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LONG-TERM CARE SYSTEMS AND SERVICES DEVELOPMENT IN ASIA AND THE PACIFIC

INTERNATIONAL SOCIAL SECURITY ASSOCIATION

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Executive summary

Long-term care (LTC) systems across Asia and the Pacific are undergoing rapid transformation in response to unprecedented population ageing. As demand for care grows in both scale and complexity, countries are developing a wide range of LTC policies, programmes and services to meet the needs of older persons while balancing affordability, accessibility, sustainability and quality.

This report, which complements the *ISSA Guidelines on Administrative Solutions for Long-Term Care Services*, examines the demographic, social, and economic drivers shaping LTC development over the past decade across the region, highlights emerging policy and service delivery models, and explores the challenges and opportunities that will influence future progress. While countries are following diverse pathways, common priorities are emerging, including stronger integration of health and social care, sustainable financing mechanisms, community-based services, workforce development, and the use of digital innovation.

Despite significant advances, challenges such as fragmented systems, unequal access to services, workforce shortages, and resource constraints remain. The report underscores the critical role of social security institutions in supporting the development of effective and sustainable LTC systems and draws on experiences from ISSA member institutions to identify good practices and shared lessons. As population ageing accelerates, strengthening LTC systems will be essential to promoting well-being, social inclusion, and resilience across the region.

1. A changing region: Context and distinctive features

1.1. Key drivers of long-term care needs

Between 2020 and 2050, the global population aged 60 or older will grow from 1 billion to 2.1 billion with a projected 80 per cent of older persons living in low- and middle-income countries (WHO, 2025a). It is estimated that 63 per cent of the increase will occur in Asia (UNFPA, 2017). A defining feature of this transition is that, unlike their Western counterparts, many Asian and Pacific economies are "ageing before becoming rich" – reaching high proportions of older population at far lower levels of per capita income than today's high-income countries did. This severely constrains the fiscal space available for building comprehensive LTC systems and means that countries must plan, build, and expand systems and services during rather than after the ageing transition.

Compounding the pace and scale of population ageing is a rapid increase in the oldest-old population (aged 80 or older) alongside an epidemiological transition toward chronic, multi-morbid conditions. Together, these trends are increasing the complexity, acuity, and duration of care needed – shifting demand away from episodic support toward sustained, often intensive, long-term care.

Traditionally, care for older persons across the region has been the domain of the family. This informal system is being eroded by structural shifts including smaller household sizes, rising female labour force participation, rapid urbanization, and rural-to-urban as well as international migration. As these forces reduce the availability and capacity of family caregivers, new and more formalized models of care are required to fill the resulting gap.

1.2. Evolving systems

- ***Diversity within the regional picture.*** Beneath these regional headlines lies enormous diversity. The region of Asia and the Pacific is home to some of the world's "super-aged" societies – Japan, Republic of Korea, and Singapore – alongside "aged" societies – China –, and "ageing" societies – India and Indonesia – that will carry very large older populations in the decades ahead, while other countries – Mongolia and Tonga –sit just at the threshold of being classified as ageing societies, with smaller populations but rapidly growing care needs (ESCAP, 2026). Economic diversity compounds this picture: high-income countries such as Japan and Singapore have been able to invest substantially in LTC systems; upper- and middle-income countries, such as Thailand and Viet Nam, face a compressed demographic transition with comparatively fewer resources; and lower-income countries, such as Lao PDR, currently retain a demographic dividend but are ageing with limited fiscal and institutional capacity.
- ***Social protection.*** Only a handful of countries – notably Japan, Republic of Korea, and Singapore – have well-developed social protection and health systems explicitly incorporating LTC. For most of the region's countries, these systems are still evolving. Adequate coverage and the sustainable financing of social protection remain persistent challenges, and the overall regional picture is mixed. In 2023, just over half the Asia and the Pacific population (53.6 per cent) was covered by at least one social protection benefit, leaving an estimated 2.1 billion people without adequate protection against life-course contingencies such as illness, disability, and old age. Regional social protection

expenditure stood at 11.8 per cent of GDP, well below the global average of 19.3 per cent.[1] Many social protection ministries have historically provided limited LTC services, primarily targeted at the most vulnerable populations. However, they are currently often poorly equipped to coordinate across sectors and unable scale up to serve the broader ageing population. On average, 43 per cent of older Asians who have a functional limitation experience a care gap, with women and the poor disproportionately affected (Donhower, 2024).

- ***Health systems.*** Health systems across Asia and the Pacific have made progress on extending health services coverage over the past decade but remain behind on providing adequate financial protection. LTC is fast emerging as a policy issue for health ministries across the region. Persistent challenges include *adequate financing and a lack of LTC service coverage under health insurance and social health protection schemes*. Where financing does exist, it is directed through means-tested social protection mechanisms rather than through integrated health coverage (ADB, 2021). *Commonly there is weak coordination with social protection actors, other ministries and local government bodies* responsible for delivery of community and home-based care and development of the workforce, and there are *constraints in workforce and training programmes*. The long-term care workforce across the region has shortages of trained caregivers, nurses, community health workers and allied service providers (ILO, 2024b and ADB, 2024a, Fig. 5.7). Strengthening training and recruitment programmes to meet demand, now and in the future, is needed. Together, these gaps reflect health systems that are still largely organized around acute, curative care rather than sustained, integrated support for chronic and functional needs of the growing ageing population.

1.3. Civil society and the emerging role of the private sector

Civil society organizations, both secular and faith-based, have traditionally played a critical role in the provision of care and support services across the region, with many operating primarily through volunteers and relying on grants, charitable giving, and philanthropic funding rather than stable public financing.

The private sector is increasingly expanding into this space, often beginning with residential care services targeted at higher-income consumers. Social entrepreneurship is also emerging to meet unmet demand, with a number of companies now expanding their models across multiple countries in the region. Recent research points to growing willingness among both current older persons and future cohorts to receive and pay for formal home care services, reflecting a clear preference for ageing in place. At the same time, surveys find that a majority of both older and younger respondents remain unwilling to receive or pay for institutional care, reflecting persistent social stigma attached to residential care settings (ADB, 2024).

In some countries, the private sector is already well integrated into the LTC system, collaborating closely with government to expand access and assure quality – as in Japan and the Republic of Korea – and private sector engagement is becoming a key component of emerging policy frameworks in countries such as China. Tapping the capacity of civil society and private providers and creating the enabling regulatory and financing conditions for them to serve mainstream populations rather than only their traditional niche markets, represents both a major opportunity and a significant challenge for LTC ecosystem development across the region.

1. Informal workers and women bear the greatest burdens of exclusion. Informal workers (66 per cent of the regional workforce) are largely excluded from contributory social insurance schemes. Women lag men in effective coverage by 6.8 per cent (ILO, 2024a).

1.4. Workforce

Rising demand for LTC is placing growing pressure on both informal caregivers and the formal care workforce. More than 80 per cent of LTC across the region is estimated to be provided by family caregivers,[2] the large majority of whom are women[3]. In response to growing care gaps, countries such as China, Hong Kong (China), Malaysia and Singapore are making increasing use of local and migrant domestic workers – many of whom are drawn from elsewhere in the region – to provide in-home care (Liem et al., 2023).

This rising demand is being met by an insufficient formal care workforce. In 2024, Japan's Ministry of Health, Labour and Welfare projected a shortfall of approximately 570,000 care workers by 2040[4] – a stark illustration of the scale of the challenge even in one of the region's most institutionally advanced systems. The region is simultaneously a major global exporter of health and care workers. As domestic care needs intensify in these same source countries, pressure on the available formal care workforce will only increase, raising difficult questions about how opportunities created by labour migration, domestic care needs, and workforce development can be reconciled.

For both informal and formal care providers, training, support systems, and social protection coverage remain inadequate. The emerging regional focus on the "care economy" is prompting a growing number of countries to better assess workforce issues and try to incorporate these more explicitly into national planning processes.

1.5. Section highlights

In short, the region is undergoing a rapid demographic transition, with a rising need and demand for care, and there is an urgent and growing demand to develop the LTC sector accordingly. Given that LTC systems require coordination across multiple sectors and stakeholders, many countries face a common set of challenges: establishing effective leadership and coordination mechanisms, developing sustainable financing architecture, effective quality of services and adequate coverage of those in need of LTC, and workforce training and recruitment mechanisms. Underlying all of these is the overarching challenge to develop clarity on the respective roles of government, the general public, the private sector, and civil society in both the provision and financing of care.

2. Jiang et al. (2024).
3. Donhower (2024).
4. Ministry of Health, Labour and Welfare (2024).

2. Policies and planning: Evolution and acceleration

The decade from 2015 to 2025 has seen growing momentum in LTC policy development across the region – a shift from fragmented pilots toward more comprehensive frameworks, system-building, and efforts to scale implementation. This evolution has been driven by rising levels of awareness among policy makers and the public, a strengthened evidence base, and growing platforms for mutual learning. Yet progress remains uneven. The persistent challenge for most countries is translating broad commitments into systems change, adequate financing, and effective services on the ground.

2.1. Regional drivers

Since 2007, the United Nations Economic and Social Commission for Asia and the Pacific (UN ESCAP) has produced regional reviews of the Madrid Plan of Action on Ageing which have kept LTC on the regional agenda, providing a platform for shared learning and sustained advocacy (ESCAP, 2022). The World Health Organization (WHO) has reinforced this effort through two regional healthy ageing frameworks – for South-East Asia (WHO, 2025b) and the Western Pacific (WHO,2021) – both of which incorporate LTC, supporting the development of some Healthy Ageing plans at the country level as well as through the recent 2025 Colombo Declaration, which committed South-East Asian member states to embed LTC within the broader continuum of health care (WHO, 2025c).

2.2. Sub-regional drivers

At the sub-regional level, the Association of Southeast Asian Nations (ASEAN)[5] has progressively elevated LTC within its policy agenda, moving from a general ageing focus toward the development of a dedicated care economy framework. The 2015 Kuala Lumpur Declaration on Ageing: Empowering Older Persons[6] called for health and social systems to support active, productive ageing. In 2021, the Regional Plan of Action to Implement the Declaration[7] was added to prioritize caregiver support and mainstream ageing into national development planning, while the ASEAN Comprehensive Framework on Care Economy[8] placed "care" across the life course at the centre of public policy. The ASEAN Centre for Active Ageing and Innovation (ACAI) was launched in 2019,[9] to support regional cooperation and innovation in LTC, and develop regional evidence (e.g. ASEAN Active Ageing Index) for LTC policy across member states (ACAI, 2025; ERIA and ACAI, 2025).

A wider ecosystem of networks and partners has accelerated progress. The Alliance on Longevity in Asia-Pacific (est. 2022) and HelpAge International have advocated for mutual learning, knowledge development and innovation. Ageing Asia (est. 2009) has catalysed private sector collaboration, focusing on sharing global good practice, sparking collaboration and improving the quality of care with

5. ASEAN is a regional intergovernmental institution promoting political, economic, and socio-cultural cooperation and integration among its member states. It is made up of 11 countries: Brunei Darussalam, Cambodia, Indonesia, Laos, Malaysia, Myanmar, Philippines, Singapore, Thailand, Timor Leste, Viet Nam.
6. ASEAN (2015).
7. ASEAN (2020).
8. ASEAN (2021).
9. ACAI (2025).

private sector, governments and community organizations.[10] UN agencies (ESCAP; International Labour Organization (ILO); WHO; United Nations Population Fund (UNFPA); UN Women), bilateral partners (Japan International Cooperation Agency (JICA); Korea International Cooperation Agency (KOICA)), multilateral banks (Asian Development Bank (ADB); World Bank), think tanks and intergovernmental organizations (e.g. Association of Southeast Asian Nations (ASEAN); Economic Research Institute for Asean and East Asia (ERIA); Organisation for Economic Co-operation and Development (OECD); Asian Development Bank Institute (ADBI)), a growing number of regional academic institutes and international NGOs (e.g. Asia Foundation, Alzheimer International, Ashoka) have all deepened engagement, supporting policy development, piloting, and capacity building across the region.

2.3. Country-level evolution

Progress at the country level is uneven but a quick review of a diverse set of examples highlights how countries have been learning and evolving, by building on available assets and capabilities and supporting innovation to actively accelerate change. These examples are not exhaustive but aim to provide a sense of the scope of action underway.

Japan and Singapore are among the region's most institutionally advanced systems. Both have built cross-government bodies with specific mandates, dedicated funding streams, and multi-decade action plans. Both countries continue to evolve their systems with the objectives of strengthening access, improving care and adapting to their super-ageing societies.

- **Japan.** Since introducing Long-Term Care Insurance (LTCI) in 2000, Japan has progressively reformed its system to address recurring constraints in care delivery and the workforce. The 2006 reforms emphasized preventive care and institutional financing (Iwagami and Tamiya, 2019); the 2015 LTCI Act reform shifted focus toward community-based integrated care, decentralizing cost and management to municipal community assistance centres (Morikawa, 2014). To address chronic workforce shortages, Japan has employed multiple strategies including Economic Partnership Agreements with Indonesia (2008), the Philippines (2009), and Viet Nam (2014), and in 2018 revised its immigration law to open access to employment for migrants in 14 occupations – including care work. In 2025 290,000 foreign nationals held the Specified Skilled Workers[11] status (providing residence status for workers in specified industry fields) in Japan. Approximately, 45,000 were employed as care workers.[12] The JICA has a been playing an important role in sharing Japanese LTC system experience, building capacity and piloting models of care across the region.

- **Singapore** became a super-aged society in 2026 and anticipated this transition with its 2016 Action Plan for Successful Ageing (Ministry of Health, 2015). The plan committed 3 billion Singapore dollars (SGD) to support 70 initiatives spanning 12 policy areas and built on existing pillars such as the Central Provident Fund and national health insurance. The Agency for Integrated Care (AIC) was established in 2009 and designated in 2018 as the single coordinating body for aged care delivery working across sectors and stakeholders. The updated 2023 Action Plan committed and additional

10. Available at https://ageingasia.com.

11. In April 2019, Japan established the "Specified Skilled Worker (SSW)" residence status. The objective is to "… welcome capable specialists from overseas countries to work in certain Japanese industrial fields, to function as workers ready to take on jobs without prior training".

12. Trends in the Number of Foreign Workers by Nationality in Japan's Nursing Care Sector Under the Specified Skills Program.

SGD 3.5 billion and now rests on three pillars – "Care", "Contribution", and "Connectedness". It is anchored in strengthening integrated, community-based care[13] and includes a comprehensive range of initiatives across domains such as transport, housing, employment, active ageing, training and volunteering, and digital inclusion.

China and Indonesia illustrate incremental system-building through national planning cycles and provincial level piloting.

- **China.** With an anticipated population of close to 400 million older than age 60 by 2035, China has built its LTC framework through successive national Five-Year Development Plans (FYPs). The 12th FYP (2011–2015) established a three-tiered home-community-residential model, targeting 90 per cent home-based care, 7 per cent community-based care, and 3 per cent residential care (Krings et al., 2022). The 13th FYP (2016–2020) introduced LTC insurance pilots in selected cities; the 14th FYP called for a coordinated elderly care system spanning home, community, and institutional settings. The current 15th FYP (2026–2030) calls for standardizing and expanding LTCI nationally and positions the "silver economy" as a core economic driver alongside the digital and green economies. In March 2026, the State Council began the rollout of the nationwide long-term care insurance system with a target of achieving whole-population coverage in three years. Efforts to strengthen the workforce include the formal recognition of "elderly care service professional" as a distinct national occupation classification[14] in 2025 and in new interim regulations (May 2026) establishing a three-tier vocational skills system and certifications (junior, intermediate, senior) covering caregivers for home, community and institutional-based settings.

- **Indonesia** has used its National Strategy on Ageing to commit to LTC service development and the 2020–2024 medium term development plan included a pilot to develop a community-based care model (Sutejo, 2024 and ADB, 2025a). The recent Care Economy Roadmap (2025–2045)[15] extends these efforts and includes caregiver training provisions. All of which is reflected in the 2025–2029 medium term development plan and is nested in the overarching 20-year long-term development plan.[16] The national planning agency (BAPPENAS) continues to develop the SILANI Elderly Information System to integrate care planning and service delivery into an overall digital system supporting policy makers, implementors and families.

Mongolia, Thailand, Tonga and Viet Nam illustrate how deliberate piloting, evaluation, and scale-up can build LTC systems under tighter fiscal and institutional constraints. Each country tested a model at small scale, generated evidence, and used it to inform national policy and, when successful, broader rollout.

- **Mongolia**'s trajectory is an example of a country's programme piloting feeding directly into legislative reform. Building on the 2017 Law on the Elderly, Mongolia's National Operational Plan for Long-Term Care (2022–2024) established three Active Ageing Hubs to test coordinated needs assessment, case management, and home care utilizing the capacities of government, private sector and NGO service providers. The evaluation fed almost immediately into policy: in 2024, the Elderly

13. Ministry of Health (2023).
14. *China Daily* (2026).
15. Launch of Road Map on Care Economy in Indonesia.
16. https://faolex.fao.org/docs/pdf/ins231825.pdf.

Law was revised to formally incorporate assessment and case management services, and the home-care budget was increased roughly twenty-fold, from 300 million Mongolian tugrik (MNT) (the equivalent of about 85,600 dollars of the United States (USD)) to MNT 5.4 billion (approximately USD 1.57 million), with further expansion under consideration (ADB, 2025b).

- **Thailand** offers the region's most mature example of pilot-to-scale-up. The country's integrated community-based long-term care programme was introduced in 2016 following a decade of work, including advocacy efforts, research studies, pilot programmes and collaboration with JICA (ADB, 2020). The model assigns a care manager – typically a community-hospital nurse – to each eligible older person. The care manager is responsible for developing individual care plans for eligible older persons and supervises trained caregivers delivering 2–8 hours of home-based support per week. Initially launched to support 100,000 beneficiaries across 1,000 subdistricts, Thailand's community-based long-term care model expanded to 193,000 beneficiaries supported by 72,000 caregivers by 2018. As of 2025, the programme has matured past localized targets, achieving near-universal subdistrict coverage and transitioning to a decentralized, multi-disciplinary care management system to address accelerated population ageing (Supakul and Toyoda, 2026). Evaluations found that paid caregivers outperformed volunteer caregivers, with volunteers providing inconsistent care, particularly as regards meeting the needs of severely dependent older people. These findings are now informing debate and new policies on workforce (professionalization of the formal care workforce and family caregiver training) and a possible dedicated social insurance model (ADB, 2022).

- **Tonga** approved its first Aged Care National Strategic Plan, 2020–2024 in 2020. In 2012 the Tonga Social Service Pilot, sought to strengthen home-based care services to 150 older people and people with disabilities through the NGO *Ma'a Fafine moe Famili*. Following a positive evaluation, the government adopted the pilot as its national home care programme, contracting the same NGO to serve up to 200 people with the highest assessed needs, at an annual cost of 208,000 Tongan pa`anga (TOP) – though this reached only about one quarter of the estimated 1,000 persons eligible (ADB, 2022, p. 22). The model fed into Tonga's first dedicated strategic plan, the Aged Care National Strategic Plan (2020–2024)[17] and a new project which aims to provide appropriate, safe, and high-quality integrated health and care services and support to caregivers[18] by strengthening the LTC system, expanding community-based care services, and enhancing caregiver support and the redistribution of care responsibilities. The demand for LTC is emerging in other Pacific countries and is driven, in part, by the out-migration of youth and the resulting loss of family caregivers for older persons remaining in local communities. The Pacific region is also home to the Pacific Australia Labour Mobility (PALM) scheme, which the Australian Government began in 2022. Its objective is to create a dedicated LTC workforce migration pathway from ten Pacific countries to support shortages in Australia and eventually help develop skills in aged care and address care shortages in the subregion.[19]

17. Available at https://www.adb.org/projects/49277-001/main.
18. ADB (2023).
19. "Pacific Australia Labour Mobility (PALM) scheme". The ten countries are: Fiji, Kiribati, Nauru, Papua New Guinea, Samoa, Solomon Islands, Tonga, Tuvalu, Vanuatu and Timor Leste.

- **Viet Nam**'s strategy has built on existing community solidarity mechanisms and infrastructure rather than new institutions. The Intergenerational Self-Help Club (ISHC) model,[20] introduced in 2006 by HelpAge International with the Viet Nam Association of the Elderly, has been expanded nationwide by the government, reaching over 484,000 people through roughly 8,432 clubs (HelpAge International Vietnam, 2025). The National Program of Action on Ageing has a target of at least one ISHC in 80 per cent of communes by 2030. Viet Nam has unique national mass organizations such as Fatherland Front, Viet Nam Association of the Elderly, Viet Nam Women's Union, and the Viet Nam Red Cross. All of these have a significant presence across the country, including in rural and remote areas, and could be utilized in an LTC system, building on their current programmes and the support of the ISHCs (ADB, 2022). In recent years, several initiatives supported by development partners have sought to strengthen the capacity of ISHC's in areas such as quality home care (World Bank, 2019) and to develop institutional linkages to the public health system with the objective of creating scalable synergies in capacity and care pathways as Thailand (ADB, 2025c).

Finally, the example of **India** illustrates how rapidly efforts to develop the country's LTC system have advanced and the pivotal role of new data and evidence in spurning action.

- **India.** A combination of new data and a high-level reform study have helped accelerate efforts to develop the long-term care system in India. In 2020, the national longitudinal study[21] was released. It highlighted that while India's population older than age 60 was around 104 million in the 2011 census (8.6 per cent of the population), it is projected to reach 319 million by 2050 (almost 20 per cent of the population).[22] The data and report raised awareness about India's demographic transition and the urgent need to develop the LTC system. In 2024, Niti Aayog released a position paper on senior care reforms in India calling for a reform agenda cutting across the health and social sectors to integrate LTC into primary care, develop the workforce, expand home and community care and integrate technology into the care sector (NITI Aayog, 2024). Importantly it also highlighted the opportunities for developing the silver economy and critical role of the private sector. Change is happening. At the national level, in 2024, the first universal health protection scheme (*Ayushman Vay Vandana Yojana*) targeted all older persons aged 70 or older with the aim of providing them with access to free hospitalization was approved.[23] In 2021, a new scheme *Atal Vayo Abhyuday Yojana* (AVYAY), consolidating under a single umbrella old-age social protection programmes, was adopted and a new portal (SAGE) initiated to certify and promote elder care startups UNFPA India and IIPS, 2023). Addressing both domestic needs and international opportunity for professional geriatric caregivers, a new program has been initiated linked to the Skill India Digital Hub (Ministry of Social Justice and Empowerment, 2025). A new report released in August 2026 (Niti Aayog, 2026) aims to develop a comprehensive framework for strengthening the sector and positions it as critical support for long-term development plans- At a sub-national level, Kerala, the fastest ageing state with a long history in community-based LTC and palliative care, is leading change. The state has recently created the first Department for Senior Citizens Welfare and the Kerala State Commission for the

20. ISCH conduct activities in eight areas: livelihoods/income security, healthcare/healthy aging, volunteer-based home care, self-help and community support, rights and entitlements, raising awareness and lifelong learning, culture – arts – visits and exchanges (spiritual life care), and resource mobilization.

21. IIPS (2020).

22. Findings also revealed that roughly 75 per cent of elderly Indians live with at least one chronic condition, 78 per cent have no pension, and only 18 per cent have any health insurance.

23. Cabinet Approves Health Coverage to All Senior Citizens of the Age 70 Years and Above Irrespective of Income under Ayushman Bharat Pradhan Mantri Jan Arogya Yojana (AB PM-JAY).

Elderly (Shaji, 2026). The 2026–27 state budget includes a budget line explicitly tied to senior citizen population data to facilitate the devolution of funds to local governments and, subsequently, the development of programmes and services tailored to local needs (*Onmanorama*, 2026).

2.4. Section highlights

Together, these nine country case studies demonstrate three complementary lessons for the region. First, comprehensive institutional architecture – China, Indonesia, Japan and Singapore – provides the planning and financing backbone for sustained reform. Second, iterative piloting – Mongolia, Thailand, Tonga and Viet Nam – offers a practical pathway to building evidence-based systems on a foundation of existing assets and capabilities, even where fiscal space and institutional capacity remain constrained. In this regard, India highlights how important data and focused policy development are for building momentum. The third and final lesson cutting across all countries is the importance of developing the care workforce (formal and informal) and the role that training and migration policies will play in determining the future of the LTC sector in the region.

3. Trends in the development of LTC systems and services

Moving from planning and policy development to the establishment of robust LTC systems and services has proven to be a challenging, iterative process for many countries across the region. To identify these challenges and highlight the approaches and actions that have enabled progress, this section draws on the WHO LTC Building Blocks (2010, updated 2022/2025),[24]the World Bank's Functional Framework for Building System Capacity in LTC,[25] and the *ISSA Guidelines on Administrative Solutions for Long-Term Care Services* (see Appendix 1). These frameworks provide a useful lens and operational insights through which to analyse the evolution of LTC trends in Asian and Pacific countries. The analysis focuses on five key system dimensions: governance and leadership, financing, service delivery, workforce, and information systems.

Together, these frameworks and guidelines offer a structured approach for examining how countries have strengthened LTC systems over time and identifying the key components required to expand access, improve quality, and enhance system sustainability. Specifically, the WHO LTC building blocks (see Figure 1) and *ISSA Guidelines on Administrative Solutions for Long-Term Care Services* are used to:

1. Promote equity: Formalize financing to reduce catastrophic out-of-pocket (OOP) payments and improve access to care.

2. Enhance efficiency: Reduce reliance on expensive acute care and prevent fragmented service delivery.

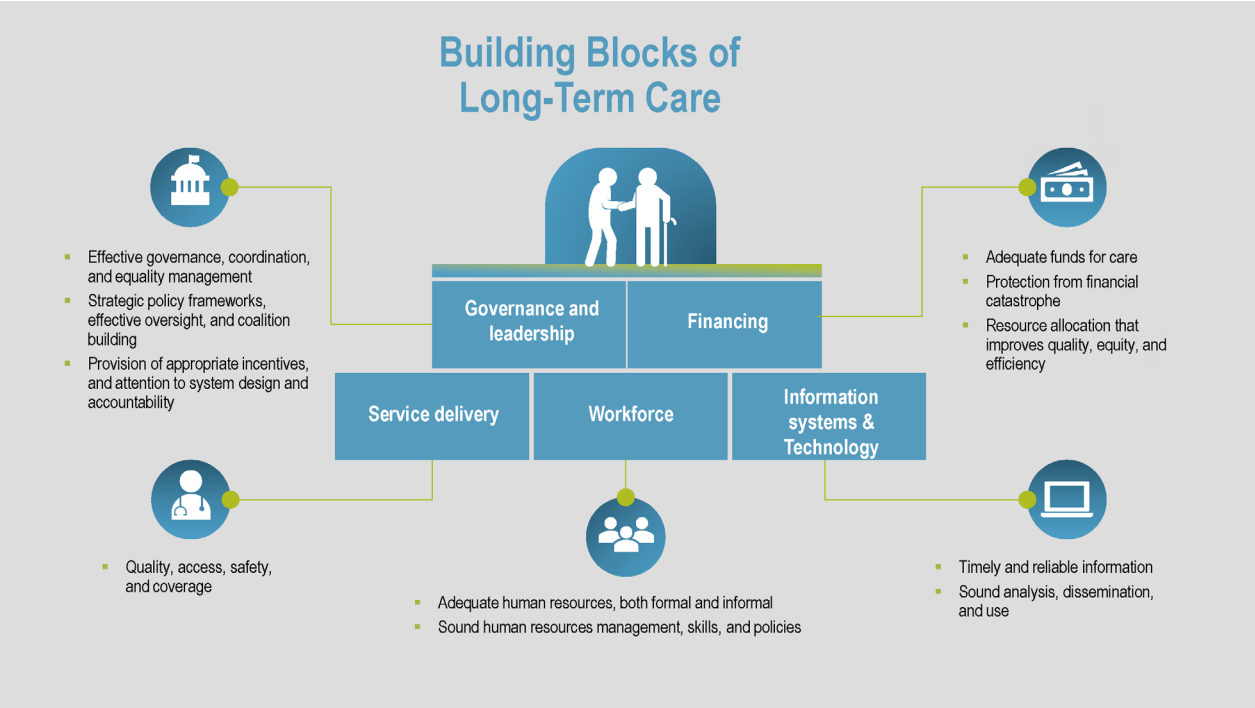
3. Support the care economy: Create pathways for informal caregivers (predominantly women) to enter the formal long-term care workforce and support unpaid carers.

4. Ensure quality: Standardize training and regulations to guarantee safety.

5. Future proofing: Transition from reactive to proactive, data-driven system planning (WHO, 2021 and 2024).

24. See "World Health Organization launches framework for long-term care" and "Strengthening long-term care systems".
25. Doetter et al. (2025).

Figure 1. **Building blocks of long-term care**



Source: WHO (2020).

3.1. Governance and leadership: From fragmentation to coordination

Effective LTC requires moving away from siloed ministerial responsibilities. Like many developed countries, the primary hurdle in Asia and the Pacific is the "Health-Social Divide", where health care and social support operate under different institutional domains, budgets and mandates. In response to this "Health-Social Divide", emerging governance models are restructuring how care is coordinated and delivered at both the macro and community levels.

• **The multi-level model:** Emerging frameworks suggest a tripartite structure: i) national (legal/fiscal standards), ii) subnational (implementation), and iii) intersectoral (coordination between health, housing, and finance).

• **Japan's LTC model:** Japan's decentralized model empowers municipalities as "insurers". A key innovation is the Community General Support Centre (CGSC) – a multidisciplinary hub located within a "Junior High School District" radius, ensuring help is reachable within 30 minutes.

• **Indonesia and Mongolia:** Both are leveraging local governance – Indonesia through village-level structures and Mongolia through formalized legal responsibilities for elderly care.

• **Viet Nam:** Recent policy breakthroughs have prioritized the integration of social pension schemes with community-based health management.

In 2025–26, Viet Nam made three significant breakthroughs in older persons policy (see Box 1).

Box 1. Viet Nam: Older persons policy

1. The National Strategy on the Elderly to 2035 (released in early 2025), officially prioritizes the "Silver Economy", shifting the policy from viewing older persons as a "burden" to a driver for social and economic development.

2. The 2024 Social Insurance Law (effective July 2025): This law significantly expanded the social protection coverage by lowering the eligibility age for Social Retirement Benefits to age 75 (and age 70 for poor households). It allows some LTC services to be covered by the health care insurance.

3. Politburo Resolution 72-NQ/TW: Starting in 2026, all older persons will be entitled to free annual health screenings and the establishment of an Electronic Health Record (EHR) to ensure continuity of care across different providers.

Source: Vietnam Law and Legal Forum (2026).

3.2. Financing mechanisms: Balancing access and sustainability

Financing remains the most contentious and difficult building block for systems in the region. Countries in Asia and the Pacific currently utilize three primary LTC financing models.

- **Social insurance models (Japan, Republic of Korea, Singapore).** The systems in Japan, Republic of Korea and Singapore use universal, mandatory contributions to create highly regulated formal care markets. Japan divides public tax revenues and citizen premiums equally from age 40. Republic of Korea includes LTCI as a surcharge of the national health insurance. Singapore uses CareShield Life through MediSave accounts from age 30, ensuring cohorts build capital during working years to avoid relying solely on next-generation cash transfers. Unlike European "cash-for-care" models, these systems often require funds to be spent on regulated service providers, stimulating a formal care market.
- **Hybrid and transitional models (Indonesia, Viet Nam).** As they navigate a major demographic shift, Indonesia and Viet Nam are employing localised pilot initiatives and incremental Social Health Insurance (SHI) reforms to build systemic capacity. Indonesia, for example, is using sub-district community health clinics (*Puskesmas*) for frontline screening and gatekeeping while piloting community care hubs in rapidly ageing regions such as Yogyakarta. Meanwhile Viet Nam is repositioning ageing as an economic asset. This shift is reflected in its policy framework through the 2024 Social Insurance Law, which aims to expand health insurance coverage to formally include rehabilitative services and geriatric nursing care.
- **Social assistance models (Mongolia, Thailand).** These frameworks, heavily reliant on tax-funded social protection, struggle to protect workers in the "missing middle": individuals and families who earn too much to qualify for government-subsidized LTC programmes, but not enough to comfortably afford private LTC services/insurance. Thailand seeks to optimize its available resources by using grassroots human capital and mobilizing Village Health Volunteers for localised monitoring. However, without sustainable public-private financing or integrated care insurance budgets, these social assistance models face severe capacity constraints as regional aged-dependency ratios rise.
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To ensure fiscal survival, countries in Asia and the Pacific also work hard to contain LTC costs by:

- **Prioritizing home and community-based services.** This is the preferred long-term care delivery mode in Asia and the Pacific. Transitioning care from nursing homes to homes and communities saves public money. Supporting older adults in their own homes reduces government capital and running costs. This approach is more efficient and aligns with the preferences of most elderly people.
- **Redistributing care responsibilities and tasks across the care workforce.** Optimizing workforce distribution helps control rising labour costs. By shifting basic tasks such as health monitoring and daily personal care from expensive clinicians to trained mid-level managers or community workers and/or volunteers, health systems can make better use of their limited budgets and keep specialized health care resources for complex cases. Thailand's Village Health Volunteers (see Box 3) and the Intergenerational Self-Help Club (ISHC) model, introduced in 2006 by HelpAge International with the Viet Nam Association of the Elderly, are two examples.
- **Implementing needs-based eligibility and gatekeeping mechanisms.** Establishing standardized, independent assessment procedures ensures public funds target those who have genuine needs. This rigorous screening prevents system overuse, controls service utilization rates, and provides an objective baseline to manage resource allocation transparently across diverse ageing populations. Taiwan (China) uses cast-mix system by paying providers based on specific service types – such as feeding or bathing – rather than accumulated care hours. This structural approach stops providers from artificially inflating hours, incentivizing staff productivity and lowering the overall cost per care episode (Chao-Hang, 2025). Japan maintains financial sustainability through a strict gatekeeping system such as a standardized fee schedule, service benefit ceiling caps, and a rigorous seven-level eligibility certification tier. Dividing beneficiaries into precise support and care levels guarantees that high-intensity resources are directed strictly to those individuals with the highest clinical needs (Ikegami, 2025).

3.3. Service delivery: The hub-and-spoke model

As mentioned, countries in Asia and the Pacific are increasingly pivoting and shifting away residential care toward developing and strengthening home and community-based care (HCBC). The hub-and-spoke model has been the preferred architecture (Howse, 2017 and Christie, 2018). This model ensures that while an older person lives at home, they are "tethered" to a LTC service network that monitors risk and intervenes before a crisis that requires costly intervention such as hospitalization. Examples of hub-and-spoke models in the region include:

• **The hub:** Japan's Community General Support Centres (CGSC)[26] or Indonesia's Community Care Hubs[27] perform intake, risk screening, need assessment, care intervention and monitoring through case management and multisectoral teams.

• **The spokes:** Local clinics, day-care centres, volunteer groups, and home-care agencies are all on-the-ground LTC service links.

26. Community General Support Centers (CGSCs): Established by municipalities (though often outsourced to NPOs or private firms), these centers are staffed by a multidisciplinary team (Social Workers, Public Health Nurses, and Chief Care Managers) who coordinate the local elder care network.

27. ADB (2025a).

Community-based care services provided by the hub and/or spokes typically include:

- **Active ageing programmes,**[28] which encompass a wide range of activities designed to support the holistic well-being of older adults. These initiatives prioritize physical and cognitive wellness through targeted physical and mental exercises, nutritional awareness programmes, and structured chronic disease management. To promote emotional and intellectual growth, they also incorporate stress management techniques alongside diverse educational opportunities focused on learning, capacity building, and empowerment. Beyond individual health, these programmes foster vibrant community connections and personal fulfilment. They facilitate communication, active social engagement, and a variety of cultural and recreational activities, while educating participants on environmental health and safety as well as modern technology. Furthermore, seniors are encouraged to remain active and productive members of society through healthy and therapeutic food preparation, community volunteering, and participation in economic activities, such as continued employment.

- **Care and support**[29] refers to the blend of practical assistance, emotional encouragement, and clinical aid provided to individuals who need help due to age, illness, or disability. The primary focus of these services is on helping individuals maintain their independence, dignity, and quality of life. This care spans a wide spectrum, starting with personal care, which includes crucial assistance with daily living activities (ADL) such as bathing, dressing, toileting., etc. It also encompasses practical support for instrumental daily living activities (IADL), helping individuals manage routine tasks such as grocery shopping, meal preparation, house cleaning, and navigating transportation. Beyond physical needs, it also incorporates social and emotional support through companionship, mental health check-ins, and assistance with staying connected to the community. For those with more complex health care issues, it includes clinical care, providing specialized medical and nursing attention for chronic conditions, dementia, or palliative needs. Ultimately, the overarching goal of this comprehensive care system is about providing all the resources necessary for a person to live as safely and fully as possible in their preferred environment.

- **Information and referral (I&R) services**[30] act as a central hub for older adults and their families, providing a single point of entry to clear, unbiased information about available resources. By offering direct connections to specific agencies or programmes, these services remove the guesswork and frustration of navigating the complex eldercare system. They bridge the gap between families and community care networks, ensuring older adults receive the right support before a crisis. I&R networks span several areas of care, including housing and home care solutions, financial and legal aid, and health and wellness programmes. They also manage practical logistics such as transportation, home safety repairs, and meal delivery programmes. This essential navigation function is a cornerstone for Japan's Integrated Community Care Support Centre, Mongolia's Active Ageing Hub, and Indonesia's Community Care Hubs in Bali and Yogyakarta.

- **Case management**[31] is a collaborative process that assesses, plans, implements, coordinates, monitors, and evaluates the options and services needed to meet an individual's specific health and social care needs. It begins with screening and stratification to identify individuals at risk of needing

28. WHO (2007) and UN Decade of Healthy Ageing (2021–2030).
29. WHO (2025d).
30. Information and Referral Call Line.
31. Commission's Case Management Body of Knowledge (CMBOK).

care based on their support level. A comprehensive assessment gathers detailed information about a client's physical, psychological, social, and financial situation. The planning phase establishes an individualized care plan with clear goals, intervention strategies, timelines, and resource allocations. Active coordination and implementation link clients to appropriate resources and schedule necessary services. Continuous monitoring and evaluation ensure long-term effectiveness by regularly reviewing client progress and making necessary adjustments. Case management binds all support elements together to create a seamless care experience. A designated case manager acts as a central advocate and navigator, ensuring smooth communication between the client, their family, medical professionals, and community support systems. The integrated approach to process of case management has been piloted in Indonesia, Mongolia, and Viet Nam under the ADB's Technical Assistance initiative since 2022.[32]

Box 2. Case Study: Preventive LTC – Japan

In 2015, Japan moved from only targeting high-risk individuals to a wider population-based approach that promotes healthier lifestyles for all older residents. It is part of the mandated services under the LTC Insurance (LTCI) Act since 2006. Its primary goal is to shift from maintenance care to prevention to reduce the burden on family caregivers and ensure the sustainability of the insurance system. Preventive LTC services include in-home support, day care, and rehabilitation to improve cognitive function and nutrition. They are meant to support older persons at "Risk level 1–2".

Source: Yamada and Arai (2020).

3.4. Workforce development: Tiers and career paths

The LTC sector is labour-intensive, with labour costs accounting for 70–80 per cent of total expenses (OCDE, 2025 and WHO, 2021). With a shrinking working-age population, the availability of a trained LTC workforce is a major constraint across the region. Key challenges include:

- **Shortages of skilled care workers.** Despite the existence of universal long-term care insurance schemes in high-income countries such as Japan and the Republic of Korea, the region faces a severe shortage of trained workers in formal long-term care. At the same time, middle- and low-income developing countries lack even basic formal care staff, with a disproportionately low number of health care and social work professionals specializing in geriatrics compared to the rapidly growing population of older adults managing multi-morbidities and functional dependencies. This structural imbalance is further exacerbated by significant wage discrepancies, which drive a continuous migration of skilled care workers from developing nations, such as Indonesia, the Philippines, and Viet Nam, to higher-income economies, including Japan and Singapore. Consequently, this domestic "care drain" depletes local health systems of their trained human resource capital, leaving developing countries deeply vulnerable.
- **High reliance on informal (formalizable) and unpaid caregivers.** In the region of Asia and the Pacific, families remain the primary providers of elder care, a practice deeply rooted in the cultural

32. TA9928: Developing Innovative Community-Based Long-Term Care Systems and Services. ADB (2022–2025). Funded by the Japan Fund for Poverty Reduction, it pilots care models for ageing populations in Indonesia, Mongolia, Viet Nam, etc.

tradition of filial piety. This reliance means that most daily care is informal and shouldered heavily by women who receive very little state support. This dynamic creates a severe, hidden economic burden as working-age adults are forced to choose between maintaining their employment or providing care, often resulting in them leaving the workforce entirely. Left to navigate complex medical conditions at home without proper clinical guidance or physical relief, these informal caregivers frequently suffer from intense psychological burnout and heightened economic vulnerability.

- **Limited training and career pathways.** The persistent shortage of skilled labour in the care economy is primarily driven by its historical undervaluation, which has prevented the development of strong, cohesive professional pipelines. Caregiving is widely perceived as low-skill, informal domestic labour, which results in depressed wages, poor labour protections, and exceptionally high staff turnover. Furthermore, many countries lack formal national qualification frameworks or standardized competency requirements for long-term care, making it difficult to attract and retain younger workers. Even when successful community-based pilot initiatives demonstrate a positive impact on improving older adults' functional abilities and on reducing caregiver stress, scaling these programmes remains incredibly difficult due to the lack of institutionalized training systems and sustainable national financing mechanisms.

To overcome these workforce challenges, countries across Asia and the Pacific are actively developing a coordinated tiered workforce structure designed to maximize limited resources.

- **Professionals: Nurses and social workers.** This tier supports high-risk, medically complex cases. Nurses provide essential clinical oversight, managing advanced chronic diseases medication regimens and post-stroke rehabilitation. Meanwhile, professional social workers conduct deeper biopsychosocial assessments to protect vulnerable seniors from systemic abuse and offer crucial mental health interventions to stabilize families during acute health crises. In Indonesia, community care hub workers collaborate with Puskesmas (district and subdistrict primary health care centres) where this tier of professionals is more concentrated to offer support.

- **Mid-level coordinators: Care managers.** These coordinators, acting as the central link, significantly reduce the navigational burden on families. They synthesize complex professional assessments into actionable care plans, organize community-based services and resolve resource conflicts. By streamlining communication between medical providers and households, they ensure no senior falls through the cracks of fragmented health care systems. This is precisely the role of case managers at Active Ageing Hub in Mongolia.

- **Community workers/Volunteers: Local human capital.** Leveraging grassroots trust, this foundational tier extends the system's reach directly into neighbourhoods. Inspired by Thailand's globally recognized Village Health Volunteers (see Box 3), local workers conduct routine wellness checks and monitor basic health changes. They also distribute essential health information effectively identifying escalating vulnerabilities before they become costly medical emergencies.

Box 3. Thailand: Village Health Volunteers (VHVs)

VHVs play the critical role in Thailand's community based LTC for older adults. They serve as a critical bridge between formal health care provision, social services and households, particularly in rural areas. They are trained to provide home-based care for vulnerable, dependent, or bed-ridden older individuals, helping them with daily living, monitoring their health and offering social support. Core responsibilities include health promotion, disease, surveillance, dementia care, mental health and palliative care. The model is considered highly effective for low- and middle-income countries in managing the increasing demand for long-term care. Despite the success, VHVs often face heavy workloads, limited resources, and the need for more specialized training in dementia care and mental health to effectively serve the ageing population. There were over 1 million VHVs in Thailand in 2025.

Source: Thailand's 1 million village health volunteers (WHO).

- **Community Care Career Track, Agency for Integrated Care (AIC).** Singapore[33] exemplifies the tiered workforce structure for upskilling, creating "career tracks" so a nursing aide can transition into management or specialized care, reducing burnout and turnover. The career track in Singapore's community care system includes:
  - *Community Care Associate (CCA).* Competence centres on delivering high-quality, holistic daily living care. CCAs assist seniors with personal hygiene, feeding, medication support, and basic vital signs monitoring. They collaborate directly with clinical and therapy teams to help older adults maintain essential independent living skills.
  - *Senior Community Care Associate (SCCA):* Building upon baseline care, SCCAs possess the competence to perform delegable nursing tasks and implement new operational procedures on-site. They apply prior health care experience to work alongside clinical teams, driving specialized care routines that maximize seniors' functional abilities.
  - *Community Care Executive (CCE):* Competence shifts to on-the-ground supervision, care coordination, and quality assurance. CCEs are responsible for overseeing daily care team activities, adjusting service workflows, and monitoring operations to ensure each older person's individual care goals are consistently achieved.
  - *Community Care Manager (CCM):* This role demands advanced strategic leadership and team management competencies. CCMs optimize team productivity, foster multi-disciplinary collaboration, resolve complex service issues, and direct external operations, including the management of next-of-kin relationships and corporate community partnerships.
- **Recognizing informal care (formalizable).** Many Asian and Pacific countries are beginning to recognize and support informal caregivers through financial incentives and training programmes. Mongolia's caregiver allowances provided through its social protection system, although currently modest,[34] represent an important step in this direction. Government's workforce development strategies should combine formal training, career pathways, and support for informal caregivers.

33. Available at https://www.aic.sg/Partners/Community-Care-Career-Track.
34. ADB (2024b).

3.5. Information systems and technology: The digital leapfrog

Digitalization is crucial for integrated care. Many low- and middle-income Asian and Pacific countries are piloting long-term care information systems, for example SILANI in Indonesia and the Digital Case Management System in Mongolia. However, challenges persist, particularly regarding interoperability. While technology adoption in long-term care across Asia and the Pacific is progressing, with China and Singapore leading, other countries are developing community care platforms to support the elderly at home.

- **Interoperability:** Singapore's NEHR (National Electronic Health Record) allows a hospital doctor and a community care nurse and/or social worker to see the same patient data, preventing medication errors and redundant testing (Box 4).

Box 4. Singapore: The National Electronic Health Record (NEHR)

"One Patient, One Health Record" is a centralized, nationwide repository managed by AIC and Synapxe. It integrates the NEHR, AIC Care Integration System, and HealthHub App for exceptional continuity of care and proactive population health management.

• *System model:* Allowing care to follow the patient across hospitals, polyclinics, community care and nursing homes. Key features are:

  – NEHR integration: Authorized clinicians in nursing homes or home-care settings can see a senior's conditions in real time.

  – AIC Care Integration System: A platform that manages referrals and financial grants (such as CareShield Life) for long-term care services.

  – HealthHub App: A caregiver-facing portal where family members can access their elderly parents' records and schedule appointments.

• *Strengths:* Exceptional continuity of care.

• *Weaknesses:* Strict privacy laws slow the onboarding of smaller, private social-care providers into the national network.

Source: "Launch of Synapxe with Minister Ong Ye Kung".

- **Smart Elder Care, China.** Large-scale adoption of IoT (Internet of Things) sensors in homes allows for "passive monitoring" (fall detection, sleep patterns) without infringing on privacy (See Box 5).

Box 5. China's "Smart Elderly Care"

China's "Smart Elderly Care" (智慧养老) policy leverages a vast information and technology system to address the "4-2-1" family structure – four grandparents, two parents, and one child.

This system operates as a decentralised yet policy-driven ecosystem. Local governments collaborate with tech giants like Tencent and Alibaba to establish "Regional Aged Care Platforms". Key features include:

- Internet + Care: IoT devices such as smart fall-detection sensors, wearable vitals monitors and "virtual nursing homes" dispatch local providers via apps.
- Information Hubs: These platforms integrate a senior's basic demographics, health records and government subsidy eligibility.
- The policy boasts rapid deployment of advanced tech like AI and robotics, supported by strong industrial backing. However, it faces challenges such as a significant "Digital Divide" for the oldest-old, fragmented data across city-level platforms and high costs for smart hardware in rural areas.

Source: Chen, Hagedorn and An (2022).

The rise of community care platforms across developing Asian and Pacific countries highlights a major technological leap in supporting caregiving within families and communities. Platforms such as Singapore's Homage[35] India's Samarth[36] and Indonesia's LoveCare[37] are utilizing app-based matching, digital health tracking, and integrated service ecosystems to professionalize home care. Concurrently, digital hubs, such as India's Desi Daughters,[38] utilize online resource centres to seamlessly bridge geographic divides, enabling overseas "diaspora" families to coordinate culturally relevant care for their ageing parents in the home country. These technological advancements are successfully optimizing scarce health care resources and transforming the regional care economy.

3.6. Section highlights

Asia and Pacific countries' wide diversity in their national wealth, institutional capacity and demographic transition make a single long-term care solution impractical. The WHO Building Blocks approach works by breaking down system-building into five distinct blocks. This allows countries to progress at their own pace from varying starting points. Ultimately, sequencing is key rather than uniformity. The apparent fragmentation across the region is a natural adaptation to each country's unique resources and position on the demographic timeline.

35. Available at https://www.homage.sg.
36. Available at https://samarth.community.
37. Available at https://lovecare.id.
38. Available at https://www.desidaughters.com.

4. Challenges and opportunities

In Asia and the Pacific, the transition from fragmented family-reliant support to formalized LTC is a demographic imperative rather than a choice. Many Asian and Pacific nations are shifting towards a more structured and modernized LTC system based on growing efforts of strategic planning and developing key elements of the WHO LTC Building Blocks. However, this transition presents both opportunities and challenges.

4.1. Opportunities

- **Formalizing informal community networks** offers a low-cost, high-trust strategy to strengthen LTC infrastructure, particularly in resource-constrained regions. By intentionally integrating traditional family structures, neighbourhood bonds, and local volunteer networks into formal health and social care systems, governments can establish deeply rooted entry points for essential care. The key to long-term success lies in building institutional sustainability and operational effectiveness around these organic networks. When properly supported, these community-driven ecosystems transform from informal, fragmented support networks into a viable, scalable pillars of the broader LTC framework. For example Shanghai's "Time Bank" initiative involves local volunteers earning service credits for the caregiving they provide today. These credits can later be used to access professional home care services as they become care receivers (Ren, Guo and Dilulio, 2025) Meanwhile, the Republic of Korea addresses workforce development through rapid micro-credentialing, utilizing specialized 320-hour training programmes.[39] This pathway allows students and informal caregivers to quickly secure formal clinical qualifications, providing them with clear transitions into professional visas or financial stipends while directly bolstering the caregiving workforce.

- **Strengthening social protection** requires a critical shift away from out-of-pocket payments toward structured long-term care insurance (LTCI) frameworks. Relying solely on immediate, out-of-pocket health care expenses places severe financial hardships on older populations and low-income families while simultaneously capping market growth for care providers. By establishing sustainable, systemic insurance frameworks, nations can protect vulnerable citizens from poverty and guarantee long-term financial stability for ageing populations. To achieve this, some nations are successfully adopting proactive funding models. Japan and Singapore utilize mandatory, graduated LTCI schemes, requiring citizens to contribute during their peak working years – specifically between ages 30 and 40 – to fund care later in life.[40] Complementing this, the Republic of Korea implements income-based, sliding-scale copayments ranging from 0–20 per cent[41] This creates a predictable market that minimizes individual financial strain while encouraging private providers to confidently invest in higher-quality care facilities. However, developing and implementing such programmes without underlying systems and in the context of high informality is a major challenge. Much more effort and innovation in developing sustainable financing models is needed to adapt to the needs of developing economies in Asia and the Pacific.

39. See Visa Policy Report.
40. See CareShield Life Framework.
41. Long-Term Care Insurance Act Enforcement Decree.

- **Public–private partnerships (PPPs).** Private sector engagement LTC is rapidly emerging across the region through social entrepreneurship, business incubators, and public-private partnerships (PPPs). These collaborative arrangements allow governments to scale critical infrastructure and expand access to services by balancing operational risks with the private sector's efficiency and the state's regulatory oversight. To incentivize developers, provinces in China, such as Hubei and Hebei, offer underused public land at near-zero cost, significantly minimizing upfront "land conveyance" fees in exchange for guaranteed affordable residential care beds (CGTN, 2026). Simultaneously, alternative regional models emphasize accountability and market expansion. Mongolia has expanded service access by piloting "Active Ageing Hubs" operated by government services, NGOs, and the private sector. The Mongolian government has been moving towards performance-based contracts tied to service outcomes (ADB, 2025b). Furthermore, countries such as the Republic of Korea have embraced the marketization of LTC by opening their sectors to diverse operators, including private-for-profit providers. To maintain public accountability, governments enforce strict market-entry rules and quality benchmarks, formalizing a purchaser-provider split that shifts the state from a direct operator to a strategic purchaser of care (World Bank, 2022; Kwon and Park, 2025).

- **Digital innovation** serves as a powerful workforce multiplier in health care, significantly improving operational efficiency through automation. A prime example is Singapore's "Age Well SG" platform, which optimizes case management by utilizing a single standardized assessment visible to all providers. This integrated digital approach successfully eliminates inefficient paper trails and manual processing delays, enabling smoother care coordination across teams.[42] Furthermore, remote IoT monitoring dramatically scales care capacity by allowing providers to track patients dynamically. In China, the implementation of wearable sensors and AI-powered "smart badges" facilitate a practice known as "intervention by exception".[43] This advanced tracking system alerts caregivers to intervene when an abnormality or emergency occurs, allowing a single case manager to monitor hundreds of seniors simultaneously, ensuring timely medical responses while maximizing limited health care resources.

- **Developing the "silver economy"** transforms long-term care into a thriving growth industry by viewing seniors as active consumers rather than passive dependents. China and Singapore lead this paradigm shift with explicit national strategies. Notably, the China's 15th Five-Year Plan (2026–2030) establishes the silver economy as a core national priority alongside digital and green development, driven by a dedicated policy outlining 26 guidelines across smart health care, financial planning, age tech, and age-friendly infrastructure.[44] To accelerate these markets, regional governments are implementing specialized innovation hubs and inclusive community designs. Thailand's Phayao Province[45] stimulates the sector by offering tax exemptions and targeted grants to "Eldertech" startups specializing in AI fall detectors and universal design products. Concurrently, Singapore targets urban isolation through pioneering intergenerational co-living projects, such as Kampung Admiralty[46] and Henderson,[47] which integrate senior housing with childcare and student housing to foster meaningful, daily social interaction. Strategically, viewing older persons as an economic asset and active economic participants transforms LTC into a growth industry.

42. Age Well SG (ASG)."
43. "Digital Technology Transforms Elderly Care Services In China.
44. "China unveils measures to develop 'silver' economy".
45. "Thai Silver Economy Projected to Hit 3.5 Trillion Baht in Consumption".
46. *NTUCHealth* (2026).
47. Kit (2024).

4.2. Systemic challenges and creative solutions

Creating a sustainable, resilient LTC infrastructure in Asia and the Pacific will require moving beyond fragmented, ad hoc programmes and developing creative solutions (Table 1). As demographics evolve, health systems face structural challenges: pilot projects often fail due to financial instability, bureaucratic silos disconnect social care from medical care, and acute workforce shortages leave rural populations underserved. Forward-thinking governments are addressing these gaps by shifting from temporary workarounds to structural policy changes. They combine innovative financing, such as blending health and social budgets, public-private Viability Gap Funding (see Table 1, row 5), and linking mandated wage increases to skill credentials, with localized delivery networks. These approaches transform isolated successes into scalable, permanent national care systems.

Table 1. ***Transforming care systems through innovative financing and local delivery***

Challenge	Creative solutions	Asia and the Pacific country examples
Sustainability trap: Pilots collapse when initial grant funding ends.	Exit-to-policy clauses: Mandating that successful pilots automatically migrate to core ministry budgets.	China: Uses a "legislation-first" roadmap to transition 49 pilot cities into a formal LTC insurance system.[48]
Service fragmentation: Silos between health and social care cause "bed blocking".	Pooled budgeting: Merging municipal health and social care funds into a single "Elderly Care Fund".[49]	Japan: Assigns a Certified Case Manager to every LTC recipient to bridge the health-social gap.[50]
Workforce shortages: High demand versus low pay and a "care drain" because of out-migration.	Stackable credentials: Tying bite-sized certifications (e.g. dementia care) to mandatory wage increases.	Singapore: The "Progressive Wage Model" mandates salary increases for every skill level reached.[51]
Geographic disparities: Urban hubs have high-end care; rural areas have none.	Hub-and-spoke delivery: Using urban specialists (Hub) to guide rural lay-workers via telehealth.[52]	Thailand: Mobile "Clinic-on-Wheels" units visit remote provinces to provide screenings for non-communicable diseases; and the use of digital records.[53]
Limited private interest: High capital costs and low margins deter investors.	Viability Gap Funding (VGF): Government grants covering 20–40% of construction costs in exchange for fee caps.	India: Provides VGF to private developers to build elder care centres in smaller, underserved cities.[54]

Source: Authors' elaboration.

48. Zhou, Yao and Tian (2026).
49. Tebaldi and Stokes (2020).
50. OECD (2015).
51. SkillsFuture Singapore.
52. Subramaniam et al. (2022).
53. Pluetrattanabha and Direksunthorn (2025).
54. Viability Gap Funding Scheme.

4.3. Section highlights

Reflecting on strategies in Asia and the Pacific, it is evident that modernizing long-term care depends less on building heavy infrastructure and more on restructuring and enhancing existing systems. Governments can formalize informal community networks, turning organic, high-trust neighbourhood bonds into reliable care pillars. Shanghai's Time Banks in China, Japan's case management model, and India's Viability Gap Funding initiatives share a common goal: transforming fragile, informal, or pilot-stage solutions into sustainable systems by embedding them in formal budgets, workforce credentialing structures, and regulatory frameworks. Sustainable eldercare is not about spending more; it is about validating, upskilling, and legally protecting grassroots networks. It is about developing the political and administrative will to turn successful ideas, the strengths of technology and promising pilots into lasting systems.

5. Concluding remarks

The unprecedented demographic transformation underway across Asia and the Pacific is reshaping societies, economies, and social protection systems. As populations age at an unprecedented pace, many countries face the challenge of population ageing before achieving high levels of economic prosperity. This reality demands a fundamental shift from traditional models of informal, family-based care towards comprehensive, sustainable, and person-centred long-term care systems that can respond effectively to rising and increasingly complex care needs.

Addressing this challenge requires more than expanding services. It calls for a whole-of-society approach that bridges the divide between health and social care, strengthens coordination across institutions, and promotes integrated care pathways that support people throughout the life course. Countries across the region are pursuing different routes towards this goal, ranging from comprehensive national long-term care insurance schemes to incremental, locally driven models that are tested, adapted, and scaled over time. Despite these different approaches, successful long-term care systems share common foundations: strategic planning, coordination and leadership, sustainable financing, community-based and home-centred care, a well-trained and valued care workforce, strong public-private partnerships, and the strategic use of digital technologies to improve access, quality, and efficiency.

Investing in long-term care is not only a social necessity but also an economic imperative. Increasingly, countries in the region are realizing this and integrating long-term care into their long-term development plans. Well-designed care systems can enhance the well-being, dignity, and independence of older persons, support families and caregivers, promote labour market participation, and strengthen social cohesion. Ultimately, the ability of countries to transform the challenge of population ageing into an opportunity for inclusive and sustainable development will be a defining factor in the resilience and prosperity of the region in the decades ahead.

Social security institutions are particularly well positioned to contribute to this transformation. As administrators of the rights and obligations of insured persons, beneficiaries, and employers, they draw on extensive expertise in administering complex systems, notably delivering quality services and collecting contributions. Furthermore, in many countries, they are expanding beyond their traditional functions. Where their mandates and capacities allow, they are increasingly taking on a more prominent role in people's empowerment, labour market participation, health promotion, disease prevention, and rehabilitation. By helping individuals maintain their functional ability and independence for as long as possible, institutions contribute not only to improved well-being in older age but also to the development of healthier, more inclusive, productive, and resilient societies. More broadly, these developments reflect the increasingly strategic role of social security institutions in addressing the challenges and opportunities of population ageing.

Realizing this potential requires stronger coordination across social security branches, including health, disability, employment, and pension schemes. An integrated, people-centred approach can better address the multidimensional needs of older people while strengthening solidarity and social cohesion across generations. To respond effectively and sustainably to these needs, institutions must anticipate emerging risks and develop innovative, tailored responses that support individuals throughout the life course.

Recognizing the growing importance of long-term care (LTC), the International Social Security Association (ISSA) has developed the *ISSA Guidelines on Administrative Solutions for Long-Term Care Services* (ISSA,

2025). The Guidelines provide a practical framework to support social security institutions in strengthening the governance, design, administration, and delivery of accessible, person-centred, and sustainable LTC services. Drawing on international experience and good practices, they are structured around six key building blocks: creating an enabling environment; ensuring institutional capacity; providing person-centred LTC services; enhancing service quality and delivery; preventing loss of autonomy and promoting healthy ageing; and strengthening support for the LTC workforce (Appendix, Figure A.1).

This report complements the ISSA Guidelines on Administrative Solutions for Long-Term Care Services by examining how countries and social security institutions across Asia and the Pacific are translating these principles into practice. Through policy reforms, institutional innovations, and service delivery initiatives, the report highlights emerging approaches to strengthening LTC systems in the region. Together, the ISSA Guidelines and this report offer both a strategic framework and practical insights for policy makers and social security institutions seeking to build sustainable, inclusive, and resilient long-term care systems for ageing societies.

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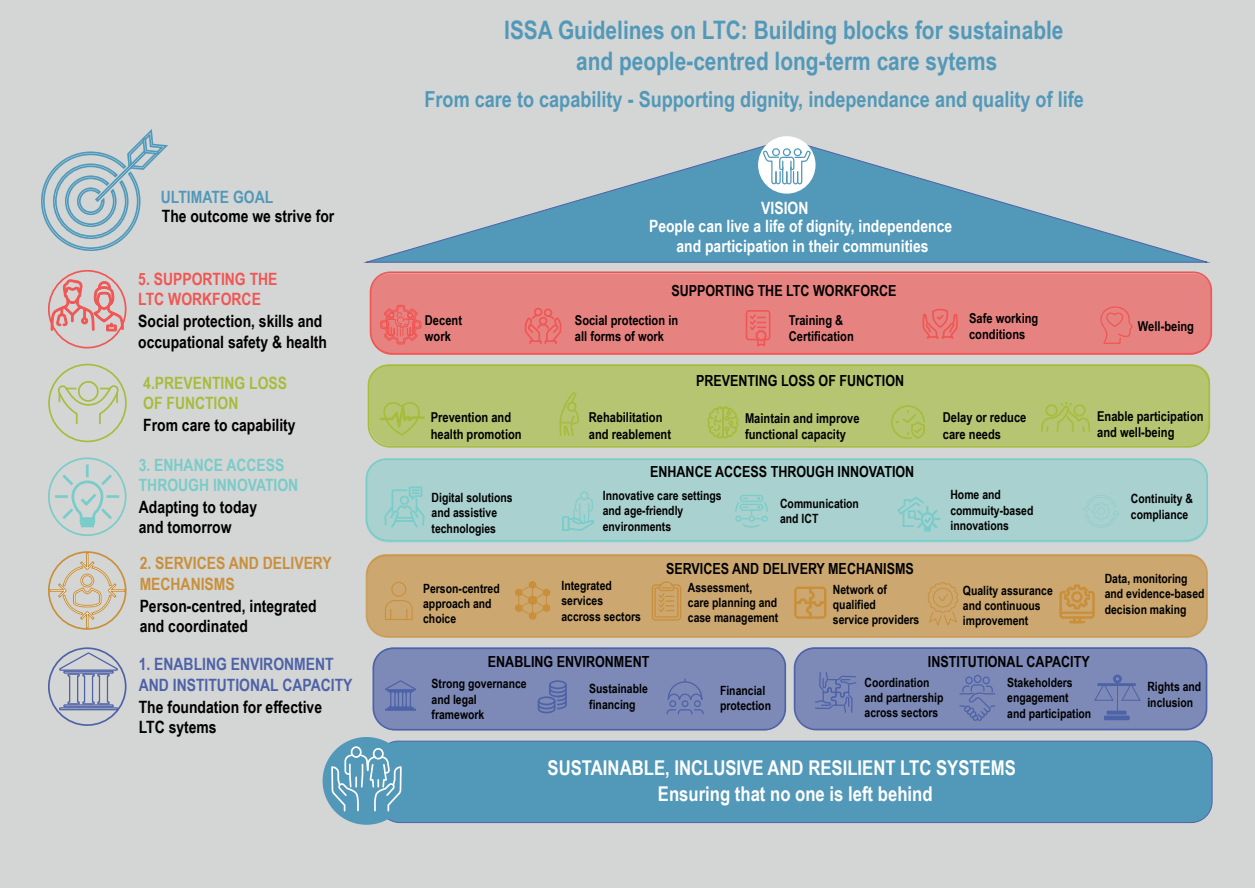
Appendix

Figure A.1. Overview of the ISSA Guidelines Framework



Source: Authors' elaboration based on ISSA (2025).

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