategy, this comprehensive national agenda encompasses reforms across health care, social protection, education, the economy, and the environment. Among its central goals are the extension of life expectancy and the expansion of primary health care services (Oliy Majlis of the Republic of Uzbekistan, 2018).

Despite these strategic directions, the implementation of health promotion in Uzbekistan remains fragmented. Various standalone programs exist, including school-based health education, maternal and child health initiatives, and community-based outreach through *mahalla* committees. However, these programs are not strategically coordinated or integrated under a unified national framework (WHO, 2021; Republic of Uzbekistan, 2018). Furthermore, intersectoral collaboration is limited, and a systematic performance monitoring and evaluation framework for health promotion has not yet been institutionalized (ADB, 2017; UNDP, 2023).

As Uzbekistan enters an epidemiological transition marked by the growing burden of non-communicable diseases and population ageing, the absence of a comprehensive national strategy for health promotion presents both structural challenges and policy opportunities. To improve public health and ensure the long-term sustainability of the health system, it is essential to strengthen the institutional foundations for health promotion, establish mechanisms for intersectoral coordination, define clear performance indicators, and adopt a life-course approach within an integrated strategic framework.

Policy Foundations

Goal Setting

Uzbekistan is currently pursuing a major health sector reform centered on strengthening primary health care with a focus on prevention, guided by the *Concept of Health System Development 2019–2025* and the *Uzbekistan Strategy 2030*. This marks a shift away from a traditionally treatment-centered system toward a more community-based, continuous, and comprehensive model of preventive and management services. The ultimate goal goes beyond simply extending life expectancy, aiming instead to enhance overall quality of life.

The *Concept of Health System Development 2019–2025*, formalized through Presidential Decree PF-5590 (December 7, 2018)**,** presents a comprehensive response to systemic weaknesses—such as insufficient preventive services, poor service integration, human resource imbalances, and underdeveloped digital health infrastructure. Key policy priorities include the prevention and early detection of noncommunicable diseases (NCDs), promotion of healthy lifestyles, and proactive interventions targeting high-risk groups. To support this, efforts are underway to strengthen the capacity and functionality of primary health care facilities, including health posts, family clinics, and rural medical centers.

These reforms are closely aligned with the broader national development vision outlined in the *Uzbekistan Strategy 2030*, which positions health as a key pillar alongside welfare improvement, poverty reduction, and economic growth. The strategy emphasizes increasing life expectancy and expanding access to primary health services for all citizens.

In response to the growing national burden of NCDs, Uzbekistan is also adapting the WHO's Package of Essential Noncommunicable (PEN) Disease Interventions to fit the national context. Successful pilot projects implemented in rural areas are now being scaled up nationwide (WHO, 2021). These efforts reflect a policy shift toward standardized screening and follow-up management of chronic conditions at the primary care level.

GEDSI

Uzbekistan recognizes the reduction of disparities in health access and outcomes among different population groups—including by gender—as a key policy priority in the process of strengthening primary health care (PHC). In recent years, efforts to promote gender equity have been particularly prominent, aligning with the objectives of Sustainable Development Goal (SDG) 5 (UNDP, 2023; ADB, 2017).

A notable example is the establishment of a national policy framework for reproductive, maternal, newborn, child, and adolescent health (RMNCAH), which includes comprehensive legislation and standard guidelines on antenatal care, childbirth, postnatal services, and adolescent health (Republic of Uzbekistan, 2018).

Additionally, recent reforms have emphasized the importance of equity-focused monitoring and evaluation frameworks. In particular, the Universal Health Coverage (UHC) monitoring system used in ADB's *Primary Health Care Improvement Project* in Uzbekistan functions as a key tool to ensure that no population group is left behind in the process of health system transformation (ADB, 2017).
This framework provides a critical foundation for expanding the scope of PHC services and for designing and implementing health policies centered on equity.

Nevertheless, equity considerations have yet to be fully integrated into the broader health system, and further efforts are needed to establish tailored response mechanisms at the PHC level that address gender- and socioeconomically-driven vulnerabilities, supported by data-driven policy improvements.

Life-Course Orientation

Uzbekistan's health system increasingly incorporates a life-course approach into individual health policies, particularly those related to preventive and primary care. Early life interventions are well established, with high rates of antenatal care coverage, skilled birth attendance, and childhood immunization (WHO, 2021). Adolescents benefit from school-based health education programs that promote hygiene, nutrition, mental health awareness, and reproductive health knowledge (Republic of Uzbekistan, 2018). For the adult population, the focus is on early detection and management of NCD risks through the adoption of WHO's Package of Essential NCD Interventions (PEN) in primary care facilities. Older adults, while not yet fully supported by a formal long-term care system, are increasingly addressed through efforts to integrate eldercare into PHC services and expand the care economy, recognizing the demographic shift toward an aging population (UNDP, 2023).

Shift to Prevention

The government of Uzbekistan has been gradually expanding disease prevention efforts through a range of programs. In 2020, a legislative package was introduced to support the implementation of a team-based, community-oriented primary health care (PHC) model with a stronger focus on health promotion and disease prevention. This initiative reflects a broader policy shift from curative care toward preventive service delivery (WHO, 2024d).

In addition, the introduction of the WHO Package of Essential Noncommunicable Disease Interventions (PEN) in family polyclinics has strengthened the capacity for basic diagnostic services and preventive counseling, particularly in rural areas (ADB, 2017). This has contributed to the practical implementation of preventive approaches by enabling early detection and risk management of chronic diseases.

Furthermore, the government's efforts to strengthen primary health care—articulated in both the *Concept of Health System Development 2019–2025* and the *Uzbekistan Strategy 2030*—are directly linked to the expansion of preventive services. These strategies promote infrastructure development for primary care facilities, retraining of health professionals, and the implementation of electronic health records, all of which serve as essential components for building a prevention-oriented service system that enables early intervention and continuous management at the community level.

Nevertheless, financial investment in preventive care remains limited. As of 2024, only 3% of total health expenditure is allocated to preventive services, highlighting the persistent imbalance in favor of curative over preventive care (WHO, 2024d).

Evidence-Based Risk Factor Prioritization

Uzbekistan systematically identified the nationwide prevalence of key noncommunicable disease (NCD) risk factors through the WHO STEPS survey conducted in 2019, thereby establishing an evidence base for national health promotion policies and risk factor prioritization. According to the survey results, 16.5% of adults were current smokers, and

26.1% engaged in physical activity levels below WHO recommendations. Furthermore, 56.4% of the adult population was classified as overweight, 23.5% as obese, and 36.6% reported frequently adding salt to their food—highlighting the high prevalence of major health risk factors across the population(WHO, 2022).

Gender-specific differences were also observed: among men, smoking, alcohol consumption, and hypertension were the most prominent risk factors, while among women, insufficient physical activity, obesity, hypercholesterolemia, and lack of cervical cancer screening were most significant(WHO, 2022).

These STEPS survey findings serve as a critical foundation for the Government of Uzbekistan in developing national health promotion strategies and NCD prevention policies. Based on actual prevalence data, government interventions have prioritized improving dietary habits, increasing physical activity, regulating tobacco and alcohol use, and managing hypertension and obesity—targeting the risk factors with the greatest impact on public health(WHO, 2022).

This evidence-based prioritization of risk factors, grounded in the STEPS survey, plays a pivotal role in ensuring efficient resource allocation and in designing effective health promotion programs. It is expected to contribute meaningfully to reducing the burden of NCDs and extending healthy life expectancy in the long term.

Policy Alignment

Uzbekistan's *National Strategy Concept for Healthcare Improvement 2019–2025* identifies the achievement of universal health coverage (UHC) as a core objective and places key elements of health promotion—such as chronic disease prevention, early detection, and long-term care—at the center of national health reform. The strategy clearly prioritizes strengthening primary health care (PHC), transitioning to a prevention-oriented service model, and expanding community-based health promotion activities (WHO, 2021). In particular, the introduction of WHO's Package of Essential Noncommunicable Disease Interventions (PEN), along with the expansion of risk-based screening, health counseling, and behavior change campaigns through family polyclinics at the community and rural levels, reflects the growing implementation of practical health promotion programs (WHO, 2016).

This policy direction aligns closely with evidence from risk factor analyses such as the WHO STEPS survey. Based on the 2019 survey results—which revealed high prevalence rates of smoking, physical inactivity, and obesity—the government has prioritized preventive and health promotion policies targeting dietary improvement, physical activity, tobacco control, and obesity management. Screening and health education have also been increasingly integrated into the PHC system (WHO, 2022).

However, gaps remain in policy execution, particularly in terms of intersectoral coordination and institutional accountability. Nonetheless, the alignment of national strategy, the adoption of the PEN protocols, and the integration of STEPS data into policymaking represent important progress in Uzbekistan's move toward more strategic and evidence-based health promotion policy development.

Policy Governance and Funding Structure

Lead Institutions

The Ministry of Health (MoH) serves as the central governing body for health promotion policy in Uzbekistan. It oversees the overall organization, planning, and operation of the national health system and is responsible for a wide range of functions, including the development of health legislation and regulations based on presidential decrees and other high-level laws, the establishment of service standards and quality control guidelines, population health monitoring, the licensing and accreditation of healthcare providers and personnel, and the coordination of international health cooperation (WHO, 2008).

Additionally, the MoH evaluates the implementation of government and interministerial policies, provides policy guidelines to the Ministry of Health of the autonomous Republic of Karakalpakstan, and supervises and supports health authorities at the oblast (province), city, and rayon (district) levels (WHO, 2008).

Within this multi-tiered structure, the MoH leads the development and implementation of national-level health promotion policies, while subnational health authorities (at the oblast and rayon levels) are tasked with implementing and managing community-based health promotion programs. This clear division of roles between central and local levels, along with a hierarchical oversight mechanism, is a defining feature of Uzbekistan's health promotion policy governance and leadership structure.

Multisectoral Collaboration (HiAP)

National development strategies such as the *Uzbekistan Strategy 2030* encompass a broad range of sectoral goals that influence health, including improving quality of life, reducing poverty, strengthening social protection, and expanding access to education and healthcare. To implement these strategies, a network of government institutions—including the Presidential Agency for Strategic Reforms, the national and local parliaments, central ministries, and regional committees—has been established to oversee and coordinate policy execution.

However, this governance structure is primarily focused on aligning policy goals and monitoring implementation progress. It does not yet constitute a fully operational framework for the practical application of the Health in All Policies (HiAP) approach, which requires the systematic integration of health considerations across all sectors. Moving forward, the realization of HiAP will require the development of formal intersectoral coordination mechanisms, shared data systems, and integrated evaluation frameworks across policy domains (Nugmanova & Nuruddinova, 2023).

Additionally, International organizations play a crucial role in advancing health promotion in Uzbekistan, not only through financial contributions but also by supporting strategic planning, capacity development, and system reform. Key partners include the World Health Organization (WHO), the World Bank, and the Asian Development Bank (ADB), each of which has provided financial and technical assistance aligned with the country's health reform priorities.

A notable example is the *Primary Health Care Improvement Project*, supported by the ADB, which channels investments into rural health infrastructure—upgrading polyclinics, supplying essential diagnostic equipment, and training healthcare personnel (ADB, 2017). These interventions directly enhance the delivery of preventive and promotive health services, especially in underserved areas. Beyond infrastructure, donor organizations support institutional capacity-building, the development of monitoring frameworks, and the alignment of national programs with global strategies such as the Sustainable Development Goals (SDGs) and WHO's recommended practices.

Their engagement reinforces Uzbekistan's efforts to embed health promotion within a broader, multisectoral framework and to build a resilient health system capable of delivering person-centered, prevention-oriented care.

Decentralization

Although the governance of health promotion remains primarily centralized, Uzbekistan has pursued limited forms of decentralization, particularly in the delivery and administration of primary healthcare services. Local health authorities at the oblast (regional) and rayon (district) levels are responsible for implementing public health campaigns, providing essential primary care, and managing the day-to-day operations of health facilities within their jurisdictions (WHO, 2008).

However, despite this administrative delegation, strategic functions such as health planning, regulatory standard setting, and decision-making authority remain highly centralized under the Ministry of Health. This governance arrangement—often characterized as "administrative delegation without devolution"—means that while local actors are tasked with implementing policies, they have limited influence over their design or adaptation to local conditions (WHO, 2008). As a result, implementation capacity tends to vary significantly across regions depending on local leadership, staff competencies, and logistical infrastructure (WHO, 2021; ADB, 2017). The lack of structural autonomy at the subnational level has created inconsistencies in the scope, quality, and timeliness of service delivery, particularly in underserved or rural areas.

Funding Mechanisms

Health promotion in Uzbekistan is primarily financed through public funds derived from general taxation, with budgets centrally allocated by the national government and distributed to local authorities at the oblast, rayon, and city levels. While the actual execution of the budget is carried out by regional health departments, key decisions regarding budget formulation, expenditure priorities, and performance criteria remain concentrated within the central government—namely the Ministry of Health and the Ministry of Finance. This centralization limits the flexibility of local authorities to adapt programs to regional health needs or to exercise policy discretion (WHO, 2024d; ADB, 2017).

Although preventive and health promotion services are formally included in the national benefit package, the public health budget continues to be heavily skewed toward hospital-

based and curative care. As of 2019, only 3% of total health expenditure was allocated to preventive care, while inpatient and pharmaceutical spending accounted for approximately 60% (WHO, 2024d). Moreover, spending specifically earmarked for health promotion is not reported as a separate budget line, making it difficult to assess how much is actually invested in prevention. This lack of budgetary visibility further hinders financial accountability and strategic planning.

Primary health care (PHC) is nominally provided free of charge; however, out-of-pocket (OOP) payments remain widespread, particularly for specialist visits, hospitalizations, and medication. As of 2021, OOP accounted for over 60% of total health expenditure, posing significant financial barriers to access—especially among low-income populations. While PHC and some essential services are covered by the national benefits package, the scope of coverage is limited, and eligibility criteria are not closely aligned with household income levels. As a result, financial protection for vulnerable groups remains inadequate. Informal payments have also been reported in some areas, further constraining access to preventive services for those who can least afford them (WHO, 2024d).

In response, the government has initiated efforts to reform the health financing structure to better support preventive care and health promotion. A 2018 Presidential Decree and 2020 legislative reforms emphasized the need to strengthen prevention-oriented health systems. In line with these reforms, a pilot of the State Health Insurance Fund (SHIF) has been launched in Syrdarya region. This pilot introduces capitation-based financing for PHC and case-based payments for inpatient services, aiming to enhance the efficiency of resource allocation (WHO, 2024d).

Policy Implementation

Health Workforce Involvement

Uzbekistan's health promotion and PHC strategies have increasingly emphasized the integration of preventive services into frontline health delivery systems. One of the major pillars of policy implementation has been the expansion of the PHC workforce, particularly through the deployment of family doctors and nurses at local facilities. The Primary Health Care Improvement Project, supported by the Asian Development Bank, explicitly targeted strengthening rural family polyclinics with better equipment and a more capable workforce, including general practitioners trained to conduct NCD risk assessments, provide basic diagnostic services, and deliver lifestyle counseling (ADB, 2017; WHO, 2021). Although the formal concept of community health workers has not been widely adopted, nurses and feldshers have increasingly taken on responsibilities for community outreach, home visits, and basic preventive education, particularly in rural areas where physician density remains low (WHO, 2021).

Incentives for Local Resource Engagement

Community mobilization is a central component of Uzbekistan's health promotion strategy, with citizen engagement primarily facilitated through Mahalla Committees. Mahalla refers to

a socio-economic and territorially based self-governing public institution in Uzbekistan (Nugmanova & Nuruddinova, 2023), rooted in shared values and community solidarity. Traditionally, each mahalla includes elected representatives, elders, and respected local figures who organize economic and emotional support for vulnerable populations such as the unemployed and low-income households. They also mediate household conflicts and offer advice and counseling in cases of social norm violations (World Bank et al., 2019).

There are currently around 12,000 mahallas across Uzbekistan, each comprising 150 to 1,500 households. Following the collapse of the Soviet Union, some informal functions of mahallas were formalized, and in certain areas, they now serve as an extension of local government implementation authority (World Bank et al., 2019). Today, Mahalla Committees are legally recognized as participants in the planning, execution, and monitoring of public health services, and recent reforms have aimed to strengthen their legal mandates and operational capacities (WHO, 2010).

The *Uzbekistan Strategy 2030* also highlights the importance of enhancing mahalla functions. As part of its key performance indicators (KPIs) for promoting the rule of law and citizen-centered governance, the strategy includes the rollout of "one-step" administrative service systems and the full-scale implementation of a mahalla budgeting system. These measures aim to institutionalize the autonomy and accountability of mahallas in local governance.

However, despite this strategic emphasis, there remains a lack of clear incentive structures to promote sustained community engagement in health promotion. Moving forward, it will be essential to introduce formal incentive mechanisms—such as performance-based grants—to foster voluntary participation and enable locally driven public health initiatives.

Strategies for Older Adults

While Uzbekistan's national strategies—such as the Uzbekistan Strategy 2030—highlight the importance of increasing life expectancy, strengthening primary health care (PHC), and promoting preventive approaches, large-scale health promotion programs specifically targeting older adults are not yet in place. The *Law on Social Services for the Elderly, Persons with Disabilities, and Other Vulnerable Groups* provides a legal basis for the provision of social services to older persons. However, the law remains largely focused on general welfare support and does not specifically aim to prevent disease or enhance the quality of life and well-being of the elderly through structured health promotion initiatives.

Monitoring & Performance

Standardized Indicators

Uzbekistan has established a national set of standardized health indicators to support its health promotion agenda. These indicators align with the Sustainable Development Goals (SDGs) and the WHO Global Monitoring Framework for Noncommunicable Diseases

(NCDs), and cover key areas such as maternal and child health, NCD prevention, service coverage, and financial protection (WHO, 2021).

At the primary health care (PHC) level, the country has adopted the WHO Package of Essential NCD Interventions (PEN), which enables systematic screening of high-risk groups, risk stratification, and standardized follow-up care. In addition, a national strategy to promote healthy diets, physical activity, and sport was introduced by presidential decree in 2020 (WHO, 2021).

However, indicators specific to older populations have not yet been systematically incorporated. The performance metrics used in national surveys such as WHO STEPS primarily target adults aged 18–69, omitting elderly-specific health indicators such as functional status, frailty, or age-related risk profiles (WHO, 2022). Most available data are aggregated into three broad age groups—18–29, 30–44, and 45–69—making it difficult to assess health behavior changes and risk patterns among older adults in a disaggregated manner.

Moving forward, it will be essential to develop age-disaggregated performance indicators that specifically address older populations, ensure regular public dissemination of such data, and integrate these insights into the design of age-friendly health promotion policies.

Data and Monitoring Sources

Uzbekistan's health promotion policy is designed and implemented based on multiple data sources and monitoring systems. The Institute of Health and Medical Statistics under the Ministry of Health plays a central role in collecting and analyzing health-related data, including population health status, health care utilization, service quality, demographic trends, environmental factors, and lifestyle behaviors. These data serve as key evidence for policy formulation and performance evaluation (WHO, 2010).

Notably, in collaboration with the WHO, Uzbekistan conducted the STEPS survey on noncommunicable disease (NCD) risk factors in 2014 and 2019. This nationally representative survey systematically measured health behaviors such as smoking, alcohol consumption, dietary patterns, and physical activity, along with biological risk indicators including anthropometry, blood pressure, blood glucose, and cholesterol levels, using standardized methodologies. The results are widely used to inform national NCD policies, health promotion strategies, and to monitor progress toward the Sustainable Development Goals (SDGs) (WHO, 2022).

In addition, various data are generated through international projects and evaluation studies led by organizations such as the World Bank, ADB, and UNICEF. These projects often include well-defined performance indicators and structured data collection and reporting mechanisms, which enable the quantitative evaluation of policy outcomes. Regular external evaluations and monitoring processes further contribute to the effectiveness and accountability of health promotion policies (ADB, 2017; World Bank, 2019a).

Meanwhile, digital health information systems (e.g., HMIS) have been piloted in certain regions, but nationwide data integration and real-time monitoring frameworks remain in the

early stages of development (WHO, 2024d). Furthermore, existing data systems are often fragmented across institutions, and there is limited interoperability between administrative and survey data. Strengthening data integration and promoting interoperability will be crucial to improving the comprehensiveness and utility of health information in the future.

Evaluation and Feedback Loops

Uzbekistan has gradually strengthened its mechanisms for regular evaluation and policy review through international collaboration. Programs led by donors such as WHO, UNICEF, and the World Bank have contributed to building the country's capacity for health program evaluation and introduced standardized tools for monitoring and feedback (WHO, 2021). For example, the monitoring framework developed under the *Primary Health Care Improvement Project***,** supported by the Asian Development Bank, served as a model for systematically tracking performance in rural health centers (ADB, 2017). National health reviews are also conducted periodically with the participation of diverse stakeholders, including government ministries, development partners, and academic institutions. These reviews assess progress toward strategic goals such as achieving Universal Health Coverage (UHC), controlling noncommunicable diseases (NCDs), and improving maternal and child health (WHO, 2021).

However, despite the existence of these evaluation mechanisms, the feedback loop from assessment to actual policy adjustment and program redesign remains underdeveloped. In many cases, evaluation results are mainly reflected in donor-led program adjustments, while their translation into broader national policy reforms is limited. As a result, policy adaptations tend to be reactive, based on external evaluations or recommendations from international organizations, rather than proactive internal reviews (World Bank, 2020). Consequently, even when data clearly reveal the need for intervention—such as disparities in primary care service quality or gaps in NCD risk factor screening—systematic and timely corrective action at the national policy level is often delayed.

3.9.3 Long-term care policies

Contexts

Uzbekistan, like many post-Soviet states, faces a growing need for structured long-term care (LTC) policy frameworks in response to demographic and socioeconomic changes. As of 2023, approximately 7.1% of Uzbekistan's population—about 2.5 million people—were aged 65 and over, a figure projected to rise steadily due to improvements in life expectancy and persistently low fertility rates (WHO, 2021). While this aging rate remains lower than in most high-income countries, the shift is nonetheless significant, particularly when considered alongside the country's limited existing capacity for formal eldercare. This gap highlights the need to reevaluate and expand Uzbekistan's current approach to long-term care, which is primarily anchored in social protection mechanisms rather than health- or function-based care systems.

Historically, elderly care in Uzbekistan was rooted in the Soviet model, which emphasized family-based support, modest public pensions, and limited institutional care facilities (WHO, 2008). Following independence in 1991, economic contraction and reduced state capacity constrained the government's ability to maintain universal social welfare coverage, including services for older adults. Much of the state response shifted toward targeting vulnerable groups with basic safety net programs rather than comprehensive care models.

A critical policy milestone came with the enactment of the "Law on Social Services for the Elderly, Persons with Disabilities, and Other Vulnerable Groups" in 2016—commonly referred to as the Elderly Act (Oliy Majlis of the Republic of Uzbekistan, 2022). This law established a legal basis for delivering social services to older adults and persons with disabilities. It outlines entitlements such as home-based assistance, provision of assistive equipment, rehabilitation, and access to social pensions. However, the law's provisions are limited to general social welfare, lacking specification of continuous LTC services such as skilled home care, dementia care, or custodial nursing facilities. This legal and policy ambiguity reflects a broader systemic absence of a nationally defined LTC framework.

Community-level support, meanwhile, is largely informal. Uzbekistan's traditional mahalla system—a decentralized neighborhood governance structure—serves as the primary avenue for community engagement and limited care provision for elderly residents. Mahalla committees assist with basic tasks such as grocery shopping, emotional support, or local coordination of benefits for older adults living alone or in poverty (World Bank, 2019). However, these structures are informal, volunteer-based, and vary significantly in capacity. They lack sustainable financing, technical guidelines, and integration with medical or public health services, limiting their scalability and effectiveness as a nationwide LTC platform.

More recently, discussions around the "care economy" have begun to frame eldercare as not only a social responsibility but also an economic opportunity. A 2023 report by the United Nations Development Programme (UNDP) emphasized that strategic investment in home- and facility-based care could generate jobs, support female labor force participation, and address the unmet needs of older adults—especially in rural areas (UNDP, 2023). However, these proposals remain largely aspirational. No comprehensive national strategy has yet been adopted to link workforce development, training, and care delivery under an LTC framework.

Institutionally, Uzbekistan lacks a coherent long-term care (LTC) system that integrates medical and social care functions. The Law on Social Services (2022) provides the legal foundation for various forms of LTC—including home-based services, residential institutions, and short-term stays—but it does not outline mechanisms for coordination with the health system (Oliy Majlis of the Republic of Uzbekistan, 2022). Together, these structural and legal gaps underscore the fragmentation between health and LTC systems, leaving the needs of older adults—especially those with chronic or functional impairments—insufficiently addressed.

In summary, Uzbekistan's long-term care landscape is defined by a patchwork of social protection programs, minimal institutional services, and informal community support. The Elderly Act of 2016 established a basic rights-based framework, but the absence of a dedicated LTC policy, financing mechanism, and workforce development plan hinders progress toward a universal, equitable system. As population aging accelerates, Uzbekistan must contend with a growing mismatch between demographic trends and care system capacity. Future development may hinge on integrating community-based pilot initiatives, expanding health workforce training, and establishing sustainable financing streams—potentially through social insurance or public-private partnerships. Without strategic policy commitment, Uzbekistan risks perpetuating a fragmented system that inadequately supports the health, dignity, and independence of its aging population.

Governance

Long-term care legislation and strategy

The governance of LTC in Uzbekistan is rooted in a developing but gradually formalizing framework. While the country does not yet operate a comprehensive public LTC system comparable to those in high-income countries, a number of legislative and institutional mechanisms provide a foundation for future expansion.

Uzbekistan's principal legislative basis for elderly services is the *Law on Social Services for Elderly, Persons with Disabilities, and Other Socially Vulnerable Groups* (Law No. ZRU-415), first enacted in 2016 and updated in 2022. This law regulates the rights and procedures for providing social services, emphasizing principles such as legality, accessibility, individualized support, and preventive orientation (Oliy Majlis of the Republic of Uzbekistan, 2022). Although comprehensive in covering social assistance, it does not establish a distinct national strategy specifically focused on long-term care. Health-related support measures, including rehabilitation and home-based care services, have been developed through broader health system strengthening projects like the Primary Health Care Improvement Project (ADB, 2017), but these are not yet integrated into a structured LTC framework.

Governance structure

The governance structure for elderly and social care services is characterized by distributed responsibilities across several institutions rather than centralized management. The Ministry of Health (MoH) oversees health-related elderly support, while the Ministry for Support of the Mahalla and Family coordinates local-level social service initiatives through Uzbekistan's traditional mahalla networks (WHO, 2021). In addition, regional and municipal authorities, known as *hokimiyats*, manage elderly homes and social assistance centers. However, formal LTC services remain scarce, and the current structure suffers from fragmentation, with limited integration between health and social sectors. There is no single national authority solely dedicated to coordinating or regulating LTC, resulting in policy gaps, uneven service availability, and limited oversight of quality standards.

Accountability mechanisms for LTC-related services in Uzbekistan remain underdeveloped. According to the *Law on Social Services for Elderly, Persons with Disabilities, and Other Socially Vulnerable Groups* (2022), governmental agencies must ensure transparency and maintain service quality standards for social services, including those for older adults. However, practical enforcement of these requirements is limited. Independent audits or external evaluations are rare, and most performance reviews are conducted internally without systematic public disclosure (UNDP, 2023). International organizations like WHO and UNDP have occasionally conducted program evaluations, especially for donor-supported projects, but integration of their findings into formal policy revisions has been inconsistent (UNDP, 2023). Financial accountability is also a challenge: funding for elderly services is embedded within general social protection and health budgets rather than allocated through a dedicated LTC fund. Recent studies have highlighted the need for more sustainable and transparent financing mechanisms as Uzbekistan's population continues to age.

Despite these limitations, recent policy discussions show an emerging awareness of the need for a more structured governance model for LTC. Reports such as the UNDP's 2023 care economy analysis emphasize the importance of enhancing inter-ministerial coordination, establishing clearer funding streams, and formalizing monitoring systems to ensure sustainable and equitable development of elderly services (UNDP, 2023).

Financing

Expenditure

Across key national planning and financial reporting documents, LTC-specific expenditures are not disaggregated within Uzbekistan's national health accounts. This lack of visibility in financial data reflects broader fragmentation between health and social protection sectors and signals a policy gap in addressing the needs of the ageing population.

Revenue raising

The primary source of funding for elderly social services in Uzbekistan is general taxation. Government revenues collected through taxes finance a range of social protection programs, including pensions, disability allowances, and basic social support for vulnerable groups (WHO, 2021; Juraev & Ahn, 2023). There is no separate LTC insurance contribution or earmarked funding stream dedicated specifically to elderly care. This reliance on general taxation creates vulnerabilities, as budget allocations for elderly services must compete annually with other priorities such as education, defense, and general healthcare.

Pooling resources

Social protection systems in Uzbekistan, including those for the elderly, are primarily implemented at the local government (hokimiyats) and community levels. These social services are financed through general taxation by the central government (World Bank et al., 2019). Local governments generally rely on budget transfers from the central government rather than raising independent revenue, and they plan and administer services based on these allocations.

However, unlike structured vertical fiscal mechanisms such as Korea's matching fund system, Uzbekistan lacks a formalized and predictable framework for fiscal transfers or budget allocation between central and local levels. In most cases, service delivery is carried out in an ad hoc manner, heavily dependent on the financial capacity and discretion of each local unit. In practice, each mahalla is subject to different monthly expenditure caps, which can lead to delays in benefit applications or reductions in the amount and duration of assistance. Some mahallas attempt to supplement their limited resources through donations from wealthier households or voluntary community support, but this approach is highly dependent on local economic conditions. In certain areas, non-functioning mahalla structures have resulted in prolonged periods without any form of public assistance (World Bank, 2019b).

In conclusion, while Uzbekistan's social services are centrally funded through general taxation, the absence of a standardized and equitable fiscal allocation mechanism at the local level contributes to regional disparities and inconsistent service accessibility.

Purchasing goods and services

Purchasing of goods and services for elderly care in Uzbekistan follows a centralized, publicly administered model. Social service centers operated by regional or municipal authorities provide available services according to national guidelines. However, there is currently no explicit mechanism that links budget allocation to service volume, making volume-based reimbursement or performance-based contracting infeasible within the existing LTC financing structure. As a result, service provision and cost structures vary considerably across regions. While long-term care services are generally offered free of charge for eligible groups, some users may encounter informal payments or service gaps, especially in settings where resource constraints limit the availability or quality of services.

Several policy reports highlight the challenges associated with the current financing approach. According to UNDP (2023), low public investment in elderly services and the lack of dedicated financing mechanisms pose major obstacles to expanding access and improving quality. Without structural reforms, Uzbekistan risks facing an escalating care deficit as its population continues to age.

Recent discussions around care economy investments suggest an emerging recognition of the need for more sustainable LTC financing strategies. The government's collaboration with UNDP and other partners emphasizes the importance of developing dedicated funding streams, piloting insurance-based models, and exploring public-private partnerships to enhance resource mobilization for LTC services (UNDP, 2023).

Workforce

Existing Workforce

The development of a specialized long-term care (LTC) workforce in Uzbekistan remains at an early stage, reflecting the broader structural absence of a formal public LTC system. In practice, home-based elder care is predominantly provided by informal caregivers, who are typically middle-aged female family members over the age of 40 with no formal training in long-term care (ADB, 2023). Despite playing a central role in care delivery, these caregivers operate without structured support systems, standardized training programs, or integration with formal health and social service frameworks. Moreover, the lack of disaggregated official data on the age and gender composition of the eldercare workforce poses significant challenges to the planning and management of targeted workforce policies.

This institutional gap is partially addressed by *mahallas*, traditional community-based organizations in Uzbekistan. Mahallas play a central role in providing informal care and support to older persons, persons with disabilities, and other vulnerable groups within the community. In the absence of a fully developed and professionalized long-term care workforce, *mahalla* members—including volunteers, local leaders, and residents—often serve as frontline caregivers, partially compensating for the shortage of formal personnel. However, their contributions fall short of constituting a professional workforce, and there are clear limitations in terms of service quality, coordination, and integration. Accordingly, it is recommended that Uzbekistan invest in the training and deployment of qualified professionals, including social workers, care managers, and home-based care workers (WHO et al., 2019).

Capacity-building and Professionalization

The capacity-building and professionalization of the LTC workforce are limited. Uzbekistan does not currently operate a formal certification system for caregivers specializing in elderly care. General nursing qualifications and social work training provide the foundational skills for those delivering eldercare services (WHO, 2021). Although some continuing education opportunities exist, such as short-term training on geriatric care for healthcare workers, these programs are largely ad hoc, donor-funded, and localized to urban areas. There is no national

standard or examination requirement for certification as a personal care worker, and career development pathways specifically targeting the eldercare sector are absent.

Career advancement for workers involved in elderly services is constrained by the lack of a recognized professional track. Consequently, eldercare remains a relatively low-status, low-reward field, with limited incentives for professional growth (UNDP, 2023).

Service delivery

Eligibility and gatekeeping

According to Uzbekistan's Law on Social Services, long-term care (LTC)–related support is guaranteed as a rights-based provision for socially vulnerable groups, including older persons, persons with disabilities, individuals without caregivers, and low-income populations. While no explicit income or age thresholds are defined, eligibility is determined in practice through a life situation assessment. Legally, this assessment is intended to inform the development of an individual service plan; however, standardized tools to evaluate functional limitations—such as Activities of Daily Living (ADL), Instrumental Activities of Daily Living (IADL), or medical needs—have not yet been introduced.

In practice, the *mahalla*—a traditional community-based organization—functions as the primary gatekeeper for identifying vulnerable individuals, including older persons, and linking them to public support systems such as social services and cash transfers. For example, older adults living alone or individuals with severe disabilities must apply for services through their local *mahalla* committee, which is responsible for determining eligibility, allocating benefits, and referring individuals to appropriate services. In performing these roles, *mahallas* draw on their deep local knowledge and social networks, serving as a critical intermediary between the community and the formal welfare system(WHO et al., 2019).

Settings for Public LTC Support

The service delivery framework for LTC in Uzbekistan remains in an early stage of development, reflecting the limited availability of structured public LTC services. Public LTC support is provided mainly through minimal institutional care settings and small-scale home- and community-based initiatives. Institutional care facilities (nursing homes) operated by local governments or social service agencies are extremely few, primarily targeting individuals without family support and focusing on shelter provision rather than comprehensive health and social care (WHO, 2021). Home-based care and community services are informal and largely facilitated through mahalla committees, with only basic assistance such as household tasks and food provision(WHO et al., 2019).

Service provided

Long-term care (LTC) services in Uzbekistan remain at a basic level of support, with the scope and content of formal services being extremely limited. Most care is provided informally within the community, reflecting the absence of a structured service package and a professional workforce (WHO et al., 2019).

Home- and community-based services are primarily facilitated through mahalla committees and are limited to basic assistance such as meal provision or food delivery, household chores, counseling, mediation of family conflicts, and emergency financial support.

As a result, LTC services in Uzbekistan currently rely on informal resources and provide only minimal support, with little to no individualized care based on a person's functional status, health condition, or family situation.

Integrated care and person-centered care pathways

Integration of care and person-centered care pathways are largely absent from Uzbekistan's current LTC delivery system. Service delivery remains fragmented between health and social protection sectors, and there is no formal mechanism to coordinate care across service domains. Older persons requiring both medical and social support must navigate separate bureaucratic systems with little assistance in developing personalized care plans (WHO, 2021). No standardized care pathways or service coordination protocols exist at the national or regional levels. Although PHC reforms emphasize preventive health services and chronic disease management, integration with social support services for the elderly is minimal. Efforts to develop more person-centered approaches remain at the discussion or pilot project stage, often supported by international agencies rather than being embedded in government systems (UNDP, 2023).

Quality Assurance

Quality assurance mechanisms for LTC service providers are weakly developed. Legal frameworks such as the *Law on Social Services for the Elderly, Persons with Disabilities, and Other Vulnerable Group* set out general service provision standards, but enforcement is inconsistent. Minimum facility and workforce requirements for operating elderly homes or social service centers are nominally established, but regulatory inspections are infrequent, and quality monitoring systems are underdeveloped (WHO, 2021). There is no national agency dedicated to LTC provider accreditation or licensing. In contrast to healthcare facilities, where some quality assurance measures exist through Ministry of Health supervision, social service facilities for the elderly operate with limited oversight. Penalties or sanctions for substandard care provision are rare, and consumer protection mechanisms for older adults in LTC settings are practically nonexistent.

Moreover, Uzbekistan lacks a standardized service pricing and reimbursement system for LTC. Services are provided free of charge to eligible individuals, but informal costs and inconsistent service quality often limit accessibility, particularly in rural areas. There is no

national fee schedule for personal care services or institutional care stays. Consequently, public facilities rely on constrained government budgets, and service expansion is often hindered by financial limitations (Juraev & Ahn, 2023).

Performance of long-term care service delivery

Publicly funded services for the elderly in Uzbekistan are extremely limited in scope and are implemented in a highly selective manner. The *Law on Social Services for the Elderly, Persons with Disabilities, and Other Vulnerable Groups* (2022) provides legal entitlement to basic social services only for individuals who meet specific vulnerability criteria, such as lacking family support or having severe disabilities.

However, in practice, eligibility is largely determined at the discretion of local authorities or mahallas, without a standardized, needs-based assessment system in place (World Bank, 2019b). As a result, there is no structure to objectively and systematically assess care needs. Furthermore, no standardized benefit package exists that defines the type, duration, or intensity of services, leading to discretionary and inconsistent implementation across regions. There are also no clear national standards for cost-sharing or copayment. Although services are generally provided free of charge, the actual availability, quality, and comprehensiveness of services vary significantly by region, reflecting substantial geographic disparities (WHO, 2021).

Due to the absence of a formal long-term care (LTC) system, it is extremely difficult to assess and measure the performance of service delivery. Currently, care is predominantly provided informally by female family members within community settings, and there is no standardized national system for evaluation or data collection. As a result, it is challenging to quantify the scale of unmet care needs among older persons, assess the impact of caregiving on quality of life, or examine equity in access to care services. The lack of such information poses significant barriers to ensuring the effectiveness and fairness of LTC service delivery and limits the evidence base for policymaking and resource allocation.

3.9.4 Conclusion

Uzbekistan is only at the threshold of population ageing—people aged 65 and over represent about 7 percent of the population and the old-age dependency ratio is still below 10 percent. Yet a nine-year gap between life expectancy and healthy life expectancy hints at a prolonged period of morbidity in later life and foreshadows a rapid rise in care needs if no action is taken. Because neither a comprehensive healthy-ageing strategy nor a dedicated long-term care (LTC) policy is in place, Uzbekistan now sits at a “window of opportunity”: the demographic pressure is still manageable, but the planning horizon is shrinking quickly.

Care for older people remains split between the Ministry of Health, which manages medical services, and the Ministry for Support of the Mahalla and Family, which coordinates social assistance; no single body is tasked with integrating the two spheres. The Elderly Act (2016, 2022) sets only broad social-welfare entitlements and does not define assessment tools, benefit packages, or financing for function-based LTC services. Without coordinating

authority, continuity of care is limited, quality standards are uneven, and strategic financing—such as insurance-based models—cannot emerge.

Against these backdrops, the mahalla community network is an under-used bridge between health promotion and care. Traditional mahalla committees already mobilize volunteers for household outreach, basic support, and public-health campaigns. Viewed through a healthy-ageing lens, they could become the front line of a community-based integrated-care model, linking primary-health-care teams with social-care resources much as similar structures do in other Asia-Pacific countries. Their neighbourhood reach makes them ideal for simultaneous risk-factor management, functional-status monitoring, and light home-care services. Donor projects—most notably the ADB-financed Primary Health Care Improvement Project—have already invested in rural polyclinics and community outreach, providing a practical entry point for piloting integrated services.

In such sense, strategic partnerships with international organizations could create critical chance for reform. WHO and ADB enhance its support in primary-care and prevention, while UNDP and other UN agencies can champion the economic and social-protection dimensions of care; aligning these streams around the mahalla-centric pilot would leverage existing goodwill and avoid duplication. In short, Uzbekistan can still “age well” if it moves quickly: integrate governance, empower mahalla-based delivery, and secure sustainable financing. Acting now will narrow the healthy-life-expectancy gap, safeguard family caregivers, and build a person-centred LTC system before demographic momentum makes reform costlier and more complex.

References

- Asian Development Bank. (2017). *Republic of Uzbekistan: Primary health care improvement project*. Asian Development Bank.
- Juraev, Z., & Ahn, Y. J. (2023). *Analysis of healthcare spending in Uzbekistan: Economic implications and policy recommendations*. Preprints. https://doi.org/10.20944/preprints202307.1078.v1
- Khasanbaev, A., & Pfau, W. D. (2009). *The funded pension scheme in Uzbekistan: An analysis*. *Sophia International Review*, 31(1), 75–92.
- Nugmanova, M., & Nuruddinova, A. (2023). *Report on improving the care system in the Republic of Uzbekistan: A path to economic growth, poverty reduction and improved quality of life*. United Nations Development Programme (UNDP).
- Oliy Majlis of the Republic of Uzbekistan. (2018). Concept of health system development in the Republic of Uzbekistan for 2019–2025 (Presidential Decree No. PF-5590). Tashkent. https://lex.uz/docs/4096197
- Oliy Majlis of the Republic of Uzbekistan. (2022, May 18). Law on Social Services for *the* Elderly, *Disabled* and Other Socially Vulnerable *Categories of the Population (as amended)*. LEX.UZ. https://lex.uz/en/docs/6821897
- Permanent Mission of the Republic of Uzbekistan to the United Nations Office at Geneva. (2016). *Information on national practices in the implementation of existing law in the Republic of Uzbekistan on the promotion and protection of the rights of older persons* (HRC/NONE/2016/1). United Nations Human Rights Council.
- Republic of Uzbekistan. (2018). *Policy country profile: Uzbekistan*. Tashkent: Ministry of Health.
- United Nations Development Programme. (2023). *Investing in Uzbekistan's care economy for societal well-being and economic growth*. UNDP.
- United Nations Human Rights Council. (2016). *Information on national practices in the implementation of existing law in the Republic of Uzbekistan on the promotion and protection of the rights of older persons*. HRC/NONE/2016/1.
- United Nations Multi-Partner Trust Fund Office. (2023). *Uzbekistan Vision 2030 Fund: Annual narrative report 2023*.
- World Bank, ILO, & UNICEF. (2019). *An assessment of the social protection system in Uzbekistan: Based on the Core Diagnostic Instrument (CODI)*. World Bank.
- World Bank. (2019a). *Uzbekistan: Health system improvement project (Project Appraisal Document No. PAD3065).* Washington, DC: World Bank Group.

- World Bank. (2019b). Uzbekistan Social Assistance Targeting Assessment. Washington, DC
- World Bank. (2020). *Uzbekistan health system transformation roadmap*. World Bank Group.
- World Bank. (2022). *Uzbekistan Public Expenditure Review: Better Value for Money in Human Capital and Water Infrastructure*.
- World Bank. (2024). *Age dependency ratio, old (% of working-age population) – Uzbekistan* [Data set]. https://data.worldbank.org/indicator/SP.POP.DPND.OL?locations=UZ
- World Health Organization. (2008). *Uzbekistan: Health Systems in Transition*. European Observatory on Health Systems and Policies.
- World Health Organization. (2010). *Public health strategy of the Republic of Uzbekistan 2010–2020*. WHO Regional Office for Europe.
- World Health Organization. (2021). *Health systems in action: Uzbekistan*. Copenhagen: WHO Regional Office for Europe.
- World Health Organization. (2022). *Prevalence of risk factors for noncommunicable diseases in the Republic of Uzbekistan, 2019: Results of a STEPS survey*. World Health Organization Regional Office for Europe.
- World Health Organization. (2024a). *Uzbekistan population data*. WHO Global Health Observatory. https://data.who.int/countries/860
- World Health Organization. (2024b). *Uzbekistan life expectancy data*. WHO Global Health Observatory. https://data.who.int/countries/860
- World Health Organization. (2024c). *Uzbekistan leading causes of death data*. WHO Global Health Observatory. https://data.who.int/countries/860
- World Health Organization. (2024d). *Health systems in action: Uzbekistan*. Copenhagen: WHO Regional Office for Europe.

Chapter 4. Cross-Country Comparison of Healthy Ageing and Long-term Care Policies in the Asia-Pacific Region

4.1 Convergences and Divergences in Healthy Ageing Policies Across Nine Asia-Pacific Countries

4.1.1 Introduction

Health promotion has gained strategic prominence across Asia-Pacific countries as they respond to the complex dual challenge of demographic aging and the rising burden of noncommunicable diseases (NCDs). These challenges are reshaping health systems, pushing policymakers to shift from predominantly curative, hospital-based approaches to community-rooted, preventive strategies that engage individuals throughout their lives. This transformation is not uniform; it reflects the unique policy trajectories, institutional capacities, and demographic pressures of each country.

This comparative overview analyzes nine countries—Japan, Korea, Thailand, China, Sri Lanka, Vietnam, Indonesia, Fiji, and Uzbekistan—focusing on both convergences and divergences in their health promotion approaches. Specifically, the analysis examines how countries are integrating prevention into national health strategies, mobilizing financing and governance arrangements, targeting priority populations, and adapting to aging trends. Through mapping these similarities and differences, this chapter aims to contribute to a clearer understanding of emerging regional patterns and inform future inter-country learning and systems development. It also offers insight into how health promotion policy can serve as a foundational bridge between public health and emerging long-term care systems in rapidly aging contexts.

4.1.2 Convergences Across Countries

Emphasis on Prevention and Life-Course Approaches

Most countries in this review are increasingly orienting their national health strategies around prevention and life-course approaches. This involves designing interventions that span all ages—from prenatal care and child health to youth development, adult risk management, and active aging. Japan’s Health Japan 21, China’s Healthy China 2030, and Korea’s HP2030 all frame health promotion within a structured life-course perspective. They set stage-specific targets and offer tailored interventions such as school health programs, workplace wellness promotion, and community-based elder care initiatives.

Vietnam, Indonesia, and Thailand also recognize the importance of health promotion across the lifespan, although their frameworks tend to be more programmatic and less institutionalized. These countries often implement life-course elements through pilot

programs or community platforms, such as Vietnam's ISHCs or Indonesia's Posyandu. Despite variation in formality and scale, the convergence in policy language and programmatic intent toward a life-course orientation is notable across the region. These models also demonstrate growing awareness of the need to address health vulnerabilities at multiple stages in life, with prevention efforts adapted for local and cultural relevance.

Common Risk Factor Prioritization

All nine countries identify and prioritize a similar set of modifiable risk factors—chiefly tobacco use, poor diet, harmful alcohol consumption, and physical inactivity—as critical targets for intervention. These priorities are typically informed by national burden of disease studies and are often reflected in national development strategies or public health legislation.

Thailand and China have made substantial institutional investments in addressing these risks through mechanisms like ThaiHealth or provincial NCD control offices. Vietnam's Tobacco Control Fund, established under the Law on Prevention and Control of Tobacco Harms, channels levies to support smoking cessation campaigns and enforcement. Indonesia and Fiji have embedded risk reduction messages into broader wellness strategies or school-based programs. Countries are also increasingly recognizing the importance of mental health and environmental health as emerging risk factors, although these areas are less systematically integrated. In addition, the growing burden of metabolic risks—such as obesity, hypertension, and high blood sugar—has underscored the need for stronger preventive approaches within primary health care. While the comprehensiveness of policy frameworks differs, there is substantial convergence in acknowledging these shared behavioral, metabolic, and environmental risks as foundational targets for improving population health.

Community and Primary Health-Based Delivery

A common feature of health promotion delivery across the region is the reliance on community-based and primary health care (PHC) systems. Countries leverage locally embedded platforms and community health workers to extend preventive services, disseminate health information, and promote early screening.

Thailand's Village Health Volunteers are a longstanding example of volunteer-led, community-rooted health promotion. Vietnam's ISHCs offer a model supported by local associations and international partners, mobilizing volunteers to provide health, care, social engagement, and legal support. Indonesia's Puskesmas and Posyandu serve as decentralized nodes for maternal and child health, nutrition, and health education. Japan and Korea deploy trained public health nurses through municipal networks, while Uzbekistan and Fiji are scaling up outreach through PHC revitalization efforts. Community-based approaches offer scalability, cultural acceptability, and responsiveness to local needs. Their sustainability, however, often depends on government recognition, training support, and integration into formal systems.

Gender and Equity Considerations

Many countries have begun to incorporate gender and social equity dimensions into their health promotion strategies. These efforts vary in depth but indicate a shared understanding of health disparities linked to gender, geography, socioeconomic status, and caregiving roles.

Vietnam's ISHCs specifically target older women and unpaid caregivers, offering leadership roles and health services tailored to their needs. Korea and Japan include gender-disaggregated indicators in their national health plans and are working to close HALE gaps across income and geographic lines. China's National Program for Women's Development addresses women's health across reproductive stages and supports gender-sensitive planning. Uzbekistan, Indonesia, and Sri Lanka prioritize maternal health equity and strive to eliminate disparities in service access in rural areas. A growing number of countries now link gender equity with system efficiency and social protection, viewing health promotion as a lever for broader inclusion and empowerment.

Multisectoral Intent and Policy Framing

All countries reference some form of Health in All Policies (HiAP) or an equivalent multisectoral engagement approach. Policy documents are increasingly reflecting an awareness that health outcomes are co-produced through various sectors, including education, housing, transportation, agriculture, and employment.

Thailand's ThaiHealth has institutionalized this logic with a legally backed, independently governed agency that funds cross-sectoral initiatives. Vietnam's national strategies incorporate health promotion into SDG-aligned development planning. China's One Health model connects environmental health to human well-being through inter-ministerial coordination. Even in countries with weaker institutional frameworks, such as Sri Lanka, Fiji, and Uzbekistan, health promotion is discussed in terms of its linkages to broader development and social welfare objectives. Although implementation often lags behind policy intent, the regional convergence around the importance of multisectoral action is increasingly evident. Strengthening operational mechanisms—such as shared indicators, co-financing arrangements, and joint accountability—could reinforce this trend.

4.1.3 Divergences Across Countries

National Goal Setting and Healthy Life Expectancy (HALE)

While life-course strategies are becoming more common, countries diverge significantly in how they define and operationalize measurable health promotion targets, particularly concerning Healthy Life Expectancy (HALE) and the gap between life expectancy (LE) and HALE, which serves as a proxy for morbidity compression.

Japan stands out for explicitly setting national targets aimed at compressing morbidity, i.e., reducing the gap between LE and HALE. These targets are embedded in national health promotion strategies, regularly updated, and linked to regional performance monitoring. China has also adopted clear HALE goals with implementation timelines, although it focuses more on extending HALE rather than explicitly addressing the LE–HALE gap. Korea emphasizes HALE in its *Health Plan 2030 (HP2030)* framework, positioning it as a headline indicator of well-being. However, unlike Japan, Korea stops short of setting explicit targets for reducing the LE–HALE gap. The policy emphasis remains on extending healthy years of life, without systematically addressing morbidity compression or regional disparities.

Vietnam, Indonesia, and Sri Lanka express general intent to improve population health and aging outcomes but have not formally adopted HALE as a core or regularly tracked indicator. Their national strategies tend to focus on broad well-being measures rather than specific life expectancy metrics. Fiji and Uzbekistan, meanwhile, do not use HALE benchmarks in strategic planning. Their policy focus remains on traditional indicators such as mortality rates, disease prevalence, or service coverage, rather than tracking quality-adjusted life years or healthy aging outcomes.

This variation highlights a vital policy distinction: some countries are moving toward integrated health promotion frameworks that aim to reduce time spent in poor health, while others focus solely on increasing HALE or remain anchored to more conventional indicators, such as crude mortality.

Degree of Institutionalization of Healthy Ageing Systems

The degree of institutionalization refers to the extent to which health promotion is firmly embedded within a country's legal, organizational, and financing structures. Drawing on elements of our framework—including national strategies, legislation, dedicated budgets, lead agencies, and performance monitoring—we found the maturity and integration of national health promotion systems largely varies.

Thailand and China exhibit high institutionalization. Thailand's ThaiHealth operates under a dedicated legal mandate with earmarked sin taxes, autonomous governance, and systematic multi-sectoral coordination. China embeds health promotion in national legislation and five-year plans, with subnational implementation and regular outcome tracking.

Korea and Japan demonstrate moderately high institutionalization. Both have long-standing national health promotion plans backed by legislation and centralized public health authorities.

Vietnam and Indonesia are at a transitional stage. They have legal and strategic frameworks (e.g., Vietnam's Health Protection and Promotion Strategy), but institutional ownership is fragmented, and budget and monitoring systems remain weak.

Sri Lanka, Fiji, and Uzbekistan reflect more nascent institutionalization. Health promotion is often embedded in general public health services without a dedicated agency, legal mandate, or ring-fenced funding, and efforts rely heavily on external or project-based support.

Institutionalization is not a binary process, but rather a multidimensional one involving policy anchoring, stable financing, organizational leadership, and accountability through effective monitoring.

Financing Mechanisms and Earmarking

Another area of divergence lies in the structure and source of financing for health promotion. Some countries have institutionalized earmarked financing mechanisms, particularly through health-related levies, which support dedicated health promotion activities beyond general health system expenditures.

Thailand and Korea stand out for channeling revenues from sin taxes (tobacco and alcohol) into health promotion funds. In Thailand, ThaiHealth is financed through a 2% surcharge on excise taxes, providing a stable and autonomous funding base for national and local initiatives, cross-sectoral programs, and research. Korea similarly earmarks a portion of tobacco taxes for health promotion under the National Health Promotion Fund, although central authorities more tightly regulate its use.

Vietnam operates the Vietnam Tobacco Control Fund, established under the Law on Prevention and Control of Tobacco Harms. While this is a strong example of issue-specific earmarking, its scope is mainly limited to tobacco-related interventions and does not cover broader NCD or lifestyle-related health promotion.

In contrast, Sri Lanka, Fiji, and Uzbekistan rely on general health budgets or external donor funding, without dedicated earmarks for health promotion. As a result, financing for preventive and promotional activities tends to be fragmented, project-based, and vulnerable to annual budget fluctuations. In many cases, such activities remain underfunded or externally driven, lacking integration into national budget processes and long-term development plans.

This divergence in financing mechanisms reflects more profound differences in governance capacity, fiscal autonomy, and political prioritization of prevention-oriented public health investments.

Monitoring, Evaluation, and Data Systems

Countries vary in how monitoring and evaluation (M&E) systems are structured and used to inform health promotion. Japan, Korea, and China have well-developed national frameworks that include regular surveys, longitudinal data, and formal evaluation cycles. These systems support tracking of health risks and program impact, and are integrated into national planning and governance processes.

Vietnam and Indonesia collect and publish health promotion data, but face challenges with system integration and subnational disaggregation. This limits the use of data for policy adjustment and coordinated response.

In Uzbekistan, Sri Lanka, and Fiji, M&E remains fragmented and project-based, with limited alignment to national strategies. As a result, data often fails to inform decision-making or guide program improvements.

Embedding M&E more systematically within national institutions is essential to strengthen feedback loops between evidence and policy.

Inclusion of Older Adults in Promotion Strategies

Despite demographic aging trends, many countries still fail to integrate older adults into their health promotion policies fully. Japan and Korea offer the most comprehensive models, with programs on fall prevention, memory care, social connectedness, and mobility. These are integrated into mainstream public health programming and backed by research and funding.

Vietnam's ISHCs are an innovative model of community-level engagement for older people, integrating social, health, and economic empowerment; however, scaling up and securing public financing remain challenges. Indonesia has begun piloting age-friendly primary care but lacks national policy integration. Thailand, Fiji, Sri Lanka, and Uzbekistan have yet to mainstream aging concerns in their health promotion efforts. Their policies tend to treat aging through the lens of long-term care or welfare support, rather than prevention, which limits the system's ability to support functional independence and healthy aging.

4.1.4 Conclusion

The Asia-Pacific region is advancing toward a shared recognition of health promotion as a cornerstone of resilient and equitable health systems. Across the nine countries analyzed, there is a growing alignment in acknowledging the value of preventive, life-course approaches, the need to reduce behavioral risk factors, and the importance of community-based delivery systems. These areas of convergence create potential entry points for collective action, shared tools, and cross-border learning.

Nonetheless, divergences remain substantial, particularly in institutional maturity, financial commitment, policy focus on aging, and the integration of data into strategic planning. While some countries have embedded health promotion into long-term visions with measurable targets, others still rely on fragmented delivery and inconsistent support. These gaps increase the risk of expanded morbidity, which in turn threatens to intensify the health and care burden associated with demographic and epidemiological transitions.

Moving forward, more precise articulation of measurable goals—such as HALE benchmarks—stronger institutional arrangements, and stable financing will be essential. Additionally, regional platforms can help share best practices, develop joint indicators, and explore context-sensitive models of integrating health promotion with broader social protection and long-term care reforms.

Understanding both convergence and divergence is thus not merely academic—it is crucial for policy coherence and successful implementation. As population aging and the prevalence of chronic diseases accelerate, placing health promotion at the heart of system transformation is both an opportunity and a necessity for sustainable development in the region.

Table 4: Summary of Convergences and Divergences in Health Ageing

Dimension	Converging Countries	Diverging Countries or Observations
Life-Course Orientation	Japan, China, Korea, Vietnam, Indonesia, Thailand	Less formalized in Fiji, Sri Lanka, Uzbekistan
Risk Factor Prioritization	All nine countries (tobacco, diet, alcohol, inactivity)	Variation in enforcement and comprehensiveness
Community-Based Delivery	Thailand, Vietnam, Indonesia, Korea, Japan	Emerging or less structured in Fiji, Uzbekistan, Sri Lanka
Gender and Equity Focus	Vietnam, Korea, Japan, China, Indonesia	Less institutionalized in Sri Lanka, Fiji
Multisectoral Governance (HiAP)	Thailand, Vietnam, China, Korea	Weaker implementation in Sri Lanka, Fiji, Uzbekistan
HALE Goal Setting	Japan, China	Absent or less defined in Vietnam, Indonesia, Fiji, Uzbekistan
Institutionalization	Thailand (ThaiHealth), Korea (KHEPI)	Limited in Indonesia, Fiji, Sri Lanka, Uzbekistan
Financing Mechanisms	Thailand, Korea, Vietnam (partial)	General budgets/donor reliant in Fiji, Sri Lanka, Indonesia
Monitoring & Evaluation Systems	Japan, Korea, China	Fragmented or weak in Fiji, Sri Lanka, Uzbekistan
Inclusion of Older Adults	Japan, Korea, Vietnam	Limited focus in Thailand, Fiji, Sri Lanka, Uzbekistan

Table 4.1: Policy Foundations

Section	Topic	Key findings
Goal Setting	Clear targets on health/HALE	● (Japan) Explicitly targets extending HALE and implicitly aims for morbidity compression (i.e., extending HALE more than LE) ● (Korea) Targeting improvement in HALE, while the reduction of the LE–HLE gap has not yet been set as a distinct policy objective ● (Thailand) While improving healthy life expectancy (HALE) is a stated goal, specific strategies to achieve it are lacking. ● (China) The "Healthy China 2030" initiative sets explicit targets for improving life expectancy and reducing health disparities, including gender-based differences. ● (Sri Lanka) While life expectancy (LE) and healthy life expectancy (HALE) are tracked in both national and international health assessments, Sri Lanka does not explicitly position them as overarching goals within its national health promotion agenda or strategic policy documents ● (Vietnam) The Vietnam Health Programme (2018–2030) aims to improve well-being, stature, lifespan, and quality of life for Vietnamese people. ● (Indonesia) The national health reform focuses on six pillars: strengthening primary health care, improving referral systems, ensuring health system resilience, developing human resources, reforming health financing, and advancing health technology integration. These pillars aim to modernize Indonesia's health system in response to epidemiological shifts and aging. However, explicit targets on HALE are not specified in Indonesia's RPJMN (2020–2024). ● (Fiji) The National Wellness Policy (2015) do not explicitly aim to increase life expectancy or Healthy Life Expectancy (HALE). ● (Uzbekistan) The Uzbekistan 2030 Strategy identifies health as a key development priority, emphasizing improved access to healthcare services and decent living conditions for vulnerable populations. However, a dedicated National Health Promotion Strategy centered on life expectancy (LE) and healthy life expectancy (HALE), along with clear targets, is still lacking.
GEDSI	Gendered lens and consideration of the vulnerable population	● (Japan) Explicitly considers reducing regional & socioeconomic inequity of HLE as goals of the plan and explicitly adds "women's health across the lifespan" as a priority. ● (Korea) Explicitly considers reducing regional and income related inequity of HLE as goals of the plan. Gender-specific indicators are being monitored. ● (Thailand) Gender considerations are explicitly integrated into budgeting processes, and gender-specific indicators are actively monitored ● (China) National Program for Women's Development (2021–2030) aims to eliminate gender gaps in education and health access. ● (Sri Lanka) Although improving the health of vulnerable populations is identified as a key expected outcome—with strategic support aimed at achieving it—there is no explicit integration

Section	Topic	Key findings
		of gender considerations ● (Vietnam) Intergenerational Self-Help Clubs (ISHCs) prioritize older women and female caregivers by promoting their leadership, social inclusion, and access to health and income services. The *National Action Program on Aging (2021–2030)* recognizes care needs but lacks a gender equity framework in LTC policy and financing. ● (Indonesia) Indonesia's RPJMN (2020–2024) included specific priorities on gender, such as access to education, employment, health status, and political participation. ● (Fiji) As a guiding policy principle, Fiji emphasizes the application of a gender-sensitive lens, ensuring that men, women, boys, and girls are equitably considered across all aspects of the policy. ● (Uzbekistan) National health reforms increasingly incorporate a gendered lens and address the needs of vulnerable populations through RMNCAH policies and equity-focused monitoring systems.
Life-Course Orientation	Age-specific strategies covering whole life-course	● (Japan) Explicitly adopts a life-course approach with age-specific targets and interventions from infancy to old age, including functional maintenance at older age. ● (Korea) Life-course approach suggested as the principle of the plan, life-course specific indicators and programs are suggested ● (Thailand) Although some initiatives target specific population groups, a systematic life-course approach is generally absent ● (China) China's health policies emphasize a life-course approach, recognizing that early-life factors significantly impact health in later years. This perspective is integrated into strategies addressing health across all age groups ● (Sri Lanka) The Health Promotion Bureau implicitly adopts a life-course approach through setting-based interventions, focusing on schools, maternal health, and the workforce; however, but lacks clearly defined, age-specific strategies for older adults. ● (Vietnam) The programme focuses on healthcare across the life course, including children, adults, and older people. ● (Indonesia) The Strategic Plan incorporates a life-cycle approach to healthy ageing, focusing on improving public health across all age groups, from infants to older people. ● (Fiji) While there may be some overlap, the national health promotion policy in Fiji adopts a 'settings-based' approach rather than a life-course approach. The settings include schools, workplaces, and urban communities such as towns and cities ● (Uzbekistan) Health interventions span all stages of life, including antenatal care, childhood immunization, school-based education, adult NCD prevention, and early efforts to integrate elder care into primary health care services.

Section	Topic	Key findings
Shift to Prevention	Systemic shift to prevention	● (Japan) Shift to prevention in a 2015 LTC reform emphasizing community-based and social determinant-focused preventive approach. ● (Korea) Importance of the shift is being mentioned, but the share of funding devoted for health promotion remains marginalized (compared to NHI funding). ● (Thailand) The importance of shifting toward health promotion is recognized, exemplified by the establishment of the Thai Health Promotion Foundation (ThaiHealth) ● (China) The "Healthy China 2030" plan marks a paradigm shift from disease treatment to prevention, focusing on health promotion and early intervention to reduce the burden of chronic diseases ● (Sri Lanka) The national healthcare system remains predominantly curative-focused, with limited progress toward a preventive care model ● (Vietnam) The Vietnam Health Programme emphasizes preventive medicine and health management at the community level, including national-level screening and risk prevention programs ● (Indonesia) Indonesia launched an annual free health screening program to prevent early deaths, marking a significant shift towards preventive care. However, funding for health promotion facilitating NCD prevention is much lower than the funding for public health insurance focusing on treatment. In 2024, only around 1% of health expenditure was spent on preventive and promotive activities ● (Fiji) While Fiji's healthcare system is generally focused on clinical services, there is a strategic shift toward prevention through the establishment of the National Wellness Centre—a dedicated unit for health and wellness promotion—based on the recognition that early intervention is more cost-effective than delayed action ● (Uzbekistan) The National Health Strategy 2030 promotes a prevention-oriented system through the implementation of WHO PEN protocols, expansion of screenings, and behavior-focused public campaigns.
Evidence-based Risk Factor Prioritization	Focus on behavioral/environmental risks	● (Japan) Evaluation of previous plans and analysis of current health statistics (NCDs, risk factors like smoking, salt intake, physical inactivity, etc.) ● (Korea) National burden of disease and risk factors studied, formal consultation process with domestic/international experts were conducted ● (Thailand) National studies have been conducted on the burden of disease and associated risk factors ● (China) China prioritizes addressing behavioral and environmental risk factors, such as tobacco use, unhealthy diets, and pollution, through evidence-based interventions to improve public health outcomes ● (Sri Lanka) As the national health promotion agenda is still in its developmental stage, the strategy

Section	Topic	Key findings
		is not yet firmly grounded in evidence or aligned with key risk factors ● (Vietnam) Implements strategies to reduce tobacco and alcohol use, and promotes healthy lifestyles, which were decided based on scientific evidence (e.g., BOD study) ● (Indonesia) The Ministry of Health, with WHO support, focuses on reducing major risk factors for noncommunicable diseases, including tobacco use, unhealthy diets, physical inactivity, and indoor air pollution ● (Fiji) Rather than being confined to biomedical risk factors for disease, Fiji's health promotion strategy emphasizes seven dimensions of wellness, encompassing physical, occupational, and spiritual well-being, based on international recommendations. ● (Uzbekistan) National health priorities are guided by WHO STEPS survey data, focusing on modifiable behavioral risks such as tobacco use, poor diet, physical inactivity, and environmental health concerns.
Policy Alignment	Alignment of health promotion policies with national strategy	● (Japan) Health Japan 21 aligns with disease-specific programs (e.g., Dementia Strategy "New Orange Plan", cancer control), LTCI reforms (e.g., Community-Based Integrated Care System), and other national strategies (e.g., workplace health). The Cabinet Office coordinates broader ageing policy across ministries. ● (Korea) HP2030 acting as a blueprint linking other national level initiatives for health promotion, but bottom-up initiatives also affect national plan (e.g., AFCC). Further alignment with broader health policies (e.g., NHI, LTCI) is limited. ● (Thailand) ThaiHealth's strategies are well-aligned with Thailand's National Health Development Plans (NHDPs), with a focus on reducing risk factors—such as tobacco use, alcohol consumption, poor diet, and physical inactivity—and preventing non-communicable diseases (NCDs) ● (China) Health promotion is a central component of China's national strategy, with "Healthy China 2030" serving as a guiding framework to integrate health objectives across various sectors and policies. ● (Sri Lanka) The National Health Promotion Policy (NHPP) was aligned with other national health policies through a systematic policy review process to ensure policy coherence ● (Vietnam) Screening and prevention policies are embedded in national strategies, but coordination and systematization remain areas for improvement ● (Indonesia) Health promotion efforts are aligned with Indonesia's national health priorities, as evidenced by partnerships with organizations like WHO and the World Bank. Indonesia struggles to align preventive health promotion—especially NCD prevention—with its ongoing efforts to expand Universal Health Coverage (UHC), as service delivery remains treatment-oriented and fragmented. ● (Fiji) The National Wellness Policy for Fiji (2015) states that the country's health promotion policy is aligned with other key health frameworks and legislation, including the National Health

Section	Topic	Key findings
		Promotion Policy for the Fiji Islands and the Public Health Act. ● (Uzbekistan) Health promotion policies are embedded across sectoral and national development strategies (e.g., Healthcare Improvement Strategy 2019–2025, Vision 2030), but remain fragmented due to the lack of a unified national health promotion strategy.

Table 4.2: Policy Governance and Funding Structure

Section	Topic	Key findings
Lead Institutions	Designated lead agency	● (Japan) Ministry of Health, Labour and Welfare (MHLW), supported by expert committees and technical/research institutions like the NIBIOHN and NIPH ● (Korea) MOHW, leveraging KDCA and KHEPI as implementation support agency ● (Thailand) The Ministry of Public Health (MoPH) holds primary responsibility for health, while the Thai Health Promotion Foundation (ThaiHealth) operates as an autonomous agency exclusively dedicated to health promotion ● (China) The National Health Commission (formerly the Ministry of Health) is the primary agency responsible for health promotion policies, coordinating efforts across different levels of government. ● (Sri Lanka) There is no independent, dedicated agency for health promotion; instead, responsibilities fall under the Health Promotion Bureau within the Ministry of Health ● (Vietnam) Ministry of Health ● (Indonesia) The Ministry of Health is the designated lead agency for health promotion policies. ● (Fiji) Fiji does not have an independent health promotion agency. National health promotion activities are primarily coordinated by the National Wellness Centre (NWC), which operates under the Ministry of Health and Medical Services (MHMS). ● (Uzbekistan) The Ministry of Health (MoH) serves as the lead agency for health promotion and PHC reform. It is responsible for policy design, regulation, licensing, monitoring, and international coordination.
Multisectoral Collaboration (HiAP)	Inter-ministerial coordination	● (Japan) The Cabinet Office houses a Council on Ageing Society for inter-ministerial coordination. Health Japan 21 National Liaison Council involves private/civil sector organizations. ● (Korea) HiAP is noticed important in HP2030, but programs involving other ministries are limited. The Presidential Committee on Low Fertility and Ageing Society complements this gap. ● (Thailand) As a supporting agency, ThaiHealth places strong emphasis on intersectoral collaboration and promotes the "Health in All Policies" approach ● (China) China employs a "One Health" approach, fostering collaboration among various ministries and sectors to address health issues comprehensively, recognizing the interconnectedness of human, animal, and environmental health ● (Sri Lanka) Health in All Policies (HiAP) is listed as the first priority in the Health Promotion Bureau's strategic plan, underscoring the importance of multisectoral collaboration ● (Vietnam) Engages various sectors through national action programmes aligned with the 2030 Agenda for Sustainable Development ● (Indonesia) Indonesia has developed multisectoral coordination mechanisms to support Health

		Promotion Schools, involving the Ministry of Health, the Ministry of Education, and other sectors. Measuring the spending on sectoral actions is difficult due to the distinct budgeting systems in each sector, which have different targets and indicators. ● (Fiji) The National Wellness Policy for Fiji positions itself as a national, multi-sectoral framework that facilitates the involvement of non-health sectors in promoting population wellness, emphasizing a Health in All Policies (HiAP) approach throughout its implementation. ● (Uzbekistan) Uzbekistan applies a HiAP approach through the 2030 Strategy, with the Cabinet of Ministers overseeing integration of health into education, labor, agriculture, and transport. However, implementation is limited by weak monitoring, lack of accountability, and absence of policy feedback mechanisms.
Decentralization	Roles and responsibility local/central governments	● (Japan) Prefectural and municipal governments are critical implementers, responsible for formulating and implementing. ● (Korea) Local governments act as the implementing body, following the guidance and support from the central government. ● (Thailand) Local governments serve as implementing bodies, operating under the guidance and support of the central government ● (China) While the central government sets overarching health policies, local governments have significant autonomy in implementation, allowing for tailored health services that address regional needs and contexts ● (Sri Lanka) Although structural decentralization of health services exists, health promotion functions remain highly centralized ● (Vietnam) Health initiatives are implemented through provincial health departments and community health centers: International Self-Help Clubs (ISHC) ● (Indonesia) Indonesia's decentralization reforms (the decentralization policy enacted in the early 2000s) have given greater authority and financial resources directly to regencies and municipalities, impacting health service provision ● (Fiji) In Fiji, local government functions are limited and largely centralized under national authority. Consequently, no explicit roles are assigned to local governments in health promotion ● (Uzbekistan) While the governance of health promotion remains centralized, the delivery and administrative management of primary healthcare services are carried out by local health authorities. However, due to limited structural autonomy at the subnational level, regional disparities persist in the scope, quality, and timeliness of service delivery—particularly in rural and underserved areas.
Funding Mechanisms	Source and sustainability of funds	● (Japan) Funding appears integrated within general MHLW, prefectural, and municipal budgets. Supplemented by specific project grants (e.g., MHLW subsidies for community healthcare planning) and research funding

		• (Korea) National Health Promotion Fund, which is largely financed by earmarked taxes on tobacco used as a major funding support for central level activities as well as local implementation (through matching central and local funds) • (Thailand) By law, ThaiHealth is funded through a dedicated surcharge on tobacco and alcohol excise taxes, ensuring a stable annual budget • (China) China's healthcare financing comprises government funding, social health insurance, and out-of-pocket payments. Efforts are ongoing to enhance the sustainability and equity of funding mechanisms, especially in the face of an aging population. • (Sri Lanka) No dedicated or earmarked budget exists for health promotion; instead, funding is drawn from broader healthcare budget allocations • (Vietnam) Earmarked tobacco tax separated from national health budget fund: the Vietnam Tobacco Control Fund (VNTCF). Sources of Primary Health Center come from public financial sources (government budget, social insurance, ODA) and household OOP contributions. ISHCs receive resources from NGOs and local funds. • (Indonesia) Indonesia lacks a clear financing framework for health promotion and disease prevention, making it challenging to evaluate funding adequacy. Tax revenue sharing fund from tobacco products and the Supporting Operational Fund for Health. • (Fiji) A dedicated funding source for health promotion has not been established. While portions of the government budget are allocated to health promotion activities, there is no separate budget line for health promotion initiatives, the National Wellness Centre, or wellness programs • (Uzbekistan) Health promotion is primarily funded through centralized public budgets, with only 2.6% of health spending allocated to prevention and over 40% coming from out-of-pocket payments. Despite donor support from WHO, ADB, and the World Bank, limited local financial autonomy hampers sustainable, community-based prevention efforts.

Table 4.3: Policy Implementation

Section	Topic	Key findings
Health Workforce Involvement	Use of PHC/community health workers	● (Japan) NIPH provides specialized training for public health personnel. CHW training focuses on enhancing health literacy and NCD prevention competency ● (Korea) National Human Resources Development Institute for Health and Welfare involved in capacity building. ● (Thailand) Each provincial and district health office is responsible for health promotion, conducting outreach activities with support from Village Health Volunteers (VHVs). ● (China) Community health workers play a vital role in China's primary healthcare system, delivering essential services and health education, particularly in rural and underserved areas ● (Sri Lanka) Public officers at the Health Promotion Bureau are primarily responsible for the development and implementation of health promotion policy ● (Vietnam) Vietnam is integrating primary health workers, including community volunteers, into LTC by training PHC staff to support aging populations. ISHCs offer legal support and homecare volunteer-based services ● (Indonesia) Public community health centers (Puskesmas) lead the PHC network, with community health workers (Kaders) playing a crucial role in service delivery, especially in remote areas. Most health promotion activities at the community level are delivered by crucial works of community health volunteers (CHVs). Out of 10,321 PHCs in Indonesia, around 65% had health promoters in 2023. ● (Fiji) Detailed operational roles for health promotion have not been formally established. Instead, wellness promotion relies on the existing health workforce. Frontline health personnel, known as zone nurses, are responsible for monitoring community wellness and reporting to divisional medical officers. Over time, Community Health Workers (CHWs) are expected to be trained to support these activities. ● (Uzbekistan) Uzbekistan has expanded the role of family doctors, nurses, and feldshers at PHC facilities to deliver preventive services such as NCD risk screening and lifestyle counseling. While community health workers are not formalized, nurses and feldshers engage in outreach and home visits, particularly in rural areas.
Incentives for Local Resource Engagement	Community mobilization/empowerment	● (Japan) Municipalities implement tailored programs, with some offering financial incentives for participation in health activities and achieving health goals ● (Korea) Establishment of community-level health promotion committees or coalitions involving various stakeholders. ● (Thailand) The Local Health Security Fund (LHSF) provides matching funds to incentivize local government investment in health, and VHVs receive a monthly stipend. ● (China) China encourages community participation in health initiatives through various

Section	Topic	Key findings
		incentives, fostering local engagement and ownership in health promotion activities ● (Sri Lanka) Incentives for community participation in health promotion are predominantly non-financial, emphasizing social recognition and community engagement ● (Vietnam) Local government and mass organizations creating demand for sanitation services through household education and awareness raising ● (Indonesia) Programs like Posyandu employ volunteer community health workers to provide services. Posyandu (Integrated Health Posts) are community-based platforms led by trained cadres offering maternal, child, and increasingly elderly care. They promote health education, basic screenings, and referrals, serving as an entry point for community health engagement. ● (Fiji) Local institutions—such as schools and workplaces—are encouraged to appoint Wellness Champions, who receive training and support from the National Wellness Centre (NWC). This initiative fosters local leadership and community engagement in wellness promotion, although financial incentives remain limited. ● (Uzbekistan) Community mobilization is facilitated through mahalla and local health committees; while some receive symbolic recognition or small grants, sustained financial incentives are lacking.
Strategies for Older Adults	Participatory approach involving older adults	● (Japan) Includes targets for older adults' functional maintenance, dementia prevention, and social participation. Age-Friendly Community initiatives and "Watchover Service" exist. ● (Korea) Indicators and programs focusing on older people exists (e.g., Dementia care). Including the views and preferences of the older people in local level implementation is suggested in central level implementation guidelines. ● (Thailand) Despite broad health promotion efforts, a dedicated strategy focusing specifically on the health and well-being of older adults has been largely overlooked. ● (China) Policies have evolved to promote active aging, with programs that involve older adults in social and educational activities, enhancing their well-being and societal participation ● (Sri Lanka) Indicators and programs specifically targeting older adults are generally lacking. ● (Vietnam) Community-level planning involves older adults ● (Indonesia) Initiatives like the Elderly Golden Age School (EGAS) promote health and prosperity among the ageing population through participatory approaches ● (Fiji) The *2015 National Wellness Policy for Fiji* does not include a dedicated strategy specifically targeting older adults nor participatory mechanisms. ● (Uzbekistan) Older adults are included in PHC-based chronic disease programs, and some pilot initiatives support their participation in planning and evaluation. However, national strategies lack institutionalized, large-scale engagement mechanisms tailored to older populations.

Table 4.4: Monitoring & Performance

Section	Topic	Key findings
Standardized Indicators	Existence and use of core national performance metrics	● (Japan) Yes, Health Japan 21 (2nd Term: 53 targets; 3rd Term: 51 targets) includes specific indicators ● (Korea) Yes, with core indicators and inequity indicators selected out of total 400 indicators ● (Thailand) Key health indicators—such as tobacco use and alcohol consumption—are regularly monitored ● (China) China has developed a comprehensive set of health indicators to monitor progress toward national health goals (Healthy China), facilitating data-driven decision-making and policy adjustments ● (Sri Lanka) Sixteen key performance indicators (KPIs) have been established to measure progress across six target groups, ranging from preschool-aged children to the workforce ● (Vietnam) Vietnam Health Statistics Yearbook is published yearly by the MOH, but often does not focus on key messages, deterring decision making in a systematic way ● (Indonesia) Indonesia has a set of core health indicators and conducts national health surveys, but the completeness of vital registration remains a challenge ● (Fiji) National indicators for health promotion under the National Health (Wellness) Policy have not yet been established. However, the Non-Communicable Diseases (NCD) Strategic Plan 2015–2019, which serves as a supplementary policy focused specifically on NCDs, proposes illustrative indicators such as overweight prevalence and tobacco and alcohol consumption. Nonetheless, the confirmation and implementation status of these indicators remains unclear ● (Uzbekistan) Uzbekistan has advanced its health promotion agenda by aligning national health indicators and PHC strategies with global NCD frameworks, but lacks age-disaggregated data and elderly-specific metrics necessary for inclusive, life-course–oriented health promotion.
Data and Monitoring Sources	Institutional support and source systems for data collection	● (Japan) Monitored using data from the annual National Health and Nutrition Survey (NHNS), MHLW's "Comprehensive Survey of Living Conditions" (for HALE), and Vital Statistics Survey (for mortality). National Institute of Health and Nutrition (NIBIOHN) tracks prefectural data. Health Japan 21 (3rd Term) aims to leverage individual health data ● (Korea) KHEPI webpage shares the monitoring status of all indicators transparently, with the source of data collection specified. Further plans to increase the granularity of data to provide local level inequities. ● (Thailand) ThaiHealth supports national surveys to track these indicators ● (China) The country maintains extensive health data systems, including routine health surveys and electronic health records, supported by institutional frameworks to ensure data quality and accessibility. Regional information connectivity remains as a challenge ● (Sri Lanka) The key performance indicators developed by the Health Promotion Bureau are not

		yet publicly accessible ● (Vietnam) Data is drawn from MOH health information systems and national surveys by the General Statistics Office (GSO). ● (Indonesia) The Health Management Information System (HMIS) is used for data collection. Indonesia Longitudinal Aging Survey. ● (Fiji) The National Wellness Centre (NWC) is expected to utilize existing Strategic Framework for Coordinating Change Office (SFCCO) pathways to integrate wellness indicators into ministerial reports, although the current operational status of these mechanisms is uncertain ● (Uzbekistan) Data is collected from multiple sources including the NHIS, DHS, MICS, and WHO STEPS. However, fragmented systems, inconsistent reporting standards, and low analytic capacity at local levels hinder comprehensive, real-time monitoring.
Evaluation and Feedback Loops	Periodic review and policy revision	● (Japan) Health Japan 21 plans undergo formal mid-term and final evaluations (e.g., 2nd term evaluated in 2018 and 2022). Evaluation results are published and inform the development of subsequent plan iterations. Prefectures/municipalities encouraged to use a PDCA cycle for local plans. ● (Korea) By law, the ten-year Health Plan is reviewed and updated at the five-year mark to respond to new challenges or gaps. ● (Thailand) ThaiHealth publishes annual reports detailing program updates, expenditures, and health outcomes, and is subject to regular audits ● (China) China implements regular evaluations of health policies, incorporating feedback mechanisms to refine strategies and ensure responsiveness to emerging health challenges ● (Sri Lanka) No formal mechanisms for periodic feedback or evaluation loops are currently in place ● (Vietnam) UN/donor-supported systems (ex: Uniceif and WHO) based on Vietnam-reported administrative data and household surveys. ● (Indonesia) Periodic evaluations are conducted to assess health programs, but there is a need for more systematic and transparent policy revisions ● (Fiji) Monitoring and Evaluation (M&E) activities are expected to be carried out by the NWC. Each program within the Centre is to be assessed individually, with national health statistics employed to gauge the effectiveness of the Wellness approach at a national level. However, the functional status of these M&E mechanisms remains unclear ● (Uzbekistan) Indicators are not fully integrated into routine policy decision-making, and age-disaggregated data—particularly for older adults—remain limited. Evaluation results often guide donor programs more than domestic reform cycles.

4.2 Convergences and Divergences in Long Term Care Policies Across Nine Asia-Pacific Countries

4.2.1 Introduction

As population ageing accelerates across Asia, long-term care (LTC) has emerged as a critical policy domain requiring urgent attention. The demographic transition toward older societies poses complex challenges to existing health and social protection systems, necessitating the development of sustainable and equitable LTC frameworks. This review examines the institutional design and operational features of LTC systems across nine Asian-Pacific countries, namely Japan, Korea, Thailand, China, Vietnam, Indonesia, Uzbekistan, Sri Lanka, and Fiji, highlighting variation across governance, financing, workforce development, and service delivery. Japan and Korea stand out with well-established LTC insurance schemes and institutional infrastructure, while other countries are at different stages of development, ranging from early-stage pilots to informal care models embedded in broader social protection strategies. These findings offer insights into how institutional maturity, fiscal capacity, demographic pressures, and cultural caregiving norms shape national responses to LTC needs.

4.2.2 Governance

Long-term care legislation and strategy

Among reviewed nine Asian-Pacific countries, Japan and Korea represent the most institutionalized systems, with universal LTC insurance schemes backed by specific legislation and regularly updated national strategies. Japan's Long-term Care Insurance (LTCI) Act, introduced in 1997 and implemented in 2000, provides universal coverage funded through a combination of insurance premiums and taxes, with the Basic Plan for LTC Services revised every three years. Korea followed with the LTCI Act in 2008, supported by a five-year national strategy that guides system development.

In contrast, Thailand, China, Vietnam, Indonesia, Sri Lanka, Uzbekistan, and Fiji lack dedicated LTC legislation. Thailand's LTC approach is embedded within broader aging policies such as the Elderly Act and National Plan for Older Persons. China has introduced LTCI pilots in selected cities but has yet to establish a national law or strategy. Vietnam, Indonesia, and Uzbekistan incorporate LTC into broader aging or social protection frameworks, though often without clear targets or funding mechanisms. Sri Lanka and Fiji remain at the earliest stages, with no formal legal or strategic framework for LTC. These differences highlight a divergence in the institutional maturity and policy commitment toward LTC.

Governance structure

Asian countries exhibit two distinct patterns in the governance of LTC systems: unified/coordinated structures versus fragmented/decentralized arrangements. Japan and Korea represent highly unified models. In Japan, the Ministry of Health, Labour and Welfare sets national standards, while municipalities serve as insurers, managing local implementation and planning. Korea operates under a centralized governance structure led by the National Health Insurance Service as an implementation agency under the Ministry of Health and Welfare, with major decisions made at the national level through the Long-Term Care Committee. One of the key factors enabling the management of high-level coordination of LTC services within a single department, without fragmentation, in both Korea and Japan is the institutional arrangement whereby the health and welfare sectors are integrated at the ministerial level.

Thailand falls between two models, with the National Health Security Office overseeing national policy without setting national standards and local administrative organizations implementing services. In contrast, countries such as China, Vietnam, Sri Lanka, Indonesia, and Uzbekistan experience significant fragmentation. China splits responsibilities between the Ministry of Civil Affairs and the National Health Commission, resulting in limited coordination. Vietnam and Sri Lanka face similar challenges, as health and social services are managed by separate ministries with no centralized authority. Indonesia's decentralized structure assigns roles to various national and local bodies, yet weak alignment hampers coordination. Uzbekistan also suffers from fragmented oversight distributed across ministries and local governments without an integrated mechanism. Fiji lacks a formal governance structure altogether. These contrasts highlight institutional divergence in LTC governance, affecting service integration and policy coherence.

4.2.3 Financing

Expenditure

Share of public IC and total LTC expenditure/GDP

LTC financing across nine Asian-Pacific countries reveals two broad patterns based on the availability and scale of public expenditure. Japan and Korea exhibit clearly defined and substantial LTC spending. Japan invested 2.0% of its GDP in LTC in 2021, with institutional care accounting for 1.3%. Korea's LTC spending reached 0.37% of GDP by 2018, increasing to 0.68% when long-term care hospitals are included. China and Thailand show increasing policy attention but report more modest expenditures. China allocated around 0.35% of GDP in 2021, projected to rise to 0.68% by 2050. Thailand has expanded community-based LTC since 2016, yet national-level financial data remain limited.

In contrast, Sri Lanka, Vietnam, Indonesia, Fiji, and Uzbekistan lack robust data or formal financing mechanisms. These disparities reflect differing levels of institutional development and prioritization of LTC financing across the region.

Revenue raising

The primary source of funding

The reviewed Asian countries can be broadly categorized into those with structured insurance-based financing for LTC and those relying on general taxation, out-of-pocket payments, or fragmented sources. Japan and Korea have formal LTC insurance systems. Japan's model is funded through premiums from individuals aged 40 and over and public subsidies from all levels of government, and income-based user co-payments promoting equity. Korea similarly relies on mandatory social insurance contributions, supplemented by government subsidies and user co-payments.

Conversely, the other six countries lack earmarked financing systems. Instead, Thailand finances LTC through general taxation, offering services free at the point of use, especially to accommodate its large informal workforce. Pilots of China use a mixed model involving medical insurance funds, individual payments, and government subsidies. Vietnam blends general taxation, social health insurance, and out-of-pocket expenses but lacks a designated LTC fund. Indonesia's financing is fragmented, with limited formal mechanisms. Sri Lanka depends largely on out-of-pocket family spending. Uzbekistan funds LTC through general taxation without a distinct budget line. Fiji, without a formal LTC system, has no structured financing.

Pooling resources

The reviewed nine Asian-Pacific countries vary widely in how they pool resources for LTC, reflecting differing levels of institutional development. Japan and Korea demonstrate highly institutionalized and separate pooling mechanisms for health care and LTC. In Japan, LTC funds are managed at the municipal level, distinct from health insurance fund, with each municipality maintaining its own LTC budget. Korea operates a centralized LTC insurance fund, separate from health insurance, and uses annual actuarial assessments to ensure financial sustainability.

On the other hand, the other six countries have fragmented or underdeveloped pooling arrangements. Thailand employs a hybrid model through its Local Health Fund (LHF), which combines contributions from the National Health Security Office (central government) and local governments. LHFs are managed at the municipal level and are used to support a wide range of local healthcare activities, from health promotion to long-term care services; however, implementation varies by region. China and Vietnam pool resources at the regional level but through different mechanisms: Vietnam relies on general local budgets, while some localities in China have established pilot LTCI funds that function as dedicated funding pools. However, both countries lack a unified national LTC financing mechanism, resulting in disparities in access and quality.

Indonesia lacks a designated LTC fund and relies on general health budgets and local government support, often through temporary pilot projects. In Sri Lanka, pooling is minimal due to the limited LTC infrastructure. Uzbekistan embeds LTC spending within broader social protection budgets, without a distinct fund. Fiji lacks both a formal LTC system and a

pooling mechanism. These differences highlight the uneven institutional capacity and prioritization of LTC financing across the region.

Purchasing goods and services

Significant variation was observed in how LTC services are purchased. Japan and Korea represent formalized and structured systems. In Japan, municipalities purchase services based on a national fee-for-service schedule set by the Ministry of Health, Labour and Welfare (i.e., uniform benefits and payment system), with adjustments for care needs and regional differences. Korea's National Health Insurance Service acts as the sole purchaser, reimbursing providers through a standardized national schedule, emphasizing consistency and efficiency.

In contrast, the other seven countries have less formalized or fragmented purchasing models. Thailand emphasizes public provision, with local governments directly commissioning LTC services, which implies that implementation may vary across regions. In general, China relies heavily on public providers with limited formal procurement. Vietnam blends public and non-state providers, with funding varying across settings. Sri Lanka and Indonesia lack centralized purchasing, relying on NGOs and family spending. Uzbekistan utilizes a model of direct public provision through state-run local centers, which results in weak links between funding and service volume. Fiji lacks a formal LTC purchasing framework altogether.

4.2.4 Workforce

Existing Workforce

Key characteristics of caregivers

This review indicated that certain countries have institutionalized caregiving roles, whereas others depend largely on informal or hybrid caregiving models. Japan and Korea have well-established systems, with personal care assistants comprising the majority of the workforce, 66% in Japan and 91% in Korea, mostly middle-aged women. These countries have clearly defined roles and structured workforce development.

In contrast, the other six counties rely more heavily on informal or semi-formal caregivers. Thailand integrates family caregivers and community volunteers into the formal system. China and Vietnam depend largely on unpaid family members and village health workers. Indonesia faces similar reliance on informal care, with limited local training initiatives and workforce shortages. Sri Lanka and Uzbekistan lack formal care classifications; care is provided by family, domestic workers, or general social service staff. Fiji does not have a formal LTC workforce framework. These differences reflect varied institutional capacity and cultural caregiving norms.

Capacity-building and professionalization

Certification / training requirement

The reviewed nine Asian-Pacific countries differ significantly in LTC workforce training and certification, reflecting varying levels of system development. Japan and Korea have well-established certification systems. Japan requires personal care assistants to obtain national qualifications involving formal education and exams, while Korea mandates 240 hours of training and a provincial exam, with ongoing efforts to improve training quality. Thailand offers a semi-formal model, providing 70-hour standardized training for community caregivers and short courses for care managers to professionalize informal workers. However, the extent to which these training programs are formally linked to certification remains unclear.

In contrast, Vietnam, Indonesia, Sri Lanka, Uzbekistan, and China lack standardized national certification systems. Vietnam and Indonesia provide basic training through NGOs or local governments, but without national coordination. Sri Lanka depends on employer-based training or prior experience, and Uzbekistan offers limited, donor-funded programs. China's certification approach remains unclear. Fiji has no formal training or certification for LTC workers. These differences highlight uneven progress in professionalizing LTC workers, with implications for service quality and workforce sustainability.

Career development of PCW

The reviewed nine Asian-Pacific countries differ widely in career development opportunities for personal care workers (PCWs) in LTC. Japan stands out with a structured career grade system, allowing advancement to roles such as team leaders or skill assessors. China has introduced national standards for LTC practitioners, emphasizing training in core competencies, though career promotion pathways remain limited.

Most other countries lack formal systems for professional growth. Korea has not yet established defined advancement tracks despite policy efforts to enhance workforce development recently. Thailand provides entry into paid paraprofessional roles through community-based training but offers limited upward mobility. In Vietnam, Indonesia, and Sri Lanka, the absence of formal recognition and institutional support hinders career progression. Uzbekistan lacks career pathways or incentives specific to elder care. Fiji does not have a formal LTC workforce, making career development inapplicable. These differences highlight broader disparities in how countries value and institutionalize the caregiving profession within their LTC systems.

4.2.5 Service Delivery

Eligibility and gatekeeping

Universal or means-tested

Japan, Korea, Thailand, and China generally adopt universal or needs-based models. Japan provides coverage for individuals aged 65 and over, and for those aged 40–64 with age-related conditions, based on formal assessment. Korea also uses standardized needs assessments, with universal access for those with functional or cognitive impairments. Thailand's system is need-based and not income-tested, while China sets broad eligibility for frail individuals aged 60 and above, though criteria vary by pilots.

Vietnam, Indonesia, and Uzbekistan use more targeted models. Vietnam and Indonesia prioritize the poor and those without family support, with community-based prioritization in Vietnam and cash transfers in Indonesia. Uzbekistan applies a rights-based approach, using life circumstances to determine access. Sri Lanka and Fiji lack formal LTC systems, so eligibility frameworks are not in place.

Criteria for coverage if targeted (poverty, cost, living alone, etc.)

Nine Asian-Pacific countries demonstrate distinct patterns. Vietnam, Indonesia, and Uzbekistan adopt a targeted approach, prioritizing access for socially disadvantaged older adults, such as those living in poverty, residing alone, or lacking family support. In contrast, Thailand and China follow a more universalist model in which individuals who meet functional care needs are eligible for services without additional socio-economic criteria. Japan and Korea occupy an intermediate position between these two models. While both countries offer universal access based primarily on care needs, they incorporate income-adjusted co-payment mechanisms that provide financial relief (low copayment of exemption) for low-income older adults. This stratified design reflects efforts to balance universalism with equity-oriented cost-sharing, ensuring broader access while mitigating the financial burden among economically vulnerable groups.

Needs assessment and gatekeeping

Japan and Korea have formal, standardized systems of needs assessment. In Japan, municipalities use computerized tools, often via third-party assessors, to determine eligibility. Korea similarly relies on staff from the National Health Insurance Service to assign care grades that determine service levels, serving as a formal gatekeeping mechanism.

In contrast, other six countries use less standardized or decentralized approaches. For instance, Thailand depends on care managers, typically nurses, without a national assessment tool. China delegates assessments to local officials, leading to regional variation.

Settings for public LTC support

The reviewed nine Asian-Pacific countries differ in how LTC is supported by public funding, reflecting varying policy goals and system maturity. Japan and Korea offer a balanced mix of institutional care (IC) and home and community-based services (HCBS), with a focus on in-kind benefits.

China and Thailand also fund both IC and HCBS, though China's pilot programs emphasize HCBS and face institutional capacity limits. Thailand prioritizes home-based care in line with cultural preferences and policies to minimize institutionalization. Vietnam and Indonesia rely more on institutional settings; Vietnam primarily uses social protection centers, while community-based models have limited reach. Indonesia operates over 260 residential facilities for low-care individuals, with underdeveloped HCBS. Uzbekistan provides basic shelter-based care and informal community support. Sri Lanka and Fiji lack formal LTC delivery systems.

Service provided

Japan and Korea have the most comprehensive models, offering structured and standardized HCBS, IC, rehabilitation, respite, etc. Thailand and China provide integrated health and social care, including personal care and rehabilitation, though regional consistency remains a challenge. China's pilot programs emphasize HCBS but often offer limited service hours, increasing family burden. Vietnam and Indonesia deliver similar services in selected areas through community-based initiatives, yet coverage remains uneven. Sri Lanka relies on fragmented services from NGOs and the private sector, such as in-home nursing and peer support, without broad system coverage. Uzbekistan offers basic institutional and home care, with minimal specialized services. Fiji lacks a formal LTC delivery system.

Integrated care and person-centered care pathways

Person-centered care/integrated care

Japan, Korea, and Thailand have developed structured models of service delivery. Japan's Community-Based Integrated Care System promotes coordination across health, LTC, housing, and welfare, with personalized care plans. Korea advances integration through home-visit nursing, case management, and policy support under its 3rd Basic Plan. Thailand integrates medical and social care using multidisciplinary teams and joint funding, promoting holistic, needs-based support.

In contrast, China and Indonesia show partial integration. China's efforts remain limited to pilot areas. Indonesia links health and LTC through case management and geriatric clinics, but implementation varies across regions. Vietnam relies on informal integration via community clubs such as those supported by HelpAge. Uzbekistan's services are fragmented across sectors, lacking formal coordination. Sri Lanka and Fiji do not operate formal LTC systems.

Quality assurance

Assurance mechanism for providers, penalty, or certification requirement

Among nie reviewed countries, Japan and Korea have the most structured systems of quality assurance. In Japan, municipal governments license providers based on national standards, and both the Ministry of Health Labor and Welfare and prefectures conduct evaluations, with some performance indicators linked to financial incentives. Korea mandates service standards by law, conducts regular quality assessments via the National Health Insurance Service, and ties financial rewards to provider performance.

Thailand, China, and Sri Lanka have partial mechanisms. Thailand emphasizes training and supervision, though formal systems remain limited. China began monitoring LTC performance in 2018, focusing on metrics rather than enforcement. Sri Lanka selectively regulates services: in-home nursing is overseen by the Private Health Services Regulatory Council, and eldercare homes require certification from the Sri Lanka Standards Institute, though enforcement weakened after certification was suspended in 2015.

Vietnam, Indonesia, and Uzbekistan lack institutionalized systems of quality assurance. Oversight is minimal, relying on administrative audits or weak enforcement. Fiji has no formal mechanism.

Performance of long-term care service delivery

Unmet needs for care, financial protection for LTC costs, family burden, quality of life, and equity, etc.

Japan and Korea have relatively advanced LTC systems with high user satisfaction but still face notable service gaps. In Japan, 15.5% of older adults report unmet needs, and many remain not certified (by needs assessment system) for LTCI. Korea reports similar satisfaction levels, yet around one-third of users experience unmet needs, and informal caregiving imposes hidden economic burdens.

Thailand and China show mixed outcomes. Thailand's community-based approach improves well-being of older people but struggles with care gaps and inequity. China's pilot LTCI programs offer limited financial protection and remain unevenly implemented, especially in rural areas, where unpaid family caregiving is still prevalent.

Vietnam, Indonesia, Sri Lanka, Uzbekistan, and Fiji lack financial protection mechanism and depend heavily on informal care. These countries may experience widespread unmet needs and heavy family burden, while limited data on quality of life and equity hinder comprehensive policy evaluation.

4.2.6 Conclusion

This review reveals substantial diversity in the institutionalization and functionality of LTC systems across nine Asian-Pacific countries, reflecting differences in policy priorities, governance capacity, and demographic trajectories. Japan and Korea have developed comprehensive, insurance-based models with structured financing, formal care workforce systems, and standardized service delivery pathways. These systems are gradually shifting toward HCBS-centered and integrated care delivery models to enhance efficiency and effectiveness in response to increasing cost burdens.

In contrast, countries such as Vietnam, Indonesia, Sri Lanka, and Uzbekistan continue to rely on informal care structures and fragmented financing, often lacking formalized governance or standardized needs assessment tools. Thailand and China occupy an intermediate space, with expanding LTC frameworks and growing emphasis on home and community-based care, though constrained by regional disparities and limited institutional coherence.

Common challenges persist across countries, including unmet care needs, inadequate financial protection, and workforce shortages. The review also underscores a widespread reliance on family caregivers, particularly women, which carries significant social and economic implications. As the region continues to age, enhancing institutional capacity, promoting professionalization of care, and ensuring financial sustainability will be central to building inclusive and resilient LTC systems. These findings provide a comparative foundation to inform policy development, cross-national collaboration, and long-term planning for aging societies in Asia.

Table 4.5: Governance

Section	Topic	Key findings
Long-term care legislation and strategy	Legislation Or national strategy	● (Japan) LTCI established by the Long-Term Care Insurance Act (1997, implemented 2000), offering universal coverage funded by a mix of insurance premiums and taxes. National LTC strategy (Basic Plan for Long-Term Care Insurance Services) updated every 3 years by MHLW. ● (Korea) LTCI established by the LTCI Act (2008), offering universal coverage funded by mandatory contributions. National level basic strategy for LTC updated every 5 years. ● (Thailand) There is no law solely dedicated to long-term care (LTC); however, the Elderly Act (2003) and the National Plan for Older Persons provide guiding principles. ● (China) China has implemented LTCI pilot programs in 49 cities since 2016. While there is no overarching national LTC law, these pilots aim to establish a social insurance system providing financial support or services to long-term disabled persons for basic daily care ● (Sri Lanka) Sri Lanka lacks an official national definition of long-term care (LTC), and currently offers only limited services for older adults that do not constitute a formal LTC system. There is no legislation or national strategy exclusively dedicated to LTC; however, frameworks such as the Protection of the Rights of Elders (Amendment) Act 2011 and the National Elderly Health Policy of Sri Lanka 2017 provide indirect support and regulation ● (Vietnam) Vietnam lacks a dedicated law on LTC. However, the Elderly Law (2009) emphasizes the roles of family and community in elder care. Vietnam's *National Action Program on Ageing (2021–2030)* sets a strategic direction for elder care, approved by the Prime Minister in December 2021 The strategy lacks quantitative targets, implementation mechanisms, and dedicated financing for long-term care services.. ● (Indonesia) Presidential Decree No. 88/2021 established the National Strategy on Aging, aiming to enhance social protection, healthcare, and long-term care (LTC) services for older adults. The Care Economy Roadmap 2025–2045 outlines strategic plans to develop the care sector, including LTC services, emphasizing community-based care and support for caregivers. ● (Fiji) Fiji lacks a formal long-term care system; consequently, no dedicated legislation or national strategy has been established. ● (Uzbekistan) The Elderly Act (2016, updated 2022) provides a legal basis for elderly services, but no dedicated LTC legislation exists. There is no standalone LTC strategy; elderly support is integrated into social protection and PHC reforms like the 2015 "Year of Care" campaign.
Governance structure	Governance structure	● (Japan) MHLW sets national standards for benefit packages, prices, and eligibility. Municipalities (cities, towns, villages) act as insurers: they collect premiums from those 65+, pool funds locally, conduct needs assessments, certify eligibility, contract with providers, and develop local LTC service plans aligned with national guidelines ● (Korea) Centralized administration managed by NHIS, responsible for enrollment, contribution

Section	Topic	Key findings
		collection, eligibility assessments, and reimbursement of providers. Major policy decisions, including contribution rates and service standards, are made nationally by the Long-Term Care Committee, chaired by vice minister of MOHW ● (Thailand) LTC governance in Thailand involves centralized oversight by the National Health Security Office (NHSO) and decentralized implementation by local administrative organizations (LAOs), with coordinated efforts across the health and social sectors since 2016 ● (China) The LTC system in China is characterized by fragmented governance. The Ministry of Civil Affairs oversees social services, while the National Health Commission manages healthcare aspects. This separation poses challenges for coordination and integration of health and care services ● (Sri Lanka) Sri Lanka's long-term care governance is fragmented, with shared responsibilities across departments and agencies but no centralized authority to ensure coordination or integration ● (Vietnam) Governance is fragmented. The Ministry of Health oversees healthcare services, while the Ministry of Labour, Invalids and Social Affairs manages social protection centers. This division leads to challenges in coordinating and integrating LTC services ● (Indonesia) Governance is decentralized, with responsibilities shared among the Ministry of Health (MOH), Ministry of Social Affairs outreach (MOSA), and local governments. Local commissions for older persons (Komisaun lansia daerah) existing in 34 provinces mirror the National Commission for Older Persons (NCOP) at the local level, but they report to the NCOP rather than MOSA, resulting in implementation coordination challenges at the local level. ● (Fiji) There is no formal governance structure in place for long-term care ● (Uzbekistan) LTC governance is fragmented across MoH, Mahalla Ministry, and local hokimiyats, with no single authority or coordination mechanism.

Table 4.6: Financing

Section	Topic	Key findings
Expenditure	Share of public IC and total LTC expenditure/GDP	● (Japan) Total public LTC expenditure was 2.0% of GDP in fiscal year 2021. Institutional care (IC) accounted for 1.3% of GDP within this total. ● (Korea) LTC expenditure significantly increased since LTCI's inception, reaching 0.37% of GDP by 2018 (0.68% if including NHI covered LTCH) ● (Thailand) Since the launch of its community-based long-term care (LTC) scheme in 2016, Thailand has significantly increased public expenditure on LTC for older adults, expanding coverage to over 90% of sub-districts by 2020. However, LTC still represents a small share of total health spending, and comprehensive national-level expenditure data is not yet available ● (China) As of 2021, public expenditure on LTC was approximately 0.35% of GDP, projected to rise to 0.68% by 2050. This indicates a growing commitment to LTC funding, though current levels remain modest compared to OECD countries ● (Sri Lanka) Comprehensive information on government financial flows to the LTC sector is lacking, and systematic data on household-level LTC expenditures is also unavailable. ● (Vietnam) Specific data on LTC expenditure as a percentage of GDP is limited. However, total health expenditure was approximately 4.6% of GDP in 2022. LTC services are underfunded, with an average monthly expenditure of roughly $35 per person. ● (Indonesia) Specific data on LTC expenditure is limited. LTC expenditure is not collected under the National Health Accounts, and no systematic data on financial transactions for LTC exists in Indonesia. ● (Fiji) Not applicable (N/A), as no formal long-term care (LTC) system has been established to date. ● (Uzbekistan) LTC-specific expenditures are not disaggregated in national health accounts.
Revenue raising	The primary source of funding	● (Japan) Funded by a mix of LTCI premiums (approx. 50%) and public funds/taxes (approx. 50% - from national, prefectural, and municipal governments). User co-payments are typically 10%, but rise to 20% or 30% for individuals with higher incomes, with income-related monthly caps. Premiums are collected from individuals aged 40 and over ● (Korea) Predominantly funded through social insurance contributions (60-65%), supplemented by general government subsidies (20%) and user copayments (15-20%). Contributions are mandatory for all citizens, designed to promote intergenerational equity and sustainability. ● (Thailand) The system is financed through general taxation rather than a dedicated insurance scheme, reflecting a strategic choice to ensure equitable access—particularly given the large informal workforce—with services provided free at the point of use ● (China) Funding primarily comes from social health insurance programs, with contributions pooled from medical insurance funds, individuals, and government subsidies. This model reflects

		a combination of public and individual financing ● (Sri Lanka) Long-term care for older adults is primarily financed out-of-pocket by family members ● (Vietnam) Funding comes from general taxation, social health insurance, and out-of-pocket payments. There is no dedicated LTC insurance scheme. ● (Indonesia) LTC services are not covered under a dedicated insurance scheme; funding is limited and fragmented. ● (Fiji) N/A ● (Uzbekistan) LTC services are funded through general taxation; there is no separate LTC insurance or earmarked funding stream
Pooling resources		● (Japan) LTCI funds are pooled at the municipal level. Each municipality manages its own LTCI budget. These funds are kept separate from health insurance funds. ● (Korea) LTCI maintains its own distinct, pooled fund separate from the health insurance fund, with annual actuarial adjustments to ensure fiscal discipline and sustainability. ● (Thailand) A hybrid and decentralized pooling mechanism operates through the Local Health Fund, which combines matching contributions from the National Health Security Office (NHSO) and local administrative organizations to jointly finance LTC ● (China) Resource pooling occurs at the local or regional level, leading to disparities in funding and service availability across different areas. There is no unified national pooling mechanism for LTC funds ● (Sri Lanka) Pooling mechanisms remain limited due to the underdevelopment of the LTC system ● (Vietnam) While Vietnam has no dedicated LTC financing, pooled resources come from general tax revenues, social health insurance contributions, household spending, and NGO/donor funding Resource pooling is decentralized, resulting in disparities in service availability and quality across different regions. ● (Indonesia) Indonesia lacks a dedicated financing mechanism for LTC. Services are mainly funded through general health budgets, local government allocations, and pilot project support, resulting in uneven access and sustainability concerns. ● (Fiji) N/A ● (Uzbekistan) LTC funding is not separated but included within broader health and social protection budgets coordinated by the Ministry of Finance
Purchasing goods and services		● (Japan) Municipalities contract with providers. A national fee-for-service schedule is set by MHLW, with rates differentiated by care-need level and service type. Performance-based incentives for LTC providers are also utilized. Mechanisms like region-based fee adjustments exist. ● (Korea) NHIS serves as the sole purchaser, reimbursing providers through a nationally

		standardized fee schedule differentiated by care-needs severity. Provider payments primarily volume-based. ● (Thailand) Thailand's LTC system follows a locally driven public provision model, wherein local governments utilize pooled funds to directly hire community-based caregivers and rely on public health services, rather than purchasing care from private providers ● (China) Services are predominantly provided by public institutions, such as hospitals and community health centers. The procurement process lacks competitive mechanisms, and services are often delivered without formal procurement procedures. ● (Sri Lanka) There is no dedicated public purchasing mechanism; individuals procure LTC services directly from the market, with NGOs serving as the primary providers ● (Vietnam) Both public and non-state entities provide services. The government directly finances public units, while non-state units receive indirect funding based on the services they deliver. ISHCs are funded via hybrid models: JSDF World Bank grants, government support, member fees, revolving loans, donations, and income-generating activities—oriented toward women and disadvantaged elders. ● (Indonesia) LTC cost is mostly borne by the individual or the family, especially considering caregiver burdens for female family members ● (Fiji) N/A ● (Uzbekistan) Services are publicly administered by local authorities, but no link exists between budget and service volume; regional disparities and informal payments may occur

Table 4.8: Workforce

Section	Topic	Key findings
Existing Workforce	Key characteristics of caregivers (=personal care workers (PCW)	● (Japan) Predominantly Personal Care Assistants (*kaigo shokuin*), constituting ~66% of the LTC workforce in 2023. Mostly female (73.9%), with a majority aged 40-59. ● (Korea) Dominated by personal care assistants, constituting approximately 91% of the LTC workforce, predominantly middle-aged and older women. ● (Thailand) The LTC workforce model integrates informal family caregivers, community-based volunteers who are upgraded into paid caregivers, and formal healthcare professionals—leveraging existing community ties and public health networks ● (China) The LTC workforce largely consists of village health volunteers and informal caregivers. Only a minority of caregivers are formally employed, and there is a significant reliance on unpaid family members for care provision ● (Sri Lanka) Long-term care is primarily provided by family caregivers and domestic workers. The main family caregiver is typically a female relative. Domestic workers range from untrained individuals, who are generally more affordable, to trained providers offering nursing care services. ● (Vietnam) Family members and community volunteers predominantly provide caregiving. Formal caregiving roles are limited, and there is a shortage of trained personnel. ● (Indonesia) Informal caregivers, primarily family members, constitute the majority of the LTC workforce. Community volunteers and cadres trained through local initiatives also provide care services, with brain drain being concern. ● (Fiji) N/A ● (Uzbekistan) No distinct PCA category; eldercare is provided mainly by nurses, social workers, and informal family caregivers. Informal caregivers are mostly middle-aged women (aged 40+); no official workforce data available.
Capacity-building and professionalization	Certification / training requirement	● (Japan) National qualifications (e.g., "Certified Care Worker" - *kaigo fukushi shi*) required for PCAs providing physical care, involving specific education/training and national exams. ● (Korea) Certification for personal care assistants requires completion of 240 hours of training and passing a provincial exam. Ongoing professionalization efforts include refresher courses, specialized dementia training, and initiatives in the 3rd Basic Plan (2023–2027) to enhance working conditions and improve the education system. ● (Thailand) A standardized 70-hour training program for community caregivers, along with specialized short courses for care managers, equips informal helpers with core competencies and transforms them into a paraprofessional workforce ● (China) ● (Sri Lanka) There are no formal certification or training requirements; most in-home care agencies either provide basic training or hire individuals with prior experience

Section	Topic	Key findings
		● (Vietnam) Training programs have been initiated by organizations like HelpAge International, focusing on basic caregiving skills. However, there is no standardized national certification for caregivers ● (Indonesia) No standardized national certification for LTC workers, but Local governments and NGOs provide Basic training programs (e.g., 50-hour courses). ● (Fiji) N/A ● (Uzbekistan) No formal certification system for eldercare workers; some donor-funded short-term training exists
	Career development of PCW	● (Japan) A career grade system for care workers allows PCAs to advance to roles such as skill assessors or team leaders, offering some professional development pathways ● (Korea) Limited formal career development pathways currently exist. ● (Thailand) Although pathways exist for transitioning from informal caregiving to paid paraprofessional roles, opportunities for further career development remain limited ● (China) China has introduced a national professional standard for long-term care practitioners. Caregivers are required to undergo training covering topics such as aging, rights of older people, caregiving skills, and common diseases ● (Sri Lanka) No officially established mechanisms exist for continuous learning or career development for personal care workers ● (Vietnam) Caregivers often face limited opportunities for career advancement due to the lack of formal recognition and structured career pathways ● (Indonesia) Limited structured career pathways within the LTC sector. ● (Fiji) N/A ● (Uzbekistan) No career pathways specific to eldercare; professional growth is limited and not incentivized

Table 4.9: Service Delivery

Section	Topic	Key findings
Eligibility and gatekeeping	Universal or means-tested	● (Japan) Universal eligibility for individuals aged ≥65, and for those aged 40–64 with specified age-related diseases, based on assessed need ● (Korea) Universal eligibility for those with functional or cognitive impairments (stricter criteria applied for those under 65). ● (Thailand) The LTC scheme is not means-tested; eligibility is based on need and functional impairment rather than income or financial status ● (China) Eligibility for LTC services is generally universal for individuals aged 60 or over experiencing a degree of frailty. However, specific criteria and assessment processes vary across pilot regions ● (Sri Lanka) Not applicable, as a formal long-term care (LTC) system has not yet been established in Sri Lanka. ● (Vietnam) Eligibility for LTC services is generally means-tested, focusing on those who are poor and those without family support. Intergenerational Self-Help Clubs (ISHCs) use inclusive, community-based eligibility criteria—prioritizing older adults, especially those in vulnerable or low-income households, without applying formal means-testing. ● (Indonesia) Eligibility for LTC services is generally means-tested, focusing on the poor and those without family suppor.The Aslut program provides means-tested cash transfers to poor older adults aged 70 and above, focusing on those who are neglected, bedridden, or lack family support. It does not cover LTC service needs beyond subsistence. ● (Fiji) N/A ● (Uzbekistan) Under Uzbekistan's Law on Social Services, long-term care–related support is guaranteed as a rights-based provision for socially vulnerable groups, including older adults, persons with disabilities, individuals without caregivers, and low-income populations. While no specific income or age thresholds are stipulated, in practice, life situation assessment is incorporated to determine eligibility criteria.
	Criteria for coverage if targeted (poverty, cost, living alone, etc.)	● (Japan) Co-payments are income-related (10-30%). Reductions/waivers for meals and accommodation in IC for low-income individuals. ● (Korea) Additional copayment reductions or exemptions are available based on income level. ● (Thailand) Coverage is provided to adults aged 60 and over (as legally defined elderly) who require assistance with daily living, with no additional eligibility criteria ● (China) Coverage criteria are primarily based on functional needs assessments ● (Sri Lanka) Not applicable ● (Vietnam) Coverage is prioritized for individuals in poverty, those living alone, or without family caregivers

Section	Topic	Key findings
		● (Indonesia) Coverage is prioritized for individuals in poverty, those living alone, or without family caregivers. Publicly managed residential care (panti) eligibility determined by status of neglect by family than needs. ● (Fiji) N/A ● (Uzbekistan) Eligibility for services is determined through a life situation assessment, which takes into account various vulnerability factors such as living conditions, income, caregiver availability, and disability status.
	Needs assessment and gatekeeping	● (Japan) Needs assessment conducted by municipalities (often by contracted third-party assessors) using a standardized computerized process. ● (Korea) Eligibility determined through standardized needs assessments, assigning beneficiaries care grades that dictate service types and levels. Needs assessment conducted by NHIS staff serve as gatekeeping function. ● (Thailand) Care managers, typically nurses, conduct needs assessments and serve as gatekeepers; however, a nationally standardized assessment tool has not yet been established ● (China) Government officials conduct needs assessments to determine eligibility for LTC services. ● (Sri Lanka) Not applicable ● (Vietnam) Local authorities conduct assessments, but standardized tools and processes are lacking ● (Indonesia) Assessments are conducted by local authorities, but standardized tools and processes are lacking. ● (Fiji) N/A ● (Uzbekistan) Although the law mandates a life situation assessment and the development of an individual service plan, it does not incorporate standardized tools that assess functional limitations (e.g., ADL/IADL) or medical needs.
Settings for public LTC support		● (Japan) Both HCBS and IC are covered. Community care (center-based services like day care) is common. Primarily in-kind benefits; cash benefits are limited. ● (Korea) Strong emphasis on home and community-based services, with institutional care also widely available. Cash benefits are limited, but formal caregiving by trained family members could be reimbursed at a lower level. ● (Thailand) The LTC system is predominantly home- and community-based, reflecting cultural preferences and policy goals to promote aging in place, while institutional care remains limited and underdeveloped ● (China) Both home and community-based services (HCBS) and institutional care (IC) are available. However, the majority of pilot programs focus on HCBS, with limited availability of IC services. Cash benefits are generally not provided ● (Sri Lanka) Not applicable

Section	Topic	Key findings
		• (Vietnam) Social protection centers provide institutional housing and care, often with limited capacity. In contrast, ISHCs are community-based, offering home care, screenings, social support, and mutual aid—supported by the government but operating independently from traditional residential facilities. Services are primarily provided through social protection centers, with limited availability of home and community-based services. • (Indonesia) Residential facilities for older adults—known as panti, panti werdha, or panti sasana tresna werdha—number around 263 nationwide, offering about 18,100 beds (Most do not offer assistance with activities of daily living (ADL), as residents are generally not considered to have significant care needs). Home and community-based services (HCBS) are limited and not widely institutionalized. Limited cash benefits (the MOSA Social Assistance for Older People, ASLUT). • (Fiji) N/A • (Uzbekistan) Public LTC is limited to minimal institutional shelter-based care and informal home-based support via mahalla committees.
Service provided		• (Japan) Comprehensive range: HCBS (personal/household care, bathing, nursing, rehab), facility-based day services/respite, IC (various nursing home types), community-based services (group homes, small-scale multifunctional care), preventive services, loan/purchase of assistive equipment, home modifications • (Korea) Extensive home and community-based services (home visits, day/night care, short-term respite), alongside institutional nursing home care. Assistive devices partly covered by LTCI based on predetermined positive lists. • (Thailand) The LTC scheme offers a range of integrated health and social care services, including personal care, basic medical care, rehabilitation, and assistive devices, though consistency in service delivery across sub-districts has not been verified • (China) HCBS in pilot programs include assistance with activities of daily living, home environment modifications, basic healthcare services, rehabilitation, and social support. Service coverage is typically limited to 2–8 hours of home visits per week, placing a significant caregiving burden on families • (Sri Lanka) Existing support includes volunteer-based programs—such as those by HelpAge Sri Lanka—that train older adults to assist their peers; privately provided in-home nursing care services, which vary in quality and cost depending on the training of the caregiver; day-care centers offering social and recreational activities, supported by the National Secretariat for Elders (NSE) and NGOs; and eldercare homes, which primarily provide shelter rather than comprehensive LTC services • (Vietnam) In some localities, basic personal care, medical check-ups, rehabilitation, and daycare are offered through community clubs or pilot programs. • (Indonesia) For home care management service provisions defined by the MOSA: companionship,

Section	Topic	Key findings
		social care, daily activity aid, basic needs, IADL and ADL services, and health-care services for disabled and bedridden, etc. In some localities: basic personal care, medical check-ups, rehabilitation, and daycare offered through community clubs or pilot programs. ● (Fiji) N/A ● (Uzbekistan) Home care includes daily living support and limited nursing; institutional care offers accommodations and personal care, but lacks specialized or rehabilitative services
Integrated care and person-centered care pathways	Person-centered care (service integration for person-centered care) / integrated care (Information sharing and coordination among health, welfare, and long-term care services)	● (Japan) Major policy is the Community-Based Integrated Care System (CBICS) aiming for seamless local integration of medical care, nursing care, prevention, housing, and livelihood support by 2025. Care managers develop personalized care plans; beneficiaries have provider choice. Coordination challenges (e.g., information sharing) persist ● (Korea) Efforts towards integrating medical and LTC services through home-visit nursing and case management, with pilot programs demonstrating improved community-level coordination. The 3rd Basic Plan explicitly promotes personalized care planning and coordination for enhanced integration of health, LTC, and welfare services. ● (Thailand) The LTC system emphasizes integration and person-centeredness, combining medical and social care through multidisciplinary teams and coordinated funding mechanisms to provide holistic, needs-based support ● (China) Integration of services is limited, with only a few pilot areas achieving coordinated, person-centered care. Efforts are ongoing to improve service coordination and integration across health and social care sectors ● (Sri Lanka) Not applicable ● (Vietnam) Some pilot models (e.g., HelpAge, community-based care clubs) attempt informal coordination among health and social services. ● (Indonesia) The health system includes case management for older adults with multiple conditions, ensuring continuity of care through referrals and coordination. Post-discharge LTC is supported by geriatric clinics and home visits. In some care homes, social workers link clients to needed services, with complex cases addressed via case conferences involving specialists. The Ministry of Health launched puskesmas santun lansia in 2000 to promote healthy aging through integrated care and community support. Older adults are grouped by need, with mild cases joining activities and severe cases receiving home or hospital care. By 2018, only 48.4% of centers had implemented the model due to funding gaps and regional disparities. Geriatric clinics exist in only 88 of 2,813 hospitals, mostly in major cities across 21 provinces. Just 10 offer fully integrated services. These facilities provide various care options, from outpatient to hospice, supported by trained multidisciplinary staff, including specialists, geriatric-trained doctors and nurses, and rehab, nutrition, and pharmacy personnel (ADB 2020). Some pilot models (e.g., HelpAge, community-based care clubs) attempt informal coordination among health and social service

Section	Topic	Key findings
		● (Fiji) N/A ● (Uzbekistan) No formal integration exists; care is fragmented across sectors with no coordination mechanisms. Person-centered approaches remain at pilot stage
Quality assurance	Assurance mechanism for providers, penalty, or certification requirement	● (Japan) Municipal governments issue permits to providers based on minimum national standards (workforce, facility). MHLW and prefectures conduct evaluations; some quality indicators linked to financial incentives ● (Korea) NHIS oversees regular quality assessments of providers, publicly rating performance with financial incentives linked to quality outcomes. Minimum service standards are legally mandated ● (Thailand) While efforts are being made to enhance quality assurance through training and supervision, formal quality assurance mechanisms remain limited ● (China) Since 2018, the government has initiated monitoring and evaluation of LTC services, focusing on metrics ● (Sri Lanka) Home care providers that do not offer clinical services are not subject to official regulation. In contrast, in-home nursing care services are regulated by the Private Health Services Regulatory Council (PHSRC), which enforces compliance during registration renewals. Eldercare homes are required to obtain certification from the Sri Lanka Standards Institute (SLSI), which conducts routine inspections; however, registration has been suspended since 2015, and the implementation of revised standards remains uncertain. ● (Vietnam) Quality control mechanisms not yet institutionalized. Monitoring mainly through administrative audits of public facilities. ● (Indonesia) Quality control mechanisms not yet institutionalized. Monitoring mainly through administrative audits of public facilities. ● (Fiji) N/A ● (Uzbekistan) Legal standards exist but enforcement is weak; no national agency for LTC accreditation, inspections are rare, and penalties uncommon.
Performance of long-term care service delivery	Unmet needs for care, financial protection for LTC costs, family burden, quality of life, and equity, etc.	● (Japan) High caregiver satisfaction in some local surveys (e.g., Nagoya 86.8%). However, nationwide data indicates significant unmet ADL/IADL support needs (15.5%), and many with limitations are not LTCI certified (62.5%). ● (Korea) High overall satisfaction reported among LTCI users. Nevertheless, substantial unmet care needs persist (approximately 33.6% as of 2020), alongside significant hidden economic burdens due to extensive informal caregiving hours, underscoring gaps in financial protection and comprehensive care delivery. ● (Thailand) Thailand's rapidly expanding community-based LTC system has improved coverage and the well-being of older adults, yet challenges persist in meeting unmet care needs, ensuring financial protection, alleviating family burden, and addressing equity

Section	Topic	Key findings
		● (China) Significant unmet needs persist, especially in rural areas, due to uneven service availability and limited formal caregiving capacity. As LTCI is still in the pilot phase, there is no comprehensive financial protection; many households still bear high out-of-pocket expenses. Family members remain the primary caregivers, contributing to a high informal care burden. Quality of life improvements are not yet consistently tracked, and equity gaps remain between urban and rural populations. ● (Sri Lanka) In general, no financial protection mechanism exists, and a high level of unmet needs is anticipated, although reliable data or reports on this issue are currently lacking. ● (Vietnam) High unmet needs, particularly in rural areas. No financial protection mechanism; caregiving is mainly informal and unpaid. Family burden is substantial. Data on quality of life and equity are limited. ● (Indonesia) High unmet needs, particularly in rural areas. No financial protection mechanism; caregiving is mainly informal and unpaid. Family burden is substantial. Data on quality of life and equity are limited. ● (Fiji)) In general, no financial protection mechanism exists, and a high level of unmet needs is anticipated, although reliable data or reports on this issue are currently lacking. ● (Uzbekistan) Care is primarily provided informally by female family members within the community system, placing a substantial burden on them. Due to the absence of a formal LTC system, there is a lack of systematic data on unmet care needs, quality of life, and equity.

Chapter 5. Policy Agendas: Towards Policy Alignment and Cooperation for Healthy Ageing and Long-term Care in the Asia-Pacific Region

5.1 Background

The Asia-Pacific region is facing unprecedented demographic transitions, with several countries rapidly entering aged or super-aged societies. Although efforts to extend life expectancy (LE) have been successful, gains in healthy life expectancy (HALE) are falling behind, leading to increased burdens of chronic disease and long-term care (LTC).

This review aims to draw shared lessons and propose collaborative research and policy agendas based on the comparative findings from nine country case studies within the Asia-Pacific region.

5.2 Policy Agenda 1: Establishing Sustainable Financing for Healthy Ageing and Long-term Care

Rationale:

As populations age, the traditional reliance on informal, family-based care is becoming increasingly unsustainable. In advanced economies like Japan and Korea, demographic shifts, rising female labor force participation, and the immense burden on informal caregivers prompted nationwide reforms to establish formal LTC systems. This transition was a strategic decision to address concerns about the quality of care for older adults, to provide financial protection against the formal and informal costs of care, and improve efficiency in the delivery of health and LTC. Many countries in the Asia-Pacific region now face a similar imperative to develop sustainable financing mechanisms that can meet the growing demand for LTC.

Comparative insights:

- **Resource Generation:** Many countries that have established formal systems, such as Japan and Korea, have adopted a mandatory insurance model for LTC. China is also exploring this through various pilot programs. However, other models exist, such as Thailand's tax-funded approach, which resembles its pre-existing healthcare system. The optimal choice for revenue generation must align with each country’s existing social security framework, fiscal capacity, and political context.
- **Resource Pooling:** The method of pooling resources significantly impacts equity and efficiency. For example, Korea utilizes a single national pool under the National Health Insurance Service, ensuring nationwide risk sharing. In contrast, Japan pools funds at the municipal level, allowing for greater local autonomy and accountability but potentially leading to regional disparities. A deeper exploration of the trade-offs

between centralized and decentralized pooling is crucial for emerging systems. In Different from Japan and Korea, where health and LTC funds are separate, the pre-existing Local Health Funds of Thai—originally intended for health promotion activities—serve as a joint funding pool for long-term care, offering potential advantages for coordinating the delivery of health promotion and LTC services. This represents a unique example of an integrated funding pool between health and LTC among the countries studied, warranting further investigation.

- **Purchasing Mechanisms:** While needs assessment-based gatekeeping effectively serve as key purchasing mechanism in countries such as Japan and Korea, this is not found in many countries. Moreover, most LTC financing systems rely on volume-based payments to providers. While this model helped expand service supply, it offers limited incentives for preventive care, rehabilitation, or the integration of health and social care services. A shift towards strategic purchasing that rewards outcomes—such as improved HALE, reduced hospitalizations, and greater care quality—is needed to enhance system efficiency and person-centeredness.

Potential Agenda:

- A comparative analysis of LTC financing models (e.g., social insurance vs. general taxation vs. mixed models) to understand rationales for the choice of **revenue generation and sustainability** in diverse economic contexts.
- An examination of **universal versus targeted approaches to population coverage**, analyzing how differing eligibility criteria (e.g., needs-based, means-tested, age-based) impact equity, cost-containment, and political sustainability.
- An in-depth study on the advantages and disadvantages of different resource pooling mechanisms (e.g., national vs. subnational, integrated funding pool between health and LTC) concerning equity, efficiency, and local accountability.
- Collaborative research to design and pilot innovative **purchasing and provider payment systems** that incorporates needs assessment, incentivize preventive care, integrated service delivery, and better health and well-being outcomes for older adults.
- A study on **defining a basic and optimal service package for LTC**, considering the trade-offs between comprehensiveness of service coverage (e.g., HCBS, institutional care, preventive services) and the sustainability of financing

5.3 Policy Agenda 2: Strengthening LTC Service Delivery and Community-Based Integrated Care (CBIC)

Rationale:

Across most countries, the strategic goal of LTC reform is to enable older people to “age in place,” with home- and community-based services (HCBS) forming the backbone of service

delivery. In countries that established LTC systems earlier—such as Japan and Korea—the initial policy priority often centered on expanding institutional capacity to address pressing issues like "social hospitalization." Over time, however, both systems shifted toward an HCBS-oriented approach as the preferred and more sustainable model.

Integrated care offers considerable potential to reduce demand for costly, less-preferred institutional services by providing an optimal mix of health and LTC services tailored to older adults with complex, overlapping medical and social needs. Realizing this potential requires:

- Sustained investment in HCBS infrastructure; and
- Delivery models that integrate HCBS with healthcare to ensure continuity and comprehensiveness of care.

Comparative Insights:

Japan, Korea, China, and Thailand—all emphasize HCBS and integrated care in policy discourse, but differ in how these are operationalized:

- **Japan** embeds CBIC within a mature national LTCI framework, with municipalities as insurers and planners, and a strong performance cycle (PDCA) backed by fiscal decentralization and standardized guidelines.
- **Korea** expanded formal LTC services rapidly under a centralized LTCI system, then introduced HCBS and pilot projects for local-level medical–care coordination, though integration remains limited by centralized governance under the NHIS.
- **China** has prioritized institutional and formal service capacity through LTCI pilots in multiple cities, with integration as a subsequent policy stage.
- **Thailand** leverages pre-existing community health and volunteer networks—initially designed for health promotion—now serving as joint funding pools and delivery platforms for emerging LTC services, though capacity for high-need populations remains limited.

These differing trajectories highlight opportunities for cross-country learning: developed systems can offer lessons on scaling HCBS after initial institutional expansion, while prevention- and community-centered models can inform how to embed integrated care into primary care networks from the outset.

Potential Agenda:

- **Explore the potential of leveraging existing community structures** (e.g., mahalla, Posyandu, zone nurses) to expand HCBS investments and support integrated approaches to care.
- An **in-depth comparative case study of the effectiveness, cost-effectiveness, and scalability of different LTC service delivery systems, including CBIC models,** across diverse socioeconomic and health-system contexts in the Asia-Pacific region.

- **A comparative performance review of various approaches to improving the quality of LTC,** including the effectiveness of different purchasing models (e.g., commissioning vs. vouchers) and supply-side regulations (e.g., quality accreditation, entry barriers).
- **Strategic development of a competent and motivated multi-disciplinary workforce,** encompassing recruitment, standardized training, and retention strategies for both professional caregivers and community health volunteers
- A **study on innovative technology-based models**—such as telemedicine, remote monitoring, and shared EHRs—that enhance the efficiency, accessibility, and quality of CBIC.
- **Support cross-country learning on decentralized governance models** that empower municipalities with both financing and service planning authority.

5.4 Policy Agenda 3: Aligning Health and LTC governance – Towards Integrated Accountability

Rationale:

Across countries, LTC, universal health coverage (UHC), and health promotion policies are often developed and implemented under fragmented governance systems. Fragmentation limits resource efficiency and undermines coordinated policy accountability. Such policy imbalances often arise from the path-dependent historical evolution of health and social-welfare systems, as well as from the unique mandates and power dynamics of each ministry. In many countries, ministries of health have focused primarily on medical services and UHC, while ministries of social welfare have concentrated on welfare benefits and certain aspects of LTC, often targeting the poor and vulnerable. These independently developed trajectories entrench distinct institutional cultures, budgeting processes, and professional domains, making inter-ministerial integration and coordination difficult.

Comparative Insights:

- **Separate ministries govern LTC (e.g., social affairs) and health (e.g., MoH)** in countries like China, Vietnam, Indonesia, and Uzbekistan
- The **lack of a "shared language" and common performance indicators** across the LTC, UHC, and health-promotion sectors is a fundamental barrier to effective coordination and accountability.
- **No clear accountability mechanisms exist for shared outcomes** like reduced hospitalizations or improved HALE through LTC or prevention.
- **Fiscal incentives often do not reward preventive or LTC interventions** for reducing downstream costs (e.g., Korea's LTC system lacks direct cost-saving linkages to healthcare)

Potential Agenda:

- A **comparative study of governance models** that effectively integrate the decision-making and implementation of LTC, UHC, and health-promotion policies at both national and local levels (e.g., Thailand's Local Health Fund, Japan's decentralized LTC financing model, Korea's centralized LTC financing)
- A **study on the design and impact analysis of inter-sectoral financial incentive structures** that enhance prevention and efficiency.
  - ex) Promote **performance-based coordination mechanisms** across sectors (e.g., budget incentives for health-promoting LTC services).
- An **analysis of accountability frameworks** that ensure sustained policy linkage and performance.
  - ex) Develop joint planning and accountability frameworks that tie outcome indicators (HALE, avoidable hospitalization, unmet LTC needs, informal caregiver burden, etc.) to a common set of performance indicators that relevant ministries are jointly accountable for.

5.5 Policy Agenda 4: Measuring What Matters – Shared Monitoring Indicators for Healthy Ageing Outcomes

Rationale:

Effective policymaking requires robust data. However, few countries consistently monitor outcome indicators that reflect key policy goals such as older adults' overall wellbeing, unmet LTC needs, and financial protection. Without common metrics, it is difficult to assess policy performance, ensure accountability, and facilitate collaboration both within countries and across the region. This requires defining clear and relevant performance indicators, establishing reliable data-collection mechanisms, and creating feedback loops for policy improvement. Beyond basic clinical metrics, it is crucial to establish a comprehensive indicator set that includes core performance measures for healthy ageing and LTC—covering compression of morbidity, financial protection, unmet need, family burden, quality of life, and equity. The selection of such indicators goes beyond a purely technical exercise; it reflects underlying policy priorities and values. Because the M&E framework itself can steer policy toward more comprehensive and equity-oriented healthy-ageing goals—or, conversely, narrow its focus—we need to discuss how to structure a balanced, performance-driven set of indicators.

Comparative Insights:

- **Japan and Korea**: Use standardized indicators for HALE and LTC system performance (e.g., care grade levels, functional ability).

- **Vietnam, Indonesia**: Limited data systems for ageing outcomes; reliant on fragmented household surveys or donor-supported efforts.
- **Few countries** systematically track key concepts such as **family burden, unmet LTC needs, QoL, or equity** outcomes for older adults.

Potential Agenda:

- **Development and validation of a common minimum dataset and key performance indicators** for healthy ageing and LTC, tailored to the Asia-Pacific context with careful consideration of data availability and cultural relevance. Consider:
  - HALE/LE gap at subnational levels
  - LTC unmet needs (disaggregated by income, gender, region)
  - Family caregiver burden and out-of-pocket expenditure
  - Preventable hospitalizations/institutionalization among older adults
- A study to **strengthen national health information systems** so they can regularly collect and report key healthy-ageing indicators, including disaggregated data on vulnerable older populations.
- Promote cross-country **capacity-building for health and social data integration** (e.g., linking national health surveys with LTC registries)
- Encourage data sharing & research collaboration through **regional knowledge platforms**

Chapter 6. Conclusion

The Asia-Pacific Paradox: Compressed speed of aging with expansion of morbidity

The Asia-Pacific region is entering a new demographic era in which population ageing is not only inevitable but also occurring at a speed and scale unprecedented in human history. In many countries, the demographic transition that unfolded over more than a century in parts of Europe is being compressed into just a few decades. This accelerated pace leaves very little time for governments to adapt social protection, health, and long-term care (LTC) systems to meet the changing needs of their populations. The challenge is further compounded by an alarming pattern: while people are living longer, these extra years are not always being spent in good health. For many, the period of life spent with illness, disability, or functional limitation is expanding rather than shrinking—a phenomenon often described as the "expansion of morbidity."

This expansion of morbidity places enormous pressure on families, communities, and governments. Informal caregiving—once the backbone of care provision for older persons—is becoming less sustainable due to smaller family sizes, increased female labour force participation, and urban migration. Without systemic adaptation, the gap between the number of older adults who need care and the available capacity to provide it will continue to widen, threatening not only the quality of life of older people but also the social and economic stability of entire nations.

The Dual Imperative: Compression of morbidity and adequate supply of LTC

Against this backdrop, two policy pillars emerge as essential for an effective and sustainable response. The first is the promotion of healthy ageing, with the explicit aim of compressing morbidity—delaying the onset and reducing the duration of ill health through preventive care, health promotion, and environments that support active ageing. The second is the establishment of effective and efficient LTC systems capable of delivering timely, high-quality, person-centred care to those with significant needs. These two pillars are mutually reinforcing: investments in health promotion can reduce future care burdens, while robust LTC systems ensure that those who do develop care needs can maintain dignity and autonomy.

The Asia-Pacific region is particularly well-suited to advancing these agendas through cross-country learning. Despite wide differences in economic development and institutional capacity, many countries in the region share cultural and institutional features, such as the strong role of families, the importance of community-level networks, and hybrid governance arrangements that combine central policy direction with varying degrees of local implementation. These shared characteristics make policy innovations from one country more readily adaptable to another, in contrast to policy learning from countries with entirely different socio-cultural contexts.

This report sought to contribute to that learning process by providing a snapshot comparison of nine countries at various stages of demographic transition and system development. The purpose was not to produce a ranking, but to identify patterns, innovations, and trade-offs that could inform policymaking elsewhere.

Key lessons

First, the commitment to "ageing in place" is nearly universal. Across the countries studied, policymakers recognise that older people prefer to remain in their own homes and communities as long as possible, and that this can often be more cost-effective than institutional care. However, the pathways to achieving this goal vary. Countries like Japan and Korea, which established formal LTC systems earlier, initially expanded institutional capacity to respond to urgent care gaps—particularly to address so-called "social hospitalisation" in medical facilities. Over time, both shifted toward strengthening home- and community-based services (HCBS) and developing integrated care models that bridge health and social care. In contrast, countries such as Thailand and Viet Nam began from a prevention-oriented, community-driven base, leveraging primary health care networks and volunteer systems to meet basic needs. While these models have been effective for health promotion and low-intensity care, they face limitations in supporting those with complex needs and are now exploring ways to formalise and expand LTC services. China's approach, meanwhile, has focused on rapidly building formal service infrastructure through LTC insurance pilots before turning to the integration agenda. These contrasting trajectories illustrate that there is no single correct sequencing of policies, but they also highlight an important caveat: integrated care cannot succeed without an adequate service base. While integration is often promoted as a cost-efficient solution, relying solely on community or informal resources without parallel investment in formal services risks perpetuating caregiver strain and undermining quality of care. For integrated care to reach its full potential—particularly in reducing costly and less preferred institutionalisation—it must be anchored in sufficient HCBS capacity and supported by government policy that align medical and social services around the needs of the individual.

Second, healthy ageing and health promotion policies must be positioned as more than just adjuncts to the health system. In the most advanced examples—such as Japan's municipal-level care prevention programmes or Thailand's Local Health Funds—the linkage between prevention, primary health care, and LTC is explicit. These models not only delay the onset of dependency but also create opportunities for early intervention and smoother transitions between different levels of care. However, the study also found that in many settings, health promotion efforts remain fragmented, underfunded, or disconnected from LTC planning. Strengthening these linkages is a strategic necessity if the region is to move from managing the consequences of ageing to shaping its trajectory.

Third, governance and financing arrangements significantly influence the capacity to deliver on both healthy ageing and LTC agenda. Decentralised systems, as in Japan and to some extent Thailand, can tailor services more closely to local needs, provided that local governments are equipped with both resources and authority. Conversely, highly centralised systems may ensure greater equity in financing and access but risk being less responsive to local needs and preferences. In either case, the absence of common performance metrics hampers accountability and learning. Without shared indicators—both within countries across

localities and across countries in the region—it is difficult to assess policy effectiveness, identify gaps, or measure progress in ways that facilitate constructive exchange. Moreover, while strategies such as compression of morbidity and the promotion of integrated care can mitigate the overall growth in LTC demand, demographic realities—particularly the combination of rising numbers of older adults and a declining supply of informal caregivers—mean that unmet LTC needs are still likely to increase in the years ahead. Meeting this demand will require expanding access to formal LTC services, which in turn demands sustainable and equitable financing arrangements. This underscores the importance of not only designing efficient delivery models but also securing the necessary financing policy to fund them. Discussions on revenue generation—whether through dedicated mandatory insurance, earmarked taxation, or broader fiscal reforms—will be critical to ensure that countries can meet growing LTC needs without undermining other social priorities.

Way forward

From these findings, several policy implications arise. Sustained investment in health promotion and morbidity compression strategies is critical, not only to improve individual wellbeing but also to ease long-term fiscal pressures. Building HCBS infrastructure should be treated as a foundational step toward integrated care, rather than as a secondary or optional objective. Community assets, such as volunteer networks, local health posts, or traditional neighbourhood structures, represent valuable platforms for expanding reach, particularly in resource-constrained settings, but must be complemented by professional services to handle higher levels of need. Cross-country learning platforms, supported by comparable data and systematic evaluation, can accelerate adaptation and avoid the costly trial-and-error that occurs when countries work in isolation. Finally, sustainable financing mechanisms must strike a balance between national-level risk pooling—which ensures equity and resilience—and local autonomy in planning and service design, which ensures relevance and responsiveness.

This report represents only a first step in what should be an ongoing process of structured exchange on healthy ageing and LTC in the Asia-Pacific. By examining nine countries across a range of demographic and institutional contexts, it provides a starting point for dialogue and mutual learning. The lessons presented here suggest that while no single model can be transplanted wholesale, adaptation informed by comparative insight holds significant promise.

The demographic future is already visible. Population ageing will accelerate, and without deliberate action, morbidity will continue to expand. The policy choices made now—whether to invest in prevention, to build LTC capacity, to integrate care delivery, and to share knowledge openly—will determine whether societies can meet this challenge in ways that protect both the dignity of older people and the sustainability of national systems. The imperative is not simply to prepare for an ageing society, but to shape one in which longer lives are healthier, more fulfilling, and more connected to the communities in which people wish to remain.

Annex

1. Framework for Long-term Care Analysis

This study incorporates a cross-country comparative analysis using a defined framework in collaboration with national researchers from the included countries to collect data on the LTC policy, focusing on the systemic characteristics that facilitate person-centered integrated LTC delivery for AIP, as well as the potential challenges of such an approach.

The study utilizes the World Health Organization (WHO) Framework, which was developed to support countries in establishing an integrated continuum of LTC (World Health Organization, 2021a), as the primary tool for data collection on each country's LTC system. This framework (World Health Organization, 2021a) was selected over the earlier version developed by the WHO Regional Office for Europe (Tello et al., 2019) due to its emphasis on system-level functions and alignment with long-term care policy objectives. The framework adopted in this study takes a broader policy-oriented approach, highlighting essential system components, including governance, financing, workforce, and service delivery—key enablers of sustainable and integrated national LTC systems. Given the study's focus on cross-country LTC policy analysis in the Western Pacific, this framework offers a comprehensive and adaptable structure for comparative analysis.

Using the revised framework, this study focuses on four core elements of the LTC system to provide a person-centered analysis of LTC systems: (a) service delivery, (b) workforce, (c) sustainable financing, and (d) governance. While the original WHO framework comprises six key elements—including (e) information, monitoring, and evaluation systems, and (f) innovation and research—this study prioritizes the first four elements. This decision is guided by two key considerations. First, the healthcare system, including long-term care, can be more effectively defined by its core functions (World Health Organization, 2000). Within this functional structure, information—originally classified under element (e)—is better conceptualized as a subcomponent of governance, while monitoring and evaluation systems function as tools for assessing the effectiveness of these core functions (Papanicolas et al., 2022),. Second, challenges related to cross-country data compatibility and measurement constraints necessitated this approach. While innovation and high-quality research are undoubtedly critical for the effective provision of integrated LTC services, the absence of clear guidance within the framework makes it difficult to assess whether certain countries excel in these areas, thereby complicating cross-country comparisons (Papanicolas et al., 2022; World Health Organization, 2000).

Data on four elements of LTC systems were collected using the framework as revised by the authors. The subsections within each of the four core sections were primarily based on the existing WHO framework, with modifications made where necessary to align with the research objectives and account for data availability. Following data collection, both vertical and horizontal reviews were conducted: the vertical review aimed to analyze the structure of LTC service delivery within each country, while the horizontal review compared key system functions across countries. The study particularly examines whether the existing LTC systems in the selected countries are conducive to the person-centered, integrated delivery of LTC within community settings.

2. Framework for Healthy Ageing Analysis

This study incorporates a complementary cross-country assessment using a defined framework to analyze national strategies for health promotion and healthy aging. Conducted in conjunction with the LTC system analysis, this component focuses on the upstream policy environment that enables individuals to maintain functional ability and well-being throughout their life course and delay the onset of long-term care needs.

The study adopts an adapted *Framework for Healthy Ageing Analysis* to assess the extent to which national health promotion systems align with the principles of healthy ageing as articulated in the WHO Decade of Healthy Ageing and related global strategies. The framework centers on the role of national policies and programs in promoting intrinsic capacity and resilience, particularly through life-course–oriented and community-based interventions. It was selected to address the growing recognition that effective LTC reform requires preventive and enabling strategies that begin well before old age.

The framework emphasizes a set of interrelated system-level components—health promotion governance, strategy integration with health and LTC systems, life-stage targeting, financing models, and monitoring mechanisms—that collectively shape how societies promote healthy aging. Among these, two criteria were prioritized in the cross-country comparison. First, the *life-course orientation* of health promotion—whether policies explicitly address different stages of life and promote long-term health capacity. Second, *alignment with LTC and UHC objectives*—whether promotion efforts are institutionally and financially linked with broader service delivery reforms to support ageing in place.

The framework was applied to eight countries—Korea, Japan, China, Thailand, Viet Nam, Indonesia, Sri Lanka, and Fiji—based on a structured review of publicly available national policies, plans, and strategic evaluations. Given the variation in national health promotion architectures, the analysis focused on identifying common enabling factors, policy gaps, and system constraints relevant to the integration of LTC reform.

Data were collected using a framework adapted by the authors, grounded in WHO recommendations but adjusted for relevance and comparability. A combination of document review, expert input, and cross-case synthesis was employed to evaluate the positioning of health promotion within national aging and LTC agendas. As with the LTC framework, both vertical and horizontal reviews were conducted. The vertical review analyzed how each country structures its health promotion systems, while the horizontal review compared the scope and depth of life-course strategies across contexts.

The study concentrated on life-course policy targeting and systemic alignment as key indicators of maturity and coherence in national healthy ageing efforts. The findings help clarify the degree to which national health promotion strategies are likely to contribute to sustainable, person-centered LTC by reducing avoidable dependency and enabling aging in place.