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Abstract

This paper discusses different policies to improve the co-ordination of health and care services across different parts of government, providers and organisations to help individuals perform everyday activities (long-term care, LTC). It builds primarily on four case studies: Canada (Quebec), Costa Rica, France and Japan, which represent diverse LTC models at different stages of implementation. It discusses four key policy dimensions: governance, funding, workforce and mechanisms for data-sharing in the long term-care sector. It finds that co-ordination mechanisms are important to have adequate care provision across different sectors (horizontal co-ordination) and ensure alignment across different levels of governments (vertical co-ordination). Pooling of funds from the health and the social care sectors to the LTC system and financial incentives to reduce duplications and encourage joined-up work are also used across countries to promote care co-ordination. Countries also rely on a variety of workforce strategies to support care co-ordination, ranging from assigning care managers or co-ordinators, providing training for multidisciplinary care and setting up more structured care pathways or single-entry points for recipients to receive services or be entitled to public support for care. Ensuring shared data and interoperability of operation systems from different providers also facilitate care co-ordination and quality standards, albeit they are challenging to develop.

Résumé

Cet article analyse différentes politiques visant à améliorer la coordination des services de santé et de soins de longue durée entre les administrations publiques, les prestataires et les organisations, afin d'aider les personnes dans les activités de la vie quotidienne. Il s'appuie sur quatre études de cas — le Canada (Québec), le Costa Rica, la France et le Japon — représentant des modèles variés de soins de longue durée.

L'étude examine quatre axes principaux : la gouvernance, le financement, les ressources humaines et le partage des données. Elle montre que des mécanismes de coordination efficaces sont essentiels pour assurer une continuité des soins entre les secteurs et une cohérence entre les différents niveaux de gouvernement. La mise en commun des financements, les incitations financières, les stratégies de coordination des professionnels et le partage des données contribuent également à améliorer la qualité et l'efficacité des soins, malgré les difficultés liées à leur mise en œuvre.

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Executive summary

As demographic ageing increases the number of people in need of support for performing daily living activities such as eating, moving, washing and shopping, long-term care (LTC) has become a vital public service. LTC refers to medical and personal care and support services for people with long-term physical or cognitive impairments, focused on maintaining well-being and managing deterioration across all care settings (OECD, 2018[1]). Across OECD countries, spending on LTC accounted for 18.8 % of health expenditures in 2023 (OECD, 2025[2]) and is likely to rise as the number of older people requiring LTC support increases. LTC services comprise a range of medical, nursing, and personal care services. LTC service delivery in many countries is fragmented due to different health and social care systems, which prevents consistent access to care for those in need and continues to place a good part of the caregiving burden on families and other informal carers.

This paper reviews diverse LTC models in Canada (Quebec), Costa Rica, France and Japan to identify common approaches to improve service co-ordination between health and social care, regardless of countries (regions) having different institutional and governance arrangements or different resources and levels of need. The analysis of LTC governance, financing, workforce, and data-sharing capacities across these four LTC models offers illustrative examples of the benefits of a structured, multi-level, community-oriented model for a more co-ordinated approach to LTC.

As part of governance arrangements, establishing vertical – across different levels of government - and horizontal – across different sectors and providers - co-ordination mechanisms help clarifying roles and accountabilities across multiple sectoral stakeholders. Japan has developed a community-based integrated care system early on since 2015. The municipal governments ensure the provision of personalised case management under the direction of and in close co-ordination with the national and prefectural governments. Costa Rica launched an inter-institutional care system, *SINCA*, under the Law 10192 in 2022. *SINCA* is centrally overseen by a Technical Secretariat, located within IMAS (the Joint Social Welfare Institute), which co-ordinates care among various public and civil society actors (e.g. ministries and national agencies, municipalities, NGOs, and data bodies), within a unified legal and policy framework. Quebec and France recently established or designated an institution to be accountable for LTC co-ordination. Quebec benefits from having a single ministry that oversees health care and social care and has centralised the delivery of integrated care through multiple healthcare reforms. Under the ministry's guidance, *Santé Québec*, established in 2024, manages 34 regional centres, including 22 integrated health and social care centres (CISSS/CIUSSS), where personalised case management is provided. [1] Similarly, France introduced the Departmental Public Services for Autonomy (SPDA) in 2024 to strengthen co-ordination across health, social, and disability systems, which are overseen by departmental councils and regional health agencies (ARS) and assigned a strong role to the the National Solidarity Fund for Autonomy (CNSA) for overseeing LTC financing and service provision.

[1] Contrary to the common international approach, in Canada the term *long-term care* (LTC) refers to care in an institution, and does not include care at home (home care).

Integrated LTC financing and payment mechanisms both require and support co-ordination between various levels of government and sectors. Sustainable funding is fundamental for continuous LTC service delivery and co-ordination. Many countries (and subnational jurisdictions) operate their LTC systems on tax revenues, including Quebec, Costa Rica, and France. Japan has a contributory insurance scheme dedicated to LTC, whose premiums are combined with overall tax revenue collected by both national and subnational governments to finance the LTC system. Across all these countries (and subnational jurisdictions), LTC funding pooled at the national level is redistributed to subnational implementers according to established criteria, considering the region's demographics (Japan, Quebec), income (Japan, Costa Rica), geography (Japan), vulnerability (Costa Rica), and other strategic priorities. To incentivise service co-ordination, countries provide additional funding to LTC providers in different sectors. In Quebec, the financial incentive is provided based on a performance agreement signed between the ministry and the regional implementer. Conditional bonuses targeting efficiency and service co-ordination are also available. France covers the costs for integrated home care, support, and assistance services that can be used to pay for co-ordinating nurses' time spent on relevant activities. Japan offers add-on bonuses to the standard fee once the provider satisfies certain conditions that enhance co-ordination. In Costa Rica, income-based co-payments are foreseen under *SINCA*.

Providing training and structured co-ordination tools can enhance the workforce's capacity to collaborate effectively in any care setting. Case management is used to facilitate horizontal co-ordination of health, social home and community services in many countries. Recruiting and training case managers can improve continuity of care and help people navigate more effectively scattered LTC services across sectors. In Quebec, case managers (trained health or social care professionals) conduct needs assessment, develop individualised service plans, and co-ordinate with primary care physicians and other care providers. Similarly, in Japan, case managers create individualised care plans while co-ordinating with municipalities, primary physicians, and LTC providers, among others. Organised collaborative platforms play a central role in improving multidisciplinary care and ensuring more coherent service delivery. In Quebec, collaboration takes place through local and regional consultation tables where integrated health and social care centres (CISSS/CIUSSS) representatives, community organisations, municipal services, home-support providers, and sometimes patient representatives jointly identify service gaps and agree on shared protocols. In Japan, hospitals, clinics, home-care nursing providers, pharmacies, and LTC providers convene to strengthen multidisciplinary collaboration and ensure a 24-hour home-based care response. All four models analysed implement a single entry point for recipients to receive services or be entitled to public support for care, highlighting its role as a key element in care co-ordination. This approach helps streamline access to services, minimise duplication, and guide individuals through a coordinated and coherent care pathway. The *Cuidar.cr* platform in Costa Rica, for example, connects dependent people with public, private and non-profit care providers and offers an integrated directory of services, information on inter-institutional care system (SINCA) services, training opportunities and a self-care toolkit for caregivers.

Similarly, robust data-sharing systems streamline assessment processes and service delivery across multiple providers, enabling them to monitor outcomes, identify gaps, and adapt services in real time. Quebec's public performance dashboard provides weekly updates on key indicators across the health and social systems, incorporating data from integrated care centres and some private institutions. Its structured framework links strategic priorities, programme evaluations, policy analysis, and decision-support tools and helps ensure that organisations work toward shared co-ordination goals. In Japan, the Community-based Integrated Care "Visualisation" System centralises LTC insurance and other community-level data in an accessible format for municipalities and end users. By making data transparent and comparable, the system support local stakeholders and end-users in co-ordinating more effectively within the integrated care networks. In Costa Rica, major developments in terms of data generation and integration are also expected – including the consolidation of the National Information and Single Registry of State Beneficiaries (SINIRUBE) as the main platform for information exchange among LTC institutions, with the aim to improve

interoperability across the health, social protection and care sectors. In France, a computerised user file (*dossier usager informatisé*, DUI) aims at collecting all the necessary data and professional documentation to assess an individual's LTC needs, thereby facilitating the design, implementation, and evaluation of personalised support plans.

Co-ordinating LTC services across different parts of government, providers and organisations is essential for making the system sustainable and providing quality, effective, and equally distributed services. In the four policy areas described above, several key successful features facilitate co-ordination of LTC services, regardless of countries (areas) having different institutional and governance arrangement or different resources and levels of need.

Strong governance arrangements establish clear roles and accountability, while sustainable financing supports equitable access to services. A well-trained workforce also helps maintain care quality and continuity, and robust data systems provide the tools and platform for providers to collaborate more effectively.

1 Strengthening co-ordination in long-term care across countries

Long-term care (LTC) services help people live as independently and safely as possible when they can no longer perform everyday activities on their own. LTC includes a range of medical/nursing care services, personal care services and assistance services provided across all care settings for people who, as a result of mental and/or physical frailty and/or disability, require these services over an extended period of time and services with the aim of alleviating pain and suffering, or reducing or managing the health deterioration in patients with long-term dependency (OECD, 2018[1]). LTC usually splits into two parts: healthcare and social care components. The 'health component' encompasses medical or nursing care (e.g. wound dressing, administering medication, health counselling, palliative care, pain relief and medical diagnosis with relation to a long-term care condition) and personal care services which provide help with activities of daily living (ADLs). The 'social component' covers assistance services that enable a person to live independently and provide health-related help with instrumental activities of daily living (IADL).

The complexity of LTC needs and the way care systems are structured in countries require careful co-ordination. People receive care from different providers of the health and social services sector. This requires sustained efforts by care recipients and their families to understand and navigate the information and help needed within a fragmented health and social care system. Furthermore, in many countries, responsibilities for LTC are often divided among a range of different actors such as municipalities, regional governments, central government, insurance funds and third-sector providers. Without co-ordinated care, older people with complex needs can have emergency admissions, avoidable hospitalisations and an increase in the number and severity of limitations and diseases, which are costly to countries and consume financial and human resources that could be better directed elsewhere.

Assessing the governance, financing, workforce, and data-sharing capacities of a LTC system is central to understanding how well various actors co-ordinate care across health and social sectors, prevent service fragmentation, and ensure continuity for people with complex needs. International comparisons are key for assessing LTC systems, highlighting strengths and weaknesses, sharing best practices, and prompting policy discussions (Llena-Nozal, Barszczewski and Rauet-Tejeda, 2025[3]). The four countries or subnational areas discussed in this paper represent diverse LTC models with a different organisation set-up and at different stages of implementation in their LTC system: Japan's mature, insurance-based system facing extreme population ageing, Costa Rica's integrated social protection approach within a middle-income context, France's mixed national-local framework undergoing major reforms, and Quebec's publicly funded, community-oriented model transforming into a government-centred model.

1.1 Countries set up vertical and horizontal co-ordination mechanisms to improve long-term care governance

LTC governance often involves a wide range of stakeholders - including national and sub-national - across multiple sectors (e.g. health, social care, housing). Strong and effective governance in LTC requires that the roles and responsibilities of the actors and institutions involved be clearly defined and that there be structures and mechanisms for co-ordination and engagement with stakeholders to reduce fragmentation and harmonise service provision. Recognising the role of civil society and all stakeholders – public and private – in addressing the economic and social challenges facing communities can facilitate the creation of social economy ecosystems, conceived as a set of actions aimed at promoting, growing and developing social innovation, including through improved relations between the various actors involved (OECD/European Union, 2025[4]).

In some countries, the legislation has created focal agencies with the responsibility to support the implementation of LTC policies. As an example, France is gradually expanding the role of one public organisation – the National Solidarity Fund for Autonomy (Caisse Nationale de Solidarité pour l'Autonomie, CNSA) – in care financing and provision to ensure the full integration and development of LTC. Slovenia started a major reform to establish an integrated long-term care system through the Long-term Care Act, which was adopted by the National Assembly in 2023. A completely new branch of social insurance for long-term care has been established and the funds from this are collected in a special account of the Health Insurance Institute of Slovenia, which oversees the funds and pays the benefits. Prior to the LTC Act, people could receive different services financed through the health care (nursing homes), social care (care homes and residential units) and municipalities with different assessment procedures, different financing provision and different service delivery which was not co-ordinated.

Other countries have designed and implemented tools and processes to enhance LTC care co-ordination, horizontal and/or vertical.

Vertical co-ordination

Vertical co-ordination is more likely to be systemic and involve the alignment of governance and financing arrangements between levels of government and of residential, community and home-based services (OECD, 2015[5]).

Some countries have adopted a multilevel governance model to clarify the roles and mandates of each level of government. This multilevel governance requires a clear definition of responsibilities and effective co-ordination mechanisms to strengthen a comprehensive LTC service delivery system. For example, in Japan, the national government outlines the broad principles of the LTC insurance (LTCI) system and revises the fee schedule for LTCI every three years. The prefectural government, following the LTCI revision cycle, oversees health care planning and ensures co-ordination between health and LTC strategies by harmonising the home care provisions in its Medical Care Plans with municipal LTCI plans. As the primary administrator of LTC services, the municipal government develops its Municipal LTCI Service Plans in accordance with the Basic Guidelines issued by the Ministry of Health, Labour and Welfare.

Costa Rica provides another example of multilevel governance through the National Care and Support System for Care-Dependent Adults and Older People (SINCA), established in 2022. The system operates through an Inter-institutional Technical Commission that brings together 11 key public bodies to co-ordinate LTC policies and programmes across sectors. The National Council for Older Adults (CONAPAM) distributes funds for LTC and assigns professional teams to promote and strengthen local care committees. Territorial implementation is further supported by Regional Intersectoral Committees, established as co-ordination platforms that articulate local needs and that are also tasked with responsibilities related to care coverage, benefit adequacy, and support for implementation across municipalities and regions.

Horizontal co-ordination

Horizontal co-ordination typically brings together organisations from across different sectors and stakeholders to address the needs of beneficiaries.

In Japan, municipalities primarily lead the development of the regional collaboration system. With the support of prefectural governments and health centres, municipalities work closely with local medical associations in building a system for regional horizontal collaboration. The goal is to enable related organisations to collaborate effectively to deliver integrated in-home health care and long-term care through multi-professional cooperation.

In Quebec, collaboration occurs through consultation tables (*tables de concertation*) and joint planning committees at local and regional levels. Representatives from health and social care integrated centres (clinical managers, social service directors), community organisations, municipal services, home support providers, and sometimes patient representatives meet at the consultation table regularly to identify gaps and overlaps in services, develop joint action plans, and agree on referral protocols and information-sharing mechanisms.

Costa Rica's Care Network (*Red de Cuido*) illustrates horizontal co-ordination through community-based governance structures that bring together diverse local actors to organise care for older adults. Each local network typically includes representatives of non-governmental organisations, public institutions (including the Costa Rican Social Security Fund, the Ministry of Health and the Mixed Institute for Social Assistance), municipal governments, community leaders and older persons themselves. Implementation varies across communities, enabling pooling of local knowledge and resources while maintaining flexibility to address specific territorial needs and responding to minimum standards established at a national level. Nonetheless, coverage remains uneven across regions, reflecting differences in local capacity, institutional engagement and community participation.

Thailand provides an interesting example of a co-ordinated, community oriented LTC model (Box 1.1).

Box 1.1. The Thai community-oriented governance model

The National Action Plan for Older Persons (2023–2037) and the Community-integrated intermediary care model link the healthcare services to the LTC needs of older people at the community level in Thailand. Thailand's Act on Older Persons placed the promotion and protection of older people under the Ministry of Social Development and Human Security while the Ministry of Public Health runs the majority of public health facilities. The National Health Security Office is currently responsible for the community-based LTC programme for older people. It works with local administration organisations (LAOs), which are responsible for managing the system with the support of district health services and are under the responsibility of the Ministry of the Interior. The Local Health Fund - a matching fund between Universal Coverage Scheme and local governments - is used as a strategic mechanism in driving the development of community-based LTC systems. The National Health Security Office and LAOs transfer money into the Local Health Fund to finance the scheme.

The pilot evaluation confirmed the appropriateness of the LAOs to manage care for older persons and encouraged LAOs to establish Centres for Older People, which provide a range of services such as day care, home-based care, and case management to older people. The pilot also highlighted additional challenges to provide co-ordinated people-centred care due to the division between health care and social care services and information sharing between various providers.

Source: (Asian Development Bank, 2020[6])

1.2 Financing models and payment mechanisms to incentivise the co-ordination of long-term care

Fragmentation in the sources of funding can hamper a co-ordinated approach to care. Pooling budgets, designing effective redistribution mechanisms across different levels of government and providing in-built incentives for co-ordination across sectors are important elements when designing LTC sustainable funding which is people-centred.

Pooling budgets

LTC is mostly funded either through taxes or a mix of taxes and contributions. Most countries rely on general taxation or non-earmarked social insurance contributions, often relying on labour income. The main advantage of tax-based funding is that it relies on a broad tax base and expenditure is matched to resources. The disadvantages of these systems include fluctuations in the size of the funding base, especially in the event of an economic recession as well as a lack of transparency in the allocation of funds because, most of the time, taxes are not necessarily earmarked to LTC. Diversifying sources of funding and pooling funds is likely to help many countries ensure greater sustainability in their LTC financing. Japan's LTC system is funded through insurance premiums (50%) and public funding (50%). The public funding consists of support from the national government (25% of total LTCI costs), prefectural governments (12.5%), and municipal governments (12.5%). This pooled national fund is redistributed to municipalities (insurers) based on their old-age population ratios, and regional cost adjustments. Costa Rica pools a significant share of LTC resources through the National Council for Older Adults (CONAPAM), which acts as a central channel for earmarked funding. CONAPAM receives funding from multiple streams: 2% of the Social Development and Family Allowances Fund (financed by general taxes and a 5% payroll contribution) and 31% of revenues from tobacco and alcohol taxes. Additional funding is available through other sources at the national and sub-national levels, but fragmentation across sectoral budgets, with no dedicated budget identifiers, hinders the possibility of fully tracking LTC financing and spending. In Quebec,

Canada, the provincial government's general revenues represent the largest share, slightly more than half of total system funding in 2024-25. Federal transfers, including the Canada Health Transfer and other federal contributions, account for an additional 20% of revenues and additional provincial resources, funded by employer and individual payroll contributions, representing roughly 17% of overall system financing.

Countries seeking additional resources could consider more broad-based funding sources that are less reliant on labour income, such as other taxes, or creating an insurance dedicated to LTC (Box 1.2). Currently, Germany, Japan, Korea, Luxembourg, the Netherlands, and Slovenia operate stand-alone LTC insurance systems financed through social insurance contributions. When redesigning LTC funding, it is paramount to ensure intergenerational fairness by avoiding placing the entire burden on younger generations and raising funds from older generations. Likewise, it should be noted that pure contributory LTC insurance (e.g., Japan) provides entitlements but may present possible downsides due to increasing premiums in the face of population ageing and concerns about younger cohorts resisting paying for a highly age-predictable risk.

Box 1.2. China LTCI pilot

China has been proactive in rolling out LTC insurance. To explore the feasibility of establishing a social insurance-based LTC financing scheme, LTCI pilot programmes were established in 15 cities in 2016, extended to 20 further cities in two key pilot provinces (Shandong and Jilin) and to another 14 pilot cities and areas (including autonomous prefectures and a district) by 2020. Under the central government overall guidance, these pilots have covered home-based, community-based, and institutional care, with the financial support mechanism for LTCI relying predominantly on the allocation of a certain percentage or fixed amount per person from the existing social health insurance funds. The pilots highlighted the positive impact of the insurance in alleviating the financial burden of families and caregiving costs of family members. The pilots also found that to ensure the sustainability and equity of LTC insurance in the future, it might be necessary to introduce a funding pool for LTCI with a mandatory contribution from individuals and employers, supplemented by government subsidies.

Source: (Wang, Guan and Wang, 2023[7]) (Cousins, 2025[8]).

Redistribution mechanism

Countries use a variety of criteria to distribute funding towards subnational levels to ensure adequacy and equity while also enhancing co-ordination across different levels of government. In Costa Rica, CONAPAM's budget is transferred to certified Social Welfare Organisations and local governments to provide LTC, prioritising older adults in situation of poverty or vulnerability. In Japan, the pooled fund is redistributed based on income level and old-age population of a municipality, while municipalities with lower fiscal capacity receive an additional subsidy, the Fiscal Stability Fund.

Quebec's health and social services network is financed through a diversified mix of revenue sources. The budget is allocated to health and social care integrated centres through a program-based funding framework. This model considers demographic and regional needs, service missions (hospital care, long-term care, community services), and strategic priorities tied to governmental policy.

Payments to incentivise co-ordination (performance-based funding, additional pricing for co-ordination)

To facilitate service co-ordination, the Quebec Ministry of Health and Social Services provides financial incentives to regional integrated health and social care centres primarily through performance-based

funding mechanisms. Each centre signs a performance agreement (*Entente de gestion et d'imputabilité*) with the Ministry, which includes targets for service integration and continuity aligned with provincial and strategic objectives, often over 4-year cycles. The Ministry allocates further conditional funding, including efficiency and co-ordination bonuses to reduce duplication and improve patient flow and special envelopes for integrated care projects.

A co-ordination grant (*dotation de coordination*) in France covers the cost of actions to ensure the integrated provision of home-based care, support and assistance services. The allocation may be used to finance the time of a co-ordinating nurse necessary for scheduling co-ordination meetings, partnerships, and time for sharing best practices. To improve equity of financing, the new French payment mechanism of home-based nursing care and support services identify "packages" based on the needs and characteristics on the beneficiaries.

Under Japan's LTCI system, financial incentives are designed to promote horizontal collaboration among health and social care providers for integrated care. These are add-on payments to the standard fees that are granted when providers meet specific conditions that promote quality, co-ordination, and efficiency.

1.3 Using workforce training and delivery structures to co-ordinate long-term care

Many LTC services involve direct, hands-on care that cannot be easily automated and ensuring an adequately skilled workforce is key. This involves first supporting informal or family caregivers who often provide most of the care through financial support, work-life balance options and training). Both family caregivers and the formal workforce are likely to suffer from significant shortages which will be accentuated by population ageing. The LTC workforce is often underpaid and works in inadequate conditions. Improving working conditions, raising wages and attracting more professionals to the sector have been identified as effective policies (OECD, 2020[9]). Secondly, enhancing productivity and care co-ordination across workers and sectors is also a key component in improving LTC

Co-ordination of service delivery through care/case managers

Countries aim to have a more co-ordinated approach to service delivery through case management or by relying on care managers. In Quebec, case management is central to the PRISMA (Program of Research to Integrate the Services for the Maintenance of Autonomy) model's horizontal co-ordination of health, social, and community services. Case managers, trained health and social care professionals (mostly social workers or nurses) are responsible for needs assessment, individualised service planning and co-ordination (particularly with the primary care physicians), referrals to other professionals, monitoring and advocacy for continuity of care, including hospital discharge plans. In Japan, care managers are responsible for co-ordinating with municipalities, LTC service providers, and primary care physicians, among others, to ensure insured persons receive appropriate services based on their conditions and wishes. Care managers play a central role in co-ordinating care between the health and LTC sectors by creating an intersectoral care plan (referred to as an *LTC Service Plan* or an *LTC Prevention Service Plan)* tailored to individual needs, which is shared and adjusted among the different service providers. Based on the information and assessment results, Japanese care managers draft an individualised care plan that includes the overall care policy, care objectives, and the types and volumes of services required. Then, the draft care plan is sent to the Service Representative Meeting, which includes representatives from various service providers in the LTC, healthcare, and social welfare sectors, for review. The care plan is finalised once it is explained and agreed by the beneficiary.

Promoting teamwork through shared tools

Co-ordination of service delivery to older persons may also be the responsibility of a team (In Quebec, health professionals (doctors, nurses, rehabilitation specialists) and social care professionals (social workers, community organisers, outreach workers) work under a shared governance model to ensure continuity of care and avoid service duplication. Each health institution designates a person responsible for the integrated approach, who ensures alignment with local partners and ministry guidelines. In health promotion, social workers and community partners lead initiatives to promote healthy lifestyles, while health professionals provide education and preventive screenings. For prevention and early detection, social workers identify issues such as isolation or vulnerability, and health teams conduct clinical assessments and refer individuals to appropriate services. Service decisions are made collaboratively to ensure the right level of support at the right time.

In France, the new Home Care Service (*Services Autonomie à Domicile*, SAD) adopts an integrated approach when offering home-based assistance and care services to older persons. The service must establish formal co-ordination between professionals by adapting its organisation. A co-ordinating nurse schedules meetings, partnerships, and time for sharing best practices. Shared working spaces and training for co-ordinated care are part of the approach.

Other examples of good practices of care co-ordination by a team are available in Denmark and the Netherlands (Box 1.3).

Single entry points

Countries are trying to go one step further by developing tools to have all the information in a single place. In Costa Rica, at the community level, service delivery is co-ordinated through community care networks. These mechanisms are increasingly supported by digital tools, notably the *Cuidar.cr* platform launched in 2024, which connects people in dependency with public, private and non-profit care providers through an integrated service directory and a registry of formal and informal caregivers.

A single entry point or one-stop-shop is also being developed. In Japan, municipalities can establish Community General Support Centres, which offer information and co-ordinate services for older people in the community including preventive health activities, housing and long-term care services. The French "one-stop shop" (Departmental public service for autonomy) officially launched in May 2024, is designed to simplify older people and their caregivers' access to care services through the construction of a truly local co-ordinated public service that guarantees the same quality of service for all, regardless of the location or individual situation. In Quebec, case managers serve as the single point of entry for older adults who require integrated care.

Box 1.3. The Buurtzorg model (the Netherlands) and the *Fremfærd Sundhed og Ældre* (Denmark)

The Buurtzorg model, developed in the Netherlands since 2006, is based on independent, self-managed nursing teams that provide holistic and personalised care at community level. Each team, consisting of up to 12 nurses and care workers, looks after 40 to 50 patients in their neighbourhood. The teams are responsible for organising their work, managing tasks and decision making, actively collaborating with GPs, therapists and other local professionals, and building their own network of users through word of mouth and referrals. Buurtzorg supports the teams' operations through an IT platform to reduce administrative burdens, increase productivity and improve the quality of care. Through the platform, teams access information on performance, interventions and results, promoting mutual learning. Over time, the model has evolved in different directions. Buurtzorg+ has strengthened prevention and collaboration between nurses and therapists. BuurtzorgT has extended the self-management approach to psychiatric care, promoting equality between staff and users, the use of digital tools for joint learning and greater autonomy for users in managing their own care pathways.

Following the Summit on Older People organised in 2020 by the Danish Ministry of Health, the municipalities of Faxe, Hedensted, Haderslev, Copenhagen, Ringsted and Rudersdal launched projects aimed at reorienting care services for older people based on the specific needs of their local areas. The initiatives were implemented as part of *Fremfærd Sundhed og Ældre*, an institutional collaboration that aims to strengthen the municipal labour market's capacity to fulfil its welfare responsibilities, with a particular focus on long-term care. A committee of experts, composed of trade union representatives, local authorities and municipal administrations, established a joint development space. This space allowed managers and operators from the six municipalities to co-design new approaches to older people's care, drawing on local experience.

Source: OECD (2024[28]), Good practices in delivering integrated care: Examples from the Netherlands, Denmark, France and Ontario, Canada; www.buurtzorg.com/about-us/buurtzorgmodel; and www.buurtzorg.com/innovation/buurtzorg-te

1.4 Data-sharing arrangements make care more people-centered and comprehensive

Another area that facilitates services co-ordination is data-sharing between different pillars and actors of the care system. Interoperability is the ability of computer systems or software to exchange information. To be considered as interoperable, systems do not need to be fully integrated but must at least share common data models and communication protocols. Unfortunately, many tools in the current LTC landscape are "digitally walled", that is, they are architecturally incapable of or have very limited capability to exchange information. Such systems are not cost- and service-efficient: the same data are collected multiple times, increasing the cost of maintaining the systems and causing confusion. Building integrated data systems and interoperability is essential for the development of integrated management tools that include primary and specialised care and open the door for co-ordinated interventions, more and better information for users, less administrative work for professionals and the generation of more efficient and reliable statistics and reports.

Efforts to implement new integrated tools and databases are ongoing

Digitalisation is a first step in the process of enhancing administrative efficiency. The Japanese LTC Information Platform, scheduled to be introduced in 2026, will allow individuals, municipalities, LTC facilities, healthcare institutions, and other related stakeholders to share and utilise care-related information about beneficiaries. For example, through this online platform, primary care physicians will be able to send their notes to the municipality, and care managers can view the progress and results of the needs assessment, including the physician's notes. The introduction of the LTC Information Platform will improve operational efficiency and reduce administrative burden by replacing paper exchanges with electronic procedures.

Countries are also creating single files to have all medical and care information jointly for people and professionals. To improve data sharing and reduce paperwork, Santé Québec (Canada) will pilot a new system, *Dossier Santé Numérique (DSN)*, in two integrated care university centres in May 2026. The DSN aims to digitise all patient records across the health network and enable doctors from various establishments to access a patient's history without the need for paper file transfers. Patients will also have access to their files online. Costa Rica is making advances in building an integrated information architecture for LTC, centred on the National Information and Single Registry of State Beneficiaries (SINIRUBE), a unified socio-economic database. The platform links multiple institutional databases, supporting information exchange among institutions involved in LTC, aligning with the objective of improving interoperability across the health, social protection and care sectors. The system is being enhanced to incorporate standardised dependency assessments, enabling co-ordinated eligibility determination and referrals to services through a unified platform.

In some cases, the information is jointly compiled for the use of professionals. In France, the Digital Social and Medico-Social Establishments and Services (ESSMS) programme aims to generalise the effective use of a computerized user file (*dossier usager informatisé*, DUI) for everyone receiving support and services. This tool aims at collecting all the necessary data and professional documentation to assess individual's needs, thereby facilitating the design, implementation, and evaluation of personalised support plans.

Monitoring of service provision

Data-sharing is foundational for planning, monitoring, and evaluating the provision of services and support. In Quebec, the health and social network is closely monitored through a public performance dashboard that updates weekly key indicators across multiple areas, ranging from primary care to innovation, including care for older people. It includes data from the integrated care centres and private institutions under agreement with them, when available. This system uses a structured approach based on four main

components: tracking organisational priorities through a five-year strategic plan, evaluating ministerial programmes, analysing policies and action plans, and producing decision-support tools.

Digitisation of data on user outcomes can be a useful tool for benchmarking. The Japanese Community-based Integrated Care 'Visualization' System was launched by the national government as an analytical tool for municipalities and prefectures to conduct community management. This information system centralises various data related to the community-based integrated care systems, including LTCI data, and visualises them in an easy-to-read format for public use. The full-scale operation of this system is expected to facilitate collaboration between local stakeholders engaged in community-based integrated care.

Finland offers a useful example of an integrated data system for LTC services (Box 1.4).

Box 1.4 Kanta services in Finland

The Kanta system is Finland's national platform for electronic health and social data management. Through Kanta, health and social care professionals can access an integrated database containing medical records, treatment plans and social service information. This improves the effectiveness of the service, as all involved can quickly access the information needed to provide personalised and co-ordinated care.

Kanta takes strict security measures to ensure the protection of personal data. Citizens must give explicit consent before their data is shared between health and social services. Encryption and multi-factor authentication systems further protect data. In addition, Kanta provides citizens with the ability to monitor who accesses their information and restrict access to their data, ensuring full General Data Protection Regulation compliance.

Source: (Jormanainen et al., 2023[10]) Professionals - Kanta.fi

Co-ordinating LTC services across different parts of government, providers and organisations is essential for making the system sustainable and providing quality, effective, and equally distributed services. In the four policy areas described above, there seem to be several key successful features to facilitate co-ordination of LTC services that seem to exist regardless of countries (areas) having different institutional and governance arrangement or different resources and level of needs.

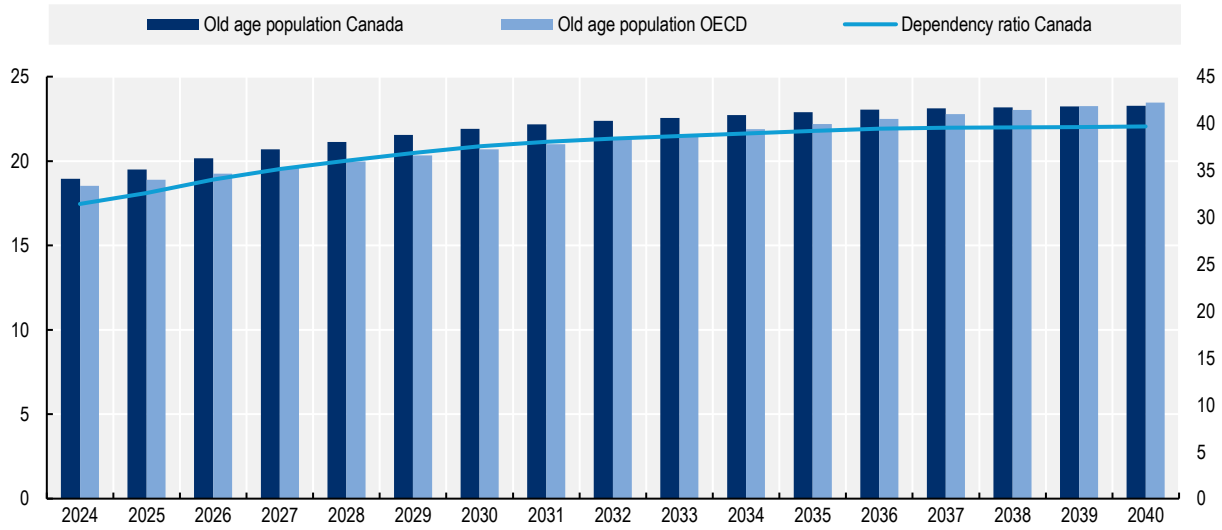
Harmonising LTC governance by having a single point of access, pooling and improving funding and workforce, and ensuring data sharing are key components of well-designed LTC systems that protect older people, reduce burdens on families, enable women to participate more fully in the workforce, and ease pressure on already stretched health systems. Focusing on the LTC systems allows a broader understanding of the institutions and processes that shape the outcomes of government-funded services. A dual approach of national guardrails plus local adaptability limits the risk of fragmentation, inequity and low-value investments in LTC.

2 How Quebec (Canada) promotes co-ordination in long-term care

2.1 Overview: Canada has a decentralised long-term care system with the province of Quebec having an integrated health and social care approach

In Canada, currently, almost one in five people is aged 65 and over, slightly above the OECD's average of 18.5% (Figure 2.1). By 2050, Canada's people aged 65 and over will make up 23.6% of the total population, with those aged 80 representing 9.2%, nearly doubling from 4.5% in 2023 (OECD, 2025[11]). Simultaneously, the dependency ratio will rise from 32.6 in 2025 to 39.7 in 2040, which is lower than the OECD average of 41.7 in 2040.

Figure 2.1. More than 1 in 5 Canadians will be aged 65 and over by 2040



Note: Old age population rate is the share of people aged 65 and over to the total population. Old age dependency ratio is the number of individuals aged 65 or older per 100 people of the working age population aged 20-64. The primary axis on the left is for the old age population rate, and the secondary axis on the right is for the old age dependency ratio.
Source: OECD Data Explorer Population Projections (2025[12]).

Canada's long-term care (LTC) spending has steadily increased over the past decade, consistently above the OECD average throughout that period. Canada's LTC expenditure accounted for 21.7% of total health expenditure in 2024, up from 19.3% in 2015 (OECD, 2025[2]). Meanwhile, the average across 35 OECD countries rose from 14.1% in 2015 to 19.2% in 2024. Given population ageing in particular, those aged 85

and over, the fastest-growing age group (Statistics Canada, 2022[13]), will significantly drive increases in care demand related to their chronic diseases and conditions.

In Canada, most home, community and residential care services are delivered and funded by provincial and regional governments. The federal government provides funding support through transfer payments for health and social services. Each province's Ministry of Health ensures the jurisdiction's legislation is followed, sets eligibility and costs, and manages applications and waiting lists. Across the country, jurisdictions offer a different range of services and cost coverage. At the same time, accessing adequate home care services remains a challenge due to limited publicly funded services, high out-of-pocket costs for private services, and the burden on informal carers (Health Canada, 2024[14]).

Across Canada, many provinces have adopted single-entry points and case management services for certain health or social care programmes, but the scope and implementation vary across jurisdictions (MacAdam, 2015[15]). Quebec is the only province that manages health and social services through a single ministry and takes an integrated approach to healthcare, including primary care physicians and hospitals, with an emphasis on a population-based approach.

In 1999, Quebec developed an integrated care model, PRISMA (Program of Research to Integrate the Services for the Maintenance of Autonomy), in the Estrie region, to improve continuity and co-ordination of health and social services for frail older people living in the community without increasing caregiver burden (MacAdam, 2015[15]). The PRISMA model was a network model approach to service delivery characterised by six features: service co-ordination, single-entry point, case management, individualised service plan, unique assessment tool, and electronic information tool. Services provided include inpatient, emergency room and outpatient hospital care, primary care, specialised geriatric care, rehabilitation, in-home nursing and institutional long-term care, therapy, personal care, home support, home-delivered meals, day centres, pharmacy, equipment, supplies and domestic care (MacAdam, 2015[15]). PRISMA services were not means-tested, and any older people aged 65 and over with significant functional disabilities who received home care support and needed formal care were eligible for the services.

The PRISMA model has since continued to serve as the guiding principle of Quebec's integrated care model, which has evolved significantly and expanded in scope through various reforms. In 2002, the Quebec Ministry of Health and Social Services (MSSS) renamed PRISMA to RSIPA (*Réseau de services intégrés personnes âgées* or Network of Integrated Services for the Elderly) and established it as a province-wide programme (Poirier et al., 2013[16]). In 2020, the RSIPA was absorbed into standard operations within regional integrated health and social care centres (CISSS/CIUSSS) rather than a standalone programme (MSSS, 2020[17]). This chapter will primarily discuss integrated health and social care centres and Santé Québec, the latest successors of the PRISMA model.

2.2 Governance: Case management and care co-ordination for older people in Quebec have gradually been integrated into a larger care structure over the past 20 years

The PRISMA model is a co-ordination-oriented integrated care model that allows participating organisations to retain autonomy while agreeing to shared responsibilities and processes. It uses a three-level governance model with clearly defined roles at the strategic, tactical, and operational levels (Hebert et al., 2010[18]; MacAdam, 2015[15]). At the strategic level, a joint governing board for health, social, and community care services determines the policy orientations and resource allocations for the integrated system. Under the governing board, there are local management committees, composed of managers of direct service agencies (tactical). These committees discuss and address resource issues (e.g., staffing and budget) and interagency communication. In field practice, multidisciplinary teams of local clinicians manage client care, create and monitor individualised care plans (operational).

Case management is central to the PRISMA model's horizontal co-ordination of health, social, and community services. Case managers, trained health and social care professionals (mostly social workers or nurses), acted as a pivot for ensuring co-ordination across local community service centres (CLSCs), hospitals, home care, and other relevant services. They were responsible for needs assessment, individualised service planning and co-ordination (particularly with the primary care physicians), referrals to other professionals, monitoring and advocacy for continuity of care, including hospital discharge plans (MacAdam, 2015[15]).

Since the PRISMA model was rolled out across the entire province as RSIPA, its governance structure has been reorganised through a series of reforms to establish integrated health and social care centres. A relatively recent reform was in 2015, which saw 13 CISSSs (centres intégrés de santé et de services sociaux) and 9 CIUSSSs (*centres intégrés universitaires de santé et de services sociaux*) replace the former health and social service centres (CSSSs) under Bill 10 (FMSQ, n.d.[19]). This reform reorganised management into two tiers, strengthening the Ministry's role while eliminating the regional-level management primarily handled by the CSSSs. According to this reform:

- The MSSS was responsible for ensuring inter-regional service co-ordination, establishing referral and service co-ordination mechanisms between institutions, distributing resources, and evaluating the performance of the co-ordination network and system (MSSS, 2018[20]).
- All health and social service providers were responsible for delivering high-quality and accessible services, respecting patients' rights, allocating available resources, conducting academic and research duties if relevant, and monitoring and reporting to the MSSS.
- Finally, those integrated health and social services centres were responsible for engaging the population in network management, planning and co-ordinating services based on ministerial directions and local needs, protecting public health, ensuring care for all, establishing service corridors and partnerships, supporting the functioning of local service networks, and allocating funding to community and private resources.

Within each local area, publicly funded CLSCs, long-term care facilities, and hospitals (except for university hospitals) were merged into CISSS.[2] These centres were tasked with planning and co-ordinating local service networks, and the representatives meet with other partners to organise care at the clinical level (MacAdam, 2015[15]). In detail, collaboration occurs through consultation tables (tables de concertation) and joint planning committees at local and regional levels. Representatives from CISSS/CIUSSS (clinical managers, social service directors), community organisations, municipal services, home support providers, and sometimes patient representatives meet at the consultation table regularly to identify gaps and overlaps in services, develop joint action plans, and agree on referral protocols and information-sharing mechanisms (MSSS, 2024[21]).

In December 2023, under Bill 15 (National Assembly of Québec, 2024[22]), a law was passed to merge the CISSSs and CIUSSSs again into Santé Québec in 2024. This central body for managing the health care system would become the sole employer for the entire health care system and would therefore have its own board of directors. The chief executive officers of the 34 regional centres, including 22 integrated health and social care centres (CISSS/CIUSSS), would report to Santé Québec rather than to boards of directors (Gouvernement du Québec, 2025[23]).

[2] The Ministry of Health and Social Services was responsible for the merger under Bill 25, *Act respecting local health and social services network development agencies* (MacAdam, 2015[15]).

2.3 Financing and payment: Tax-based funding mechanisms in Quebec incentivise care co-ordination

Quebec's health and social services network is financed through a diversified mix of provincial, federal, and dedicated revenue sources. According to the government report (MSSS, 2025[24]), the Quebec government's general revenues, allocated via the Consolidated Revenue Fund, represent the largest share, slightly more than half of total system funding in 2024-2025. Federal transfers, including the Canada Health Transfer and other federal contributions, account for an additional 20% of revenues. Additional provincial resources flow through the Fonds des services de santé (FSS), funded by employer and individual payroll contributions, representing roughly 17 % of overall system financing in 2024-2025. User fees or contributions by individuals, other government agencies, and miscellaneous revenues account for the remaining portion. Together, these sources form the financial base for the services delivered by integrated institutions such as CISSS and CIUSSS across the province.

The MSSS redistributes budget allocations to CISSS and CIUSSS through a program-based funding framework. This model considers demographic and regional needs, service missions (hospital care, long-term care, community services), and strategic priorities tied to governmental policy (MSSS, 2024[25]). While principle-based distribution guides the bulk of resource allocation, targeted envelopes often linked to federal-provincial agreements or provincial policy priorities (e.g. mental health, digital health, special projects) provide additional funding flexibility. As a result, CISSS and CIUSSS receive a blend of core financing and programme-specific resources that reflect both population needs and evolving policy directions within Quebec's health system.

To facilitate service co-ordination, the MSSS provides financial incentives to CISSS and CIUSS, primarily through performance-based funding mechanisms embedded in MSSS agreements. Each CISSS and CIUSSS signs a performance agreement (*Entente de gestion et d'imputabilité*) with MSSS, which includes targets for service integration and continuity aligned with provincial and strategic objectives, often over 4-year cycles (MSSS and CISSS de Laval, 2024[26]). In addition to accountability for meeting established goals, annual performance monitoring is required. Meeting or exceeding these targets can result in budget flexibility, the ability to reallocate funds internally without prior MSSS approval, and access to additional envelopes for innovation or priority programmes. The MSSS further allocates conditional funding, including efficiency and co-ordination bonuses to reduce duplication and improve patient flow and special envelopes for integrated care projects (e.g., home care, mental health co-ordination). However, failures to meet co-ordination objectives can lead to the integrated care centre's budget clawbacks or reduced discretionary funding.

Under the CISSS and CIUSSS, the PSOC (*programme de soutien aux organismes communautaires*) is a vital resource for supporting, overseeing, and integrating community resources into regional health and social networks (MSSS, 2023[27]). This financial support for community organisations in the health and social service sectors is managed at the regional level by each integrated care centre. Non-profit legal entities in Quebec that carry out activities aligned with the objectives of health and social services are eligible for the PSOC, including long-term care organisations providing home support, caregiver assistance, and psychosocial services. The PSOC includes three funding mechanisms: support for the overall mission (ongoing core funding for organisational capacity), a project-based implementation grant, and a one-off implementation grant (MSSS, 2025[28]). A community organisation may qualify for more than one funding mechanism if it meets the conditions of each. The amount of support is determined by the specific eligibility criteria and funding benchmarks associated with each funding mechanism. The PSOC funding often requires collaboration agreements between the community organisations and CISSS and CIUSSS, fostering integrated planning and shared accountability. Non-compliance with annual reporting and financial audit requirements may result in the reduction or withdrawal of funding.

2.4 Workforce: Interdisciplinary teams of health and social care professionals in Quebec ensure continuous care from assessment to delivery

Integrated service delivery

Quebec's approach to integrated care for older adults (*Approche intégrée de proximité pour les personnes aînées*) outlines how health and social care services collaborate (MSSS, 2024[21]). Under this approach, along with older persons and their informal care network, the following organisations and their affiliated members are defined as key actors:

- Community workers, particularly those from the Outreach Initiatives Programme for Vulnerable Seniors (ITMAV)
- Community organisations, associations, and social groups that provide services and activities to older adults
- Existing networks in the form of tables or committees that represent the interests of older adults
- Contract workers, including those under the direct allocation/service check system
- Social economy enterprises, particularly those offering home assistance
- Private companies, such as family medicine groups, community pharmacies, ambulance services, various shops and more
- Public organisations such as policy services, transportation, schools, 911 emergency centres, and others, through mechanisms that enable intersectoral collaboration
- Municipal services, including those involved in implementing the Age-Friendly Municipality approach (*Municipalité amie des aînés*, MADA)
- The health and social services network, particularly institutions with workers, liaison, and key personnel, access points, the local co-ordination officer (facilitation, mobilisation), community organisers, and more

Therefore, health professionals (doctors, nurses, rehabilitation specialists) and social care professionals (social workers, community organisers, outreach workers [ITMAV]) work under a shared governance model. Hospitals and CLSCs co-ordinate with community organisations, municipalities, and private actors to ensure continuity of care and avoid service duplication. Each health institution designates a responsible person for the integrated approach, who ensures alignment with local partners and ministry guidelines.

Collaboration between health and social care professionals occurs through key activities within integrated service delivery. In health promotion, social workers and community partners lead initiatives to promote healthy lifestyles, while health professionals provide education and preventive screenings. For prevention and early detection, ITMAV outreach workers and social workers identify issues such as isolation or vulnerability, and health teams conduct clinical assessments and refer individuals to appropriate services. Service decisions are made collaboratively to ensure the right level of support at the right time. For instance, a nurse may co-ordinate with a home support worker for post-discharge care. Additionally, social workers and ITMAV outreach workers assist older adults with administrative tasks and connect them to housing or financial aid, while health professionals oversee medical follow-up.

Co-ordination within the regional integrated care centres

Embedded within the CISSS/CIUSSS structure, RSIPA staff would be employed by the integrated care centres assigned to this integrated care network. The core RSIPA workforce includes case managers,

usually nurses or social workers, who co-ordinate care plans, ensure continuity between hospital, home care, CHSLD, and community services; nurses who provide clinical follow-up at home and act as liaisons between acute care and community services; social workers who address psychosocial needs, support caregivers, and link to community resources; physicians, often family doctors, who participate in multidisciplinary planning for complex cases; rehabilitation professionals, including physiotherapists and occupational therapists, for functional autonomy; and administrative support for scheduling, data entry, and co-ordinating appointments. Community liaison officers, who connect RSIPA with PSOC-funded organisations and volunteer networks, as well as clinical co-ordinators, who oversee programme implementation and compliance with the MSSS standards, may also be included in the RSIPA team.

After RSIPA became standard operation, its tools (e.g., case management, single access points, multidisciplinary teams) were retained, but are now implemented as part of regional mandates. Health and social care professionals working in the integrated care centres play distinct roles and collaborate in interdisciplinary teams. Across all integrated care centres in Quebec, physicians (both GPs and specialists), registered nurses, respiratory therapists, paramedics (physiotherapists, occupational therapists, dieticians, aids), social workers, other therapists, as well as administrative and executive staff, usually work within a single centre. CIUSSS may have additional staff in teaching and research roles due to their university affiliation.

- Physicians diagnose, prescribe, and oversee treatment plans, while collaborating with nurses, paramedical staff, and social workers on discharge planning and follow-up care.
- Nurses and respiratory care staff provide direct clinical care, co-ordinate with paramedical staff for rehabilitation and with social workers for home support.
- Paramedical staff work closely with nurses and physicians to implement care plans and support discharge plans to home or long-term care.
- Social workers and other health and social care professionals connect patients with community resources and ensure that their psychosocial needs are met.

Case management likewise became mainstream, as it is now incorporated into CISSS/CIUSSS regional mandates for integrated care. It is no longer limited to care for older people and has expanded to home care, mental health, rehabilitation, and chronic disease management. Case managers still serve as a single point of contact for complex cases across all programmes and for co-ordinating transitions between hospitals, CLSC, CHSLD (*centres d'hébergement et de soins de longue durée*), and PSOC-funded community services. Integrated into CLSC home care teams, hospital discharge units, and specialised programmes, case managers report through clinical directorates in the integrated care centre.

Currently, Quebec is seeking to improve the availability of skilled workers for older people in integrated care centres. In the 2024-2029 government action plan (MSSS, 2024[29]), the MSSS aims to award 1,000 scholarships to implement a new short-term training programme for patient attendants (PAB) and health and social services assistants (ASSS), who are essential for bridging home care (SAD, soutien à domicile) and other care settings where health and social needs intersect. The new training programme will qualify graduates for all care settings, including home care. For the 2025-2026 academic year, scholarships of up to CAD 12,000 each are offered to students enrolled in the Diploma of Vocational Studies in support of assistance services in health and social services institutions (Gouvernement du Quebec, 2025[30]).

Co-ordination in hospital acute care

A nurse and a physician traditionally carry out the clinical assessment of patients in the emergency department (ED). However, for older patients aged 75 and over, an interdisciplinary assessment and treatment are recommended to better understand and adapt to their health and social conditions (MSSS, 2024[31]). The interdisciplinary assessment team can include healthcare professionals who perform a clinical evaluation (i.e., nurse in geriatrics, physiotherapist, pharmacist) and social care and other

professionals who assess psychosocial needs and co-ordinate resources (i.e., social worker, personal support worker specialised in geriatric care, key stakeholder or community case manager (SAD), nurse clinician or hospital case manager). The clinical nurse in geriatrics in the ED was a newly created position to ensure the smooth flow of care for older adults and to conduct a clinical assessment in parallel with, or following, a physician's medical assessment in a CIUSSS (CIUSSSE-CHUS). Now the Ministry recommends that every ED introduce geriatric clinical nurses, as their role was associated with fewer admissions and more stable lengths of stay in the ED (MSSS, 2024[31]). Likewise, the treatment for older patients is to be jointly provided by a team comprising a triage nurse, a nurse responsible for patient care, an auxiliary nurse, a patient attendant, an emergency physician, a specialist or hospitalist, and a geriatrician. Each professional's roles and responsibilities within these interdisciplinary teams in acute care settings are clearly defined by the Ministry (see (MSSS, 2024[31])).

To enhance collaboration in geriatric emergency services, continuing education programmes targeting basic skills required for geriatric emergency medicine are suggested for the interdisciplinary team (i.e., doctors, nursing staff, patient attendants, and other health professionals) (MSSS, 2024[31]). The education programme may include the knowledge of common conditions among older people (e.g., frailty, fall, BPSD), geriatric pharmacology, palliative care, polypharmacy, functional autonomy, screening for elder abuse and neglect, and basic care. While some programmes specifically target clinical practices in the ED, several online training modules are also available to various professionals and employees of the integrated care centres (CISSS/CIUSSS).

2.5 Data sharing: Quebec's health and social care data links are progressing and could be strengthened further

Within Quebec's health and social care system, two databases have coexisted. One is the PRISMA electronic clinical chart, designed for integrated care co-ordination for older people, and the other is the DSQ (Dossier Santé Québec), a provincial electronic health record database. The PRISMA electronic clinical chart stores assessment results, service plans and case management notes (MacAdam, 2015[15]). It is mainly used by CLSCs, home care teams, and social service providers within deployed regions. The DSQ is a province-wide electronic health record (EHR) system, introduced in 2006 (Shaw and Wittevrongel, 2022[32]). The DSQ made an EHR of laboratory results, diagnostic imaging, and medication history available to both doctor and patient at the point of contact.

Data collected in the PRISMA electronic charts are primarily digital but still rely on paper records and local systems, indicating limited potential for large-scale data sharing for care co-ordination (Hébert, 2022[33]). Initial assessments for older people take place through Quebec's single point of entry system, most commonly at the local CLSC (Gouvernement du Québec, 2023[34]). Standardised tools (e.g., PRISMA-7, SMAF) that evaluate functional autonomy, health status, living conditions, and social support are distributed on paper forms in CLSCs and partner agencies. Once the forms are filled in (either at the CLSC or at home during face-to-face visits), they are then transmitted via fax or email to regional integrated care centres (CISSS/CIUSSS) case managers. The initial data are manually transcribed into regional PRISMA computerised charts, made accessible to authorised regional care providers.

Likewise, although the DSQ covers the entire province with a secure digital database, institutions have reported inconsistent digital adoption and limited interoperability (Shaw and Wittevrongel, 2022[32]). Patient data are sometimes not shared between hospitals and other healthcare settings, such as family medicine clinics, long-term care facilities, or other hospitals, without faxes, paper forms, and manual scanning (CityNews Montreal, 2025[35]). At the same time, its potential for care co-ordination remains limited because it does not, by its nature, include data related to care planning and co-ordination. The DSQ's data collection also needs improvement in coverage. Some clinical notes and information (e.g., vaccinations, allergies,

medications prescribed during the last hospital stay, hospitalisation summary), PRISMA needs assessments, and service plans remain local and outside DSQ (Shaw and Wittevrongel, 2022[32]).

To improve data sharing and reduce paperwork, Santé Québec will pilot a new system, *Dossier Santé Numérique (DSN)*, in two integrated care university centres (CIUSSS du Nord-de-l'Île-de-Montréal and Mauricie-et-du-Centre-du-Québec) in May 2026 (CityNews Montreal, 2025[35]). The DSN aims to digitise all patient records across the health network and enable doctors from various establishments to access a patient's history without the need for paper file transfers. Patients will also have access to their files online (Actual Magazine, 2024[36]).

At the same time, the health and social network in Quebec is closely monitored through a public performance dashboard that updates weekly key indicators across multiple areas, ranging from primary care to innovation, including senior care (Gouvernement du Québec, 2025[37]). It includes data from the integrated care centres (CISSS/CIUSSS) and private institutions under agreement with them, when available. This system is guided by the MSSS, which uses a structured approach based on four main components: tracking organisational priorities through a five-year strategic plan, evaluating ministerial programs, analysing policies and action plans, and producing decision-support tools. Additionally, with the recent creation of Santé Québec, the indicators for its 2025-2028 strategic plan are also monitored and linked to the dashboard (Santé Québec, 2025[38]).

3 Towards a universal long-term care system in Costa Rica

3.1 Costa Rica is undergoing a fast population ageing process

Costa Rica has a population of 5.17 million persons[3] (INEC, 2025[39]) and is undergoing one of the fastest population aging processes in Latin America and the Caribbean (Stampini et al., 2025[40]). The share of people aged 65 and over has almost doubled since 2000, driven by a sustained decline in fertility – the lowest in the region – combined with low mortality and high life expectancy (Consejo Nacional de Rectores, 2025[41]). In 2023, 10.5% of the population was aged 65 and over, and 2.2% 80 and over; by 2050, these values are projected to rise to 20.7% and 6.3% respectively (OECD, 2025[11]). Life expectancy at birth reached 81 years in 2024, up from 77 in 2000, and is expected to increase to 84 years by 2050 and 90 years by 2100 (INEC, 2024[42]). Fertility continues to fall sharply, reaching 1.53 children per woman in 2022, down from 3.21 in 1990 (OECD, 2024[43]). These demographic shifts, alongside an epidemiological transition marked by rising prevalence of non-communicable diseases, are expected to substantially increase the demand for long-term care (LTC) (Chaverri-Carvajal, 2025[44]). The 2023 National Disability Survey (ENADIS) further reveals that disability prevalence rises steeply with age, reaching 37.4% among people aged 65 and over, most of whom (145 510 out of 148 079) experience severe disability (INEC, 2025[45]).

A preliminary assessment of LTC needs based on 2019 data estimated that 13.4%[4] of older persons require support, with higher dependency rates among women and the oldest age groups (Table 3.1) (see Aranco et al. (2022[46]) for complementary estimates). In addition, the 2024 National Household Survey (ENAHO) found that 124 530 older people live alone – representing 42% of all single-person households – a growing trend among the older population.

Table 3.1. Share of dependent older adults (65 and older), by age group and gender, 2019

Older adult dependency	Age group 65 – 69	Age group 70 – 74	Age group: 75 and more	Total 65 and older
Total (men and women)	5.2	8.9	22.8	**13.4**
Men	5.2	8.9	21.2	12.4
Women	5.3	9.0	24.2	14.2

Source: Matus-López and Chaverri-Carvajal (2022[47]).

[3] As of 30 June 2024.

[4] The estimate is based solely on Activities of Daily Living (ADLs). As it does not account for other dimensions, it is likely to underestimate overall needs.

3.2 Costa Rica is advancing toward a comprehensive LTC system

Costa Rica was one of the first middle-income countries to advance toward a comprehensive LTC system. This process builds on a landscape traditionally characterised by fragmented and limited public provision, oriented towards older people lacking family support or the financial means to purchase care. Access to services has been uneven across localities, with particular challenges in rural and remote areas – where service availability and local implementation capacity remain more constrained – and across providers, with only a modest network of day centres and a small number of publicly funded residential homes. Community-based services are predominantly delivered by non-profit and non-governmental organisations (NGOs), which operate under municipal and Ministry of Health oversight while relying primarily on public transfers. Most formal care provision continues to be carried out by NGOs receiving government grants, whereas informal family care remains the dominant source of support – reinforcing gender inequalities in the labour market, due to women's disproportionate involvement in unpaid care. Although the introduction of income-based co-payments to complement public financing is foreseen by law, as of 2025 these had not yet been implemented and no official parameters had been established (Chaverri-Carvajal and Obando Viquez, 2023[48]; Chaverri-Carvajal, 2025[44]; ISSA, 2024[49]; IMAS, 2025[50]).

At the same time, in Costa Rica the right to health is a fundamental entitlement. The country operates a universal, free-at-the-point-of-use health system financed through a mix of contributions to the Costa Rican Social Security Fund (*Caja Costarricense de Seguro Social* – CCSS) and public resources. The CCSS plays a central role in the provision and financing of health services and contributes to health-related components of LTC, but it is not the main financier of LTC services[5]. The Ministry of Health is the national health authority, responsible for policy formulation, regulation and oversight (Chaverri-Carvajal, 2025[44]).

Demographic trends suggest that reliance on family care alone will be insufficient to meet future LTC demand (IMAS and MDHIS, 2021[51]; Consejo Nacional de Rectores, 2025[41]). As the gap between rising LTC needs and the availability of formal services increases, new solutions and financing mechanisms become necessary.

3.3 Policy and legislative developments are paving the way towards a universal LTC system

The LTC system in Costa Rica has historically been characterised by fragmented programmes, without a unified governance and largely targeted at specific population groups, particularly those in poverty or extreme poverty (IMAS and MDHIS, 2021[51]). In 1999, Costa Rica approved the Integral Law for Older Persons (Law 7935), which enshrined the rights of people aged 65 and over and assigned responsibilities across public institutions. The law also created the National Council for Older Adults (CONAPAM), attached to the Presidency of the Republic, as the lead body on ageing and old age, responsible for safeguarding rights and co-ordinating national action. In addition, the Ministry of Health and the CCSS have also taken steps to strengthen care provision for older adults: the National Strategy for Healthy Ageing (2018) recognised the need to develop an LTC system grounded in shared responsibility between the state, families, communities and service providers (Medellín and Jara Maleš, 2019[52]). Its updated version to 2026 broadens the focus to promoting physical, mental and social wellbeing across the life course and advancing active and healthy ageing (Chaverri-Carvajal, 2025[44]).

[5] The CCSS plays an indirect role in LTC financing by offering – within the health system – health and social-care interventions that promote autonomy and prevent functional decline – e.g. hospital discharges, home-based care, and support to family caregivers (Medellín and Jara Maleš, 2019[52]).

The National Care Policy 2021-31 marked significant progress by setting out an integrated system to address this fragmentation, co-ordinate public and private provision and expand access to quality care for all dependent people. The policy seeks to extend existing services and introduce new care modalities, such as telecare. Its implementation is guided by five strategic pillars: strengthening system governance; improving data and information for co-ordination; expanding and upgrading care services and benefits; promoting measures to reduce gender gaps in employment; and establishing mechanisms to ensure quality across the care and dependency support system (IMAS and MDHIS, 2021[51]).

Law 10192/2022 subsequently created the National Care and Support System for Care-Dependent Adults and Older People (SINCA). The law aims to universalise access to care and support services for adults and older persons with functional dependency, while enhancing the wellbeing and labour market opportunities of caregivers (primarily women), under a human-rights and shared-responsibility approach. It also seeks to reduce pressures on the health system by strengthening social care provision.

In 2023, CONAPAM launched the National Policy on Ageing and Old Age 2023-33 to guide public action over the next decade to address ageing, dependency, social inclusion, protection against abuse and institutional strengthening – shifting the paradigm from an assistance-based model to one grounded in rights, dignity and social participation. Such policy explicitly considers the need to co-ordinate actions with the National Care Policy (CONAPAM, 2023[53]).

In parallel, a constitutional reform project (Record 23.348) proposes to enshrine the right to care as a fundamental right. The initiative aims to provide a general constitutional basis for the development of specific legislation and public policies in support of the care economy. It defines care as essential for individuals' subsistence and full development, assigns the State responsibility for ensuring universal access to public care services from a human-rights perspective, and recognises care and domestic work as a key pillar of social protection and economic activity – affirming the State's duty to protect care workers' labour rights. On 29 October 2025, the project passed its third reading in Costa Rica's Legislative Assembly with no votes against (Asamblea Legislativa de la República de Costa Rica, 2025[54]).

Key services and governance

CONAPAM is Costa Rica's lead authority on ageing and older persons. Its mandate focuses on protecting the rights and wellbeing of older people, with emphasis on those experiencing poverty or social vulnerability. In practice, this has centred on channelling public funds (mainly through means-tested subsidies) to providers of institutional care, home care and day-care services for these groups (Medellín and Jara Maleš, 2019[52]). In September 2024, the government introduced Bill 24.585 to amend Law 7935 and place CONAPAM under the Ministry of Health, signalling an intention to strengthen health-sector leadership in ageing and long-term care governance (Ministry of Health, 2024[55]).

In parallel, the National Council for Persons with Disabilities (CONAPDIS), under the Ministry of Labour and Social Security, is the governing body for disability policy. In addition to promoting and safeguarding the rights of persons with disabilities, CONAPDIS administers a programme of social and economic benefits that support families in accessing care services for people under 65 with disabilities. Upon reaching age 65, beneficiaries are transferred to CONAPAM's remit. The Ministry of Health also plays a regulatory role, overseeing compliance with quality standards in residential facilities and day centres for older adults (Chaverri-Carvajal, 2025[44]).

CONAPAM structures its service delivery through three main modalities (Chaverri-Carvajal, 2025[44]; CONAPAM, n.d.[56]; Medellín and Jara Maleš, 2019[52]):

- Residential homes (*Hogares*) are privately managed, non-profit facilities accredited by the Ministry of Health that provide permanent accommodation for older adults. They receive public funding from the central government and occasionally from municipal governments (Chaverri-Carvajal and Obando Viquez, 2023[48]). Services include meals, nursing care, rehabilitation, social work, and

recreational and cultural activities. Costs vary according to the complexity of care and quality of services. Under Law 7935, residents may contribute up to 90% of their pension towards their stay, supplemented by CONAPAM funding for those in poverty or situation of abandonment. Homes often complement their financing through family contributions, fundraising, and municipal or institutional support, including funds from the Social Protection Board (*Junta de Protección Social*, JPS). The average monthly cost of subsidised residential care is estimated at CRC 658 928 (USD 1 305) per person, reaching CRC 804 285 (USD 1 593) in the private sector (Chaverri-Carvajal, 2025[44]).

- Day centres (*Centros Diurnos*) are community-based services providing daytime care for older adults who remain largely independent but face financial, social or functional vulnerability. These centres are primarily run by non-profit organisations and receive public funding to support service delivery. To access public financing, organisations must be accredited as Social Welfare Organisations (see Box 3.1), ensuring compliance with established organisational standards and quality requirements. CONAPAM provides monthly per-user subsidies ranging from CRC 80 000 to 105 000 (USD 158 to 208). Older adults who do not qualify for subsidised placed generally contribute out-of-pocket fees, which vary widely (from CRC 2 000 to 70 000 per month; USD 4 to 139); some centres accept voluntary contributions instead. The average monthly cost of care for an older person in a subsidised day centre is estimated at CRC 278 107 (USD 551), reaching CRC 436 000 (USD 863) in the private sector (Chaverri-Carvajal, 2025[44]). Out-of-pocket payments serve as a symbolic yet relevant contribution to the centre's budget (Medellín and Jara Maleš, 2019[52]; Chaverri-Carvajal, 2025[44]).
- The Care Network (*Red de Atención Progresiva para el Cuido Integral para la Persona Adulta Mayor* or *Red de Cuido*) is a key component of Costa Rica's LTC system, enabling local actors to deliver integrated social, health, and support services to older adults, particularly those in poverty, social vulnerability, or lacking family care. Established in 2011 as a public-interest initiative, it operates as a community-based, government-supported model[6] that relies on the engagement of municipalities, NGOs and other local organisations. Co-ordination between central and local government operates through a framework where CONAPAM assigns a four-person professional team specifically dedicated to promoting and strengthening the formation of local care committees in priority communities, providing training on implementing different care alternatives, and participating in programme evaluation (FODESAF, n.d.[57]). Setting up the Network requires a Social Welfare Organisation (see Box 3.1) and/or a Local Government authority that is formally accredited to manage public funds for services for older persons; and the creation of a community committee or network. This typically includes representatives of NGOs, public institutions (e.g. the CCSS, the Ministry of Health, and the Mixed Institute for Social Assistance), the municipal government, community leaders, and older persons. While all networks operate within CONAPAM's framework and public funding regulations, organisational arrangements vary across communities. Services include home and community care, assistance with daily living, social and emotional support, recreational activities, and access to residential care when needed. Yet, overall coverage remains uneven across regions, reflecting differences in local capacity, institutional engagement, and community participation (Chaverri-Carvajal, 2025[44]; Jara Maleš, Matus-López and Chaverri-Carvajal, 2020[58]; CONAPAM, n.d.[56]). As of 2022, roughly 80% of community Care Networks were run by private non-profit organisations, with municipalities overseeing the rest. Both types of providers receive public financing channelled through CONAPAM (Rivera Meza, 2023[59]).
  - The Home Care Network (*Red de Atención Domiciliar*) operated by ASCATE (*Asociación Cartaginesa de Atención a Ciudadanos de la Tercera Edad*) in Cartago province provides an

[6] The Care Network is embedded within CONAPAM's budgetary programme 'Building Bonds of Solidarity' (*Construyendo Lazos de Solidaridad*).

example of how the Care Network functions in practice. Founded in 2011 with 17 beneficiaries, the programme expanded to serve 357 older adults by 2019, providing monthly assistance including basic food supplies, incontinence products, medications not covered by the CCSS, care subsidies, housing rent support, and technical aids. The network operates through an Inter-institutional Support Commission comprising representatives from ASCATE, IMAS, the Municipality of Cartago, CCSS, the Ministry of Health, the Technological Institute, the Cantonal Sports Committee, and community representatives, with funding channelled through CONAPAM. Eligibility requires beneficiaries to be 65 years or older, living in poverty or extreme poverty, and demonstrate through socioeconomic assessment that their resources are insufficient to meet their needs. Despite demonstrated demand (with 400 people on the waiting list) the programme faces resource constraints that limit expansion (ASCATE, n.d.[60]).

According to the latest annual monitoring report, CONAPAM provided support to 17 980 older persons in 2022, operating with a budget of CRC 21 billion (USD 41.6 million) (CONAPAM, 2023[61]).

In addition to publicly supported provision, home-based care services are also available on a private basis, either through independent care workers or specialised companies. Cost estimates by Chaverri-Carvajal (2025[44]) indicate that independent carers charge on average CRC 200 000 (USD 396) per month for five hours of daily support, five days a week. Comparable services delivered by specialised companies are estimated to cost around CRC 400 000 (USD 792) per month.

Box 3.1. Social Welfare Organisations

All organisations serving older adults in Costa Rica are private entities operating under authorisation from the Ministry of Health and the respective municipality, with some seeking certification from IMAS as Social Welfare Organisations (*Organizaciones de Bienestar Social* – OBS). Once certified and having established an agreement with IMAS, these OBS can receive public funds administered by CONAPAM to subsidise care for older persons in poverty and extreme poverty (CONAPAM, n.d.[62]). Quality monitoring and accountability mechanisms are rigorous: OBS must submit liquidation reports of transferred resources each year, and supporting documents are reviewed at 100% to verify proper liquidation (FODESAF, n.d.[57]).

IDB-supported actions (see below) are expected to support the approval of a National Oversight Plan for OBS dedicated to the care of the elderly, which will allow for the identification of shortcomings and the introduction of corrective measures to improve the quality of care provided by these organisations (IDB, 2025[63]).

Source: CONAPAM (n.d.[62]), FODESAF (n.d.[57]) and IDB (2025[63]).

Ongoing and planned changes in the context of the National Care Policy and SINCA

Costa Rica undertook a major institutional reform in LTC with the creation of the SINCA under Law 10192 in 2022. Building on the existing offer, SINCA aims to optimise the use of resources, co-ordinate public and private care provision, and ensure equitable access to services for adults and older persons in situations of dependency. The system embodies principles of universality, non-discrimination, and progressive implementation, prioritising service provision according to severity of dependency while promoting home-based care over institutionalisation. It also recognises the essential role of unpaid caregivers, offering opportunities for training, social recognition, and labour market integration.

The suite of services under SINCA

SINCA comprises a set of care modalities (home care, residential care, day care, tele- or remote care, and community support networks) as well as monetary transfers for home-based caregivers and professional training programmes. Care delivery is articulated through a 'Base Model' outlining a phased expansion of modalities to address severe and moderate dependency (Box 3.2) (IMAS and MDHIS, 2021[51]; Chaverri-Carvajal and Matus-López, 2021[64]; Chaverri-Carvajal and Obando Viquez, 2023[48]):

- Residential care remains the most resource-intensive component, primarily for individuals with the highest levels of dependency. Residential facilities are operated by non-profit and for-profit organisations accredited by the Ministry of Health which, under SINCA, was assigned responsibility of developing and verifying quality standards[7]. Unit cost estimates reported in the National Care Policy 2021-31 (IMAS and MDHIS, 2021[51]) range from CRC 456 760 (USD 904) to CRC 822 717 (USD 1 629) per month.
- Home-based care is designed to support 80% of individuals with severe dependency. Services are delivered by workers who have completed the LTC assistant training provided by the National Learning Institute (INA). Care workers may operate independently after registering with the National Employment Programme (PRONAE) of the Ministry of Labour and Social Security (MTSS) or may be employed by non-profit or for-profit agencies accredited by the Ministry of Health. Unit cost estimates reported in the National Care Policy 2021-31 (IMAS and MDHIS, 2021[51]) range from CRC 119 048 (USD 236) to CRC 175 571 (USD 348) per month.
- Day-care centres complement home care and are expected to target 10% of home care and tele-assistance users. They are operated by municipal public providers and accredited private organisations. Unit cost estimates reported in the National Care Policy 2021-31 (IMAS and MDHIS, 2021[51]) range from CRC 92 000 (USD 182) to CRC 145 914 (USD 289) per month.
- Tele-assistance offers remote monitoring and guidance, enabling individuals to remain in their home environment while providing caregivers with professional support. This new service modality targets all individuals with severe dependency and 70% of those with moderate dependency. The service is provided by non-/for-profit accredited agencies, paid by the CCSS. Implementation is led by the Ministry of Science, Innovation, Technology, and Telecommunications (MICITT) in collaboration with the National Communications Fund (FONATEL). A pilot initiative was launched in 2024 in the Municipality of Heredia.
- Community-based support networks. Community networks form the local implementation arm of SINCA, building on Costa Rica's long-standing *Red de Cuido*.
- Monetary transfers for family caregivers: This monthly cash benefit of USD 184, administered by IMAS, recognises the economic value of unpaid care work and provides income support to family caregivers – predominantly women – of persons with severe dependency. The benefit is provided when (i) the dependent person qualifies for home-care assistance; (ii) the caregiver has no feasible options to participate in the labour market; and (iii) the household is in a situation of extreme poverty. The monthly transfers are part of IMAS' social protection portfolio and targets households identified through the dependency assessment scale (Box 3.2).

Although SINCA is formally defined as a universal system, in practice its operational design prioritises individuals with the highest levels of dependency, and it currently does not offer specific services for people with low levels of dependency. As a result, effective coverage is narrower than in countries where LTC systems extend more broadly across all levels of dependency (Chaverri-Carvajal, 2025[44]).

[7] In 2012, Costa Rica introduced formal regulations defining the indicators and procedures used to authorise and assess LTC facilities (Wachholz et al., 2024[107]).

Box 3.2. Costa Rica's Dependency Assessment Scale

Costa Rica's Dependency Assessment Scale (*Baremo de Valoración de la Dependencia*), formalised within the National Care Policy 2021–31, provides a structured method for assessing the care needs of individuals with limited autonomy. Dependency is defined as a persistent reduction in physical, mental, intellectual, or sensory capacity that prevents a person from performing basic activities of daily living independently. The scale evaluates the individual's ability to carry out a wide range of tasks, considering the level of performance, the type of support required, and the frequency of assistance needed.

The tool covers 68 tasks grouped into 13 core daily activities: eating and drinking; urination and defecation; personal hygiene; other bodily care; dressing; managing health; changing and maintaining body position; moving within the home; moving outside the home; performing domestic tasks; participating in social and community life; communication; decision-making and managing daily life decisions. Dependency is classified into four levels: no dependency, low, moderate, and severe. By assigning a score from 0 to 100, the tool offers a comprehensive perspective on an individual's support needs. The methodology is designed to provide objective and consistent assessments, reducing subjective interpretation by evaluators and ensuring equitable allocation of services under SINCA.

The tool also incorporates adjustments for decision-making capacity and community autonomy, reflecting the principles of the UN Convention on the Rights of Persons with Disabilities. This ensures that assessments not only capture functional limitations but also promote social inclusion, guiding the prioritisation of services for those most in need.

Source: IMAS and MDHIS (2021[51]) and IMAS (n.d.[65]).

Governance of SINCA

Governance of SINCA is highly inter-institutional. The system is overseen by a Technical Secretariat, housed within the IMAS, which is responsible for the technical, administrative and operational co-ordination of SINCA. This Secretariat leads inter-institutional articulation, designs and monitors care policies and programmes under the system and ensures coherence between the many actors involved. Governance also relies on an Interinstitutional Technical Commission, which brings together the key public bodies responsible for implementing and co-ordinating SINCA: the Mixed Institute for Social Assistance (IMAS, as chair); the National Palliative Care Council of the Ministry of Health; the Ministry of Public Education (MEP); the Social Protection Board (JPS); the Ministry of Labour and Social Security (MTSS); the Costa Rican Social Security Fund (CCSS); the National Council for Persons with Disabilities (CONAPDIS); the National Council for Older Persons (CONAPAM); the National Learning Institute (INA); the Institute for Municipal Development and Advisory Services (IFAM); and the National Information and Single Registry of State Beneficiaries System (SINIRUBE).

The law explicitly assigns responsibilities to several key institutions. IMAS serves as SINCA's co-ordinating body and implements the National Care Policy. CONAPAM contributes actions for the care and protection of older persons, while CONAPDIS oversees the inclusion and rights of persons with disabilities. The CCSS provides health and social-care services and co-ordinates health-related support needs. The MTSS is responsible for labour-market measures related to caregivers and the organisation of the care workforce, and the INA leads training and skills development for formal caregivers. INAMU intervenes in situations involving gender-based violence or abandonment affecting dependent persons or their caregivers. In addition, SINCA may engage a broader ecosystem of private providers, NGOs and organisations of the social economy, which may deliver care through public-private or public-social arrangements. SINCA relies on the SINIRUBE which centralises socioeconomic information and enables co-ordinated decision-making

across institutions (see below) (Asamblea Legislativa de la República de Costa Rica, 2022[66]). Regional implementation is supported by the Regional Intersectoral Committees of the social area (*Comités Intersectoriales Regionales*)[8], which were established in 2021 as co-ordination platforms for social policies. Under SINCA, these councils have been tasked with articulating regional needs related to care coverage and the adequacy of benefits, supporting implementation across regions (Chaverri-Carvajal and Obando Viquez, 2023[48]; IMAS and MDHIS, 2021[51]).

LTC financing

The main sources of funding of LTC

In Costa Rica, LTC is funded primarily through general taxation, with the National Care System (SINCA) introducing the additional use of co-payments (Chaverri-Carvajal and Obando Viquez, 2023[48]).

General government revenues and payroll contributions support a broad set of social programmes, including allocations from the Social Protection Board (*Junta de Protección Social*, JPS) which reinvests lottery and gaming surpluses in programmes that finance the basic needs of residents in LTC facilities. The JPS also collaborates with CONAPAM to fund Social Welfare Organisation (see Box 3.1) and community-based initiatives, among others (Medellín and Jara Maleš, 2019[52]).

A significant portion of LTC financing flows through CONAPAM, whose main source of revenue is the Social Development and Family Allowances Fund (FODESAF). FODESAF is legally required to allocate 2% of its total resources to CONAPAM (Law 5662) and is funded primarily by general taxes and a 5% payroll contribution. CONAPAM also receives 31% of revenues from taxes on cigarettes and alcoholic beverages (Law 7972) – transferred to certified Social Welfare Organisations and local governments to provide LTC, prioritising older adults in poverty or vulnerability (Medellín and Jara Maleš, 2019[52]).

Together, these funding streams provide the backbone of Costa Rica's LTC system, showing fragmentation across sectoral budgets, with no dedicated budget identifiers to track caregiving spending or to assess how much funding effectively reaches dependent persons. The absence of a comprehensive methodology to map care-related services and benefits limits the ability to precisely estimate coverage gaps. Available research nonetheless shows that coverage gaps and geographic disparities are sizeable (Chaverri-Carvajal, 2025[44]); only around 20% of older adults with functional dependence receive publicly funded LTC services (Aranco et al., 2022[46]), while families continue to shoulder much of the care burden. Given SINCA's reliance on spending decisions by multiple institutions, limited budget monitoring and financial reporting further constrain oversight. Moreover, the commitments set out in the National Care Policy Action Plans are not yet subject to systematic monitoring or evaluation (IDB, 2025[63]). Reflecting these challenges, the Inter-American Development Bank (IDB) identified budget management as a key reform area for SINCA, highlighting the need to strengthen the role of the inter-institutional technical commission to ensure that all institutions financing or delivering care services systematically reflect these expenditures in the national budget (IDB, 2025[63]).

The implementation of SINCA and prospects for the financing of LTC

Costa Rica began the implementation of SINCA-related services by allocating around 0.1% of GDP to social LTC (Chaverri-Carvajal and Obando Viquez, 2023[48]). Yet, projections presented in the National Care Policy 2021–31 estimate that fully implementing this model would require resources equivalent to 0.48% of 2018 GDP (IMAS and MDHIS, 2021[51]). Cost projections for 2024 estimate total expenditure at

[8] See https://www.mideplan.go.cr/gobernanza-regional-local and IMAS (2024[109]); referred to as 'Consejos Intersectoriales Regionales (CIR Social)' in IMAS and MDHIS (2021[51]).

approximately range between CRC 164 billion (USD 324.7 million; 0.3% of GDP) and CRC 254.8 billion (USD 504.5 million; 0.5% of GDP), rising to 0.33%-0.81% of GDP by 2040 (Chaverri-Carvajal, 2025[44]).

SINCA is designed to operate without creating or increasing taxes, with the initial investment financed through budget reallocations (Chaverri-Carvajal and Matus-López, 2021[64]). Although income-based co-payments are foreseen, no implementation details or rates are available yet. The limited funding base hinders coverage expansion and financial sustainability, and suggests that the system will require a more diversified funding model to respond to future increases in demand (Consejo Nacional de Rectores, 2025[41]; Chaverri-Carvajal, 2025[44]). This underscores the importance of consolidating SINCA as a long-term policy, while progressively diversifying financing sources and prioritising resources toward territories and population groups with higher concentration of older persons. Financing solutions may include targeted social contributions, progressive user co-payments, taxes on high-value consumption, and more effective articulation of public and private service provision (Chaverri-Carvajal, 2025[44]; Pacheco Jiménez, 2021[67]; Consejo Nacional de Rectores, 2025[41]; OECD, 2025[68]). Bill 23.719, under discussion in the Legislative Assembly, aims to strengthen the country's care economy by introducing incentives for private care providers and creating clearer mechanisms for public-private co-operation in the provision of care services, but no further information is available on the outcomes of the discussions.

The IDB recently approved a USD 250 million loan to support the strengthening and consolidation of SINCA. The programme focuses on improving the targeting, governance, and digital infrastructure of care services for dependent adults and their caregivers. Under this loan, Costa Rica aims to advance several core reforms: the development of a new targeting model that integrates poverty criteria with functional dependency assessments to determine eligibility for social benefits; the introduction of collaborative budgeting mechanisms of SINCA entities to better estimate and plan the investment needs of the care sector; the creation of a national dependency assessment system, interoperable with the National Information and Single Registry of State Beneficiaries (SINIRUBE), to standardise evaluations across institutions; and the deployment of new digital platforms, including a Self-Care Hub and a unified national care-services portal, to facilitate access, co-ordination, and service management. The project is expected to benefit around 160 000 adults with functional dependency, and around 170 000 caregivers – including 140 000 unpaid and 30 000 paid caregivers (IDB, 2025[69]; 2025[63]; Ministry of Finance, 2025[70]).

3.4 Costa Rica's workforce is still largely informal

Costa Rica's LTC workforce consists of a large base of unpaid family caregivers and a smaller group of trained formal workers. Around 214 000 people provide unpaid care – 163 000 within the household and 51 000 outside it (Stampini et al., 2025[40]); in both cases, most of them are women. Around 85% of older adults with dependency receive support from someone in their household, while 15% do not receive any help despite needing assistance (Jara Maleš, Matus-López and Chaverri-Carvajal, 2020[58]).

The formal LTC workforce remains comparatively small. Recent estimates point to 4 778 paid institutional caregivers, 5 044 home-care workers and a further 10 295 domestic workers with care responsibilities, for a total of 20 117 paid caregivers, of whom 97% are women (Stampini et al., 2025[40]). These workers often face low social recognition, weak organisation and limited career pathways. The National Care Policy 2021-31 underlines the need to strengthen job quality, develop clear occupational profiles and improve training and certification systems (IMAS and MDHIS, 2021[51]). Costa Rica has introduced explicit labour regulations for LTC workers, including minimum wage provisions for home-care assistants – amounting to CRC 15 983.96 (USD 32) in 2024, with annual adjustments (from 2024 to 2025, a 2.37% increase) (Stampini et al., 2025[40]).

The National Care Policy 2021-31 explicitly identifies unpaid caregivers as a target population requiring support to combine care with labour-market participation and to access training, self-care resources and formal recognition (IMAS and MDHIS, 2021[51]). Its action plans include measures to promote co-

responsibility for care, expand home-based services, and create employment opportunities for women who provide care (see above) (Chaverri-Carvajal and Obando Viquez, 2023[48]). Awareness and information measures have been introduced to support caregivers. The IMAS campaign *Cuidate para Cuidar Bien*[9] ('Take care of yourself so you can take good care of others') provides guidance on self-care, respite services and available programmes – including the Cared-for Caregiver (*Cuidador Cuidado*) programme run by the CCSS and workshops on empowerment and self-esteem (Stampini et al., 2025[40]). A significant step towards formalisation is the establishment of *Cuidar.cr*, an official caregiver registry under SINCA (see below). In addition, the CCSS is expected to promote social-security insurance for paid caregivers (Chaverri-Carvajal and Obando Viquez, 2023[48]).

Training and professionalisation of the LTC workforce have advanced in recent years, combining competency frameworks, occupational profiles and formal training requirements. The Ministry of Public Education has developed the Qualifications Framework for Comprehensive Care for Older People, which feeds into Costa Rica's broader National Qualifications Framework and defines the competencies and tasks associated with roles such as *home assistants for older persons* (responsible for administering medications, monitoring health conditions and supporting activities of daily living in private homes) and *nursing professionals in comprehensive care services for older people* (ILO, 2024[71]; Stampini et al., 2025[40]). Formal training is mandatory for employment in accredited LTC institutions. The National Learning Institute (INA) offers the core 700-hour programme 'Comprehensive care for older persons', which remains the principal qualification required for personal care workers (Stampini et al., 2025[40]). The National Employment Programme (PRONAE) has also piloted training for the 'Technical Assistant in Comprehensive Care for Older Adults', further diversifying the supply of qualified workers (IMAS, 2022[72]).

Quality assurance measures complement Costa Rica's efforts to professionalise the LTC workforce. In 2024, Executive Decree No. 44730-S updated the Standard for Authorising Long-Stay Homes for the Comprehensive Care of Older People, strengthening requirements on staff qualifications, staffing ratios, and infrastructure and safety conditions in residential facilities (Stampini et al., 2025[40]).

3.5 Costa Rica is improving its Information systems and data integration

SINIRUBE

Costa Rica is making advances in building an integrated information architecture for LTC, centred on the National Information and Single Registry of State Beneficiaries (*Sistema Nacional de Información y Registro Único de Beneficiarios del Estado* – SINIRUBE). Created in 2013, SINIRUBE provides a harmonised socio-economic database of individuals benefitting of social services and is used to support beneficiary identification, prioritisation and an equitable access to services.

Under SINCA, SINIRUBE is being expanded to incorporate information on dependency and care needs. The SINCA legislation establishes mandates for institutions participating in the care system to transfer and consolidate information on beneficiaries and care benefits into SINIRUBE, within defined implementation timelines, reinforcing its role as the core information platform for LTC. Such developments are part of the consolidation of SINIRUBE as the main platform for information exchange among institutions involved in LTC, aligning with SINCA's objective of improving interoperability across the health, social protection and care sectors.

The National Care Policy 2021-31 and action plans (2021-23 and 2024-26) foresee the integration into SINIRUBE of the *Scale of Assessment of Dependency and Intensity of Support* (Box 3.2). This will allow dependency assessments to be centralised and used to refer eligible persons to appropriate SINCA

[9] www.imas.go.cr/cuidateparacuidarbien

services (Chaverri-Carvajal and Obando Viquez, 2023[48]). Key measures to strengthen LTC data generation and integration include (Chaverri-Carvajal, 2025[44]):

- Developing a national statistical system on dependency, with periodic estimates of prevalence and characteristics of dependent persons and unpaid caregivers.
- Creating an interoperability module linking SINIRUBE with the CCSS electronic medical record system (EDUS), IMAS's eligibility information system (SICID), and other social-programme databases to support co-ordinated service delivery.
- Improving the availability of care-relevant information accessible to all institutions participating in SINCA, including local governments and accredited providers.
- Incorporating a poverty line adjusted for dependency, which reflects the additional costs faced by households providing or requiring care.

Cuidar.cr

Complementing these efforts, in October 2024, IMAS launched Cuidar.cr, a digital platform designed to strengthen co-ordination within SINCA. Developed with financial support from the IDB (see above) and formalised through Decree 44763-MIDHIS-MTSS, the platform connects people in dependency with public, private and non-profit care providers and offers an integrated directory of services. Cuidar.cr also provides information on SINCA services, training opportunities and a self-care toolkit for caregivers.

A core feature of the platform is the registration of formal and informal caregivers, who can upload their qualifications, experience, availability and geographic coverage. Registered caregivers receive a digital credential (Cuidar+), which aims to enhance professional recognition and may facilitate preferential access to selected public services. By increasing visibility of workers' skills and improving matching between care supply and demand, the platform is expected to strengthen employability and support the professionalisation of care work (Consejo Nacional de Rectores, 2025[41]).

4 Multiple funders and care providers managed by different levels of government in France

4.1 One in ten people will be aged 80 and over in France in 2050

In France, the share of the population aged 65 and over is projected to continue increasing in the coming decades, rising from 21.8 % in 2023 to 27.4 % in 2050 (OECD, 2025[11]). The increase has been particularly rapid among people aged 80 and over. Between 2023 and 2050, the share of the population aged 80 and over is projected to almost double – from 6.1 % to 11 %. More than one third of individuals aged 65 and over leave alone (INSEE, 2019[73])).

In 2021, more than 2 million people aged 60 years and over were experiencing a loss of autonomy and, among them, 670 000 had a severe loss of autonomy. If recent trends continue, the number of people aged 60 years and over experiencing a loss of autonomy will peak in 2052 at 2.8 million people, representing an average annual increase of 1 % and an overall increase of 36 %. Severe loss of autonomy is projected to increase even more rapidly. There will be an additional 300 000 seniors experiencing severe loss of autonomy between 2021 and the early 2050s, reflecting an average annual increase of 1.2% and an overall increase of 45 % (Dufeutrelle and Louvel, 2025[74]).

4.2 France has a public institution to manage the autonomy branch of social security

The fifth branch of Social Security dedicated to “autonomy”, in addition to the first four (family, sickness, work-related accidents/illnesses and retirement), was established by law in August 2020. It is managed by the National Solidarity Fund for Autonomy (*Caisse Nationale de Solidarité pour l’Autonomie*, CNSA), a public institution created by law in 2004, to secure the financing of autonomy support and services, and strengthen equitable access to autonomy support and services for older persons and people with disabilities. The CNSA is fully integrated into the general French social security system, while constituting a specific branch, and does not fall under an autonomous system.

The funding of the autonomy branch is set by the Social Security Financing Bill (PLFSS) - presented and voted for each year -, which sets the national health insurance expenditure target (ONDAM) in the context of the state budget.

The funding allocated to the CNSA through the PLFSS is mainly based on:

- the additional solidarity contribution for autonomy, which is levied on the amount of certain old-age and disability benefits paid to people domiciled in France. Taxable retirees contribute 0.3% of their retirement pension;

- the "activity" portion of the solidarity contribution for autonomy, which is due as part of the solidarity day, an additional day of unpaid work for employees;
- a portion of the general social contribution, a tax levied on earned income, replacement income (e.g., retirement pension, unemployment benefit), income from assets and investment.

To carry out its work, CNSA relies on its main partners: the regional health agencies (ARS) and the departmental councils (Box 4.1). To strengthen the branch's territorial governance, the CNSA Council adopted a tripartite agreement framework intended to be the operational framework for cooperation in each department for the period 2025-2028. This agreement allows for the establishment of common objectives for the various stakeholders to support the pathways of people with disabilities and the older people by closely involving their representatives. It will allow for the specificities of each territory to be considered.

Box 4.1. France has responsibilities split between regional health agencies and departments

Regional health agencies and departments both have competencies in the areas of LTC.

Regional agencies co-ordinate activities and allocate operating budgets for hospitals, clinics, care centers, and facilities for older people, people with disability, and dependent persons. They are public institutions, morally and financially autonomous, under the supervision of the ministries responsible for social affairs and health. They have two main missions: steering public health policy and regulating regional health care provision. The steering of regional public health policy encompasses three areas of intervention: health monitoring and security; the definition, financing, and evaluation of health prevention and promotion actions; the anticipation, preparation, and management of health crises, in liaison with the prefect.

Regulation of regional health care provision aims to better meet the needs of the population and ensure the efficiency of the health system. It covers the outpatient (general practitioner), medico-social (aid and support for the older people and disabled), and hospital sectors. Regulation is implemented in the agency's various areas of responsibility, including:

- Authorizing the creation of healthcare and medico-social facilities and services, monitoring their operation, and allocating their resources.
- Defining and implementing, with health insurance organizations and the CNSA, actions to prevent and manage health insurance risks in the region.
- Evaluating and promoting the quality of healthcare professional training. Improve the health of the population and increase the efficiency of the healthcare system.

Regional health agencies play a structuring role in planning care supply through regional health projects, a key element of territorial coordination.

The allocation of LTC benefits is primarily the responsibility of the departments. This authority, defined by decentralization laws, is transcribed in the Social Action and Families Code (CASF) and implemented through departmental plans (in particular, plans for autonomy and solidarity). There are 95 departments in metropolitan France, with 800 000 inhabitants on average. Social policy expenditures represent 70% of the departments' operating budget in the following areas:

- the fight against exclusion and poverty, primarily through the Active Solidarity Income
- assistance for older people, primarily through APA
- child welfare assistance
- assistance for people with disabilities.

With 41 billion Euro allocated to social action, the departments provide 4.5 million social benefits, covering 6.4% of the French population.

Source: Authors' compilation

In 2025, CNSA allocated 17.3 billion Euro to ARS to finance LTC services – both residential and home-based - aimed at supporting the autonomy of older people, and 2.9 billion Euro to Departments to finance

LTC benefits - APA for the older persons. Departments[10] financed APA with additional 3.8 billion Euro (57% of the total APA envelop).

Notwithstanding government support, out-of-pocket spending is estimated to represent 40% of median income for individuals with moderate needs and more than 100% for those with severe needs receiving public services and support at home (OECD, 2024[75]).

4.3 France has a large offer of residential care and a well-developed cash-for-care benefit scheme

There are two types of residential care facilities for older persons: those which provide medical or nursing care, personal care, assistance services and other social care services, and those that provide only personal care, assistance services and other social care services. At the end of 2023, more than 756 000 places were available in those facilities (Table 4.1). The distribution of this capacity is very heterogeneous across territories, which justifies a differentiated approach and reinforces the role of local coordination.

For older persons who need long-term medical care as well as personal and social care services, there are two types of providers: residential nursing homes and LTC departments in hospitals.

Residential nursing homes (*Etablissements d'hébergements pour personnes âgées dépendants*, EHPAD) give shelter to older persons (over 60 years old) who need regular care and medical surveillance as well as assistance to perform activities of daily living (ADL). This is the most common form of residential care for older persons, with around 610 000 places – of which 48 % in public facilities - in 2023. Care providers in nursing homes are mostly paramedical staff (certified nursing assistants and practicing nurses), working usually with a part-time physician and sometimes with a psychologist. LTC departments in hospitals (*Unité de soins de longue durée*, USLD) function like nursing homes in a hospital setting. There were 29 000 available beds in 2023.

Non-medical residential care facilities provide only personal and/or social services. The most common facilities are social residences (*residences autonomie*), which are regulated and partly funded by departments. These are residential facilities where older people live in their own apartments and share common amenities. Older people who live in these facilities are relatively independent to perform their own personal care, but they would need help with performing instrumental activities of daily living (IADL) such as laundry, meals, social and recreational activities. There were 112 000 places available in non-medical residential care facilities, of which almost two thirds in public facilities. Like social residences, *Etablissements d'hébergements pour personnes âgées,* EHPA welcome almost independent older people.

Table 4.1. Residential care capacity and ownership at end 2023

Type of facility	Number of facilities	Number of places	% of places in public facilities
Residential nursing homes (EHPAD)	7400	609970	48
LTC departments in hospitals (USLD)	560	29030	
Residential homes (EHPA)	230	5370	17.7
Social residences (*Residence autonomie*)	2180	112000	65.3
Total	10380	756370	

Source: (DREES, 2025[76]).

The main LTC benefit is the personalized autonomy allowance (*Allocation personnalisée d'autonomie*, APA). This is a cash-for-care scheme that is managed and, mostly, financed by departments. APA is paid to any person aged 60 and over who needs assistance to accomplish everyday activities or needs to be

[10] Direct and indirect taxes represent three quarters of departmental revenues, the most important be a fraction of value added tax, the tax on property transactions and the tax on insurance contracts.

continuously surveyed (individuals with an assigned GIR 1 to 4, Box 4.2). The allowance can be received at home or in residential institutions, and the amount depends on the level of dependency measured by a national scale.

In 2023, more than 815 000 people aged 60 years or more – 43.8 per 1 000 inhabitants aged 60 years or more - benefited from this program while leaving at home, for a total spending of 4.3 billion Euro.

Furthermore, departments can provide benefits (*aide ménagère à domicilie*) to people who do not qualify to receive the APA but still have some needs. This benefit finances the services of a home helper and is provided based on income. To qualify for home help, the individual must be at least 65 years old (or 60 years old for people recognized as unfit for work), have difficulty performing basic household tasks, not receive the APA, have monthly income of less than 1 034 Euro for a single person and 1 605 Euro for a couple (in 2025). In 2023, only 18 360 people benefitted from this assistance, for a total spending of 68 million Euro.

The housing benefit (Aide sociale à l'hébergement, ASH) for older people covers all or part of the accommodation costs. ASH can also pay family carers. Older people living in private homes or in a facility (public or private in the medico-social or health sector) may - depending on their resources - benefit from ASH paid by departments.

Departmental home help (*aide ménagère à domicilie)* and housing benefits (*Aide sociale à l'hébergement*) play a more targeted role and remain of more limited use.

Box 4.2. The AGGIR grid and the GIR categories

The AGGIR (Gerontological Autonomy and Iso-Resource Group) grid is used to assess a person's level of loss of autonomy: their GIR (Iso-Resource Group). It is used by the department's APA medical-social team when requesting APA at home, but also by pension fund assessors when requesting assistance for healthy aging, or by the co-ordinating physician in a nursing home. The person is assessed on 10 physical and mental activities, known as discriminating activities:

- Communicate verbally and/or non-verbally, act and behave in a logical and sensible manner
- Navigate time and space
- Wash oneself
- Dress and undress oneself
- Serve and eat oneself
- Maintain personal hygiene
- Get up, lie down, and sit down
- Move around within one's living environment
- Move around outside one's living environment
- Ability to use the telephone and an alarm (to alert in case of need)

The applicant is assessed according to her/his ability to perform these 10 activities: performs the activities alone (fully, habitually, and correctly); partially performs the activities (or not habitually or not correctly); does not perform the activities alone.

The results are used to assign one of six GIRs:

GIR 1, individuals confined to bed whose mental functions are severely impaired and who require the essential and continuous presence of caregivers

GIR 2, individuals who are confined to bed or a chair, whose mental functions are not totally impaired and who require assistance for most activities of daily living; individuals whose mental functions are impaired, but who have retained their ability to move around

GIR 3, individuals who have retained all or part of their mental autonomy, and some of their locomotor autonomy, but who require assistance daily and several times a day

GIR 4, individuals who cannot transfer themselves but who, once up, can move around inside their home; they sometimes require assistance with washing and dressing; most of them feed themselves. Individuals without locomotor problems who require assistance with physical activities and meals

GIR 5, individuals who move around their homes, feed themselves, and dress themselves. They may need occasional assistance with washing and household activities (e.g., meal preparation, cleaning)

GIR 6, individuals who are independent in all activities of daily living. They may need occasional assistance with household activities

Seven domestic and social activities, known as illustrative activities, provide additional information to better understand the older person's overall situation to support the development of the elderly person's care plan:

- Prepare meals and package them so they can be served

- Manage one's affairs, budget, and possessions, recognize the monetary value of coins and bills, use money, and know the value of belongings, carry out administrative procedures, complete forms
- Perform all routine household chores
- Voluntarily use public or private transportation
- Voluntarily purchase goods
- Follow a doctor's prescription and self-manage their own treatment
- Voluntarily engage in various leisure activities, alone or in a group

Source: Authors' compilation

4.4 There is on-going work to implement a computerised user file for LTC in France

From May to July 2020, the *Ségur de la Santé* brought together all stakeholders in the healthcare system for a consultation aimed at improving care organisation and remuneration. In addition to resources dedicated to improving the status of healthcare professions, a massive 6 billion Euro investment plan was launched, including 2 billion Euro allocated to support the large-scale and coherent development of digital infrastructure in health. This investment aims to accelerate the modernization, interoperability, convergence, and security of healthcare information systems. The ambition is to generalize the seamless and secure sharing of health data between professionals and users, for better prevention and treatment.

In its application to the social and medico-social sector, the *Ségur Numérique* mobilizes 600 million Euro from 2021 to 2025, funds from the National Recovery and Resilience Plan (PNRR) by the European Union. These funds will accelerate the momentum initiated in 2021 by the CNSA with the initial phase of the 30 million Euro Digital Social and Medico-Social Establishments and Services (*Etablissements et Services Sociaux et Médico-Sociaux*, ESSMS) programme. The Digital ESSMS program aims to generalize the effective use of a computerized user file (*dossier usager informatisé*, DUI) in ESSMS for everyone receiving support and services. The DUI is the tool that allows for the collection of all the necessary data and professional documentation to document an individual's needs, thereby facilitating the design, implementation, and evaluation of personalized support plans. This digital transformation program is based on close, on-the-ground management by the ARSs. They assess, select, and monitor projects, and ultimately validate the steps required to process payments to project leaders. The program's objective by the end of 2025 is to have engaged approximately 36 000 ESSMS, funded through around 1 400 projects. Led by the CNSA in conjunction with the Ministerial Delegation for Digital Health, the Digital ESSMS programme is part of the national digital health strategy, which focuses on modernizing healthcare management and supporting vulnerable individuals.

The generalization of digital tools, in particular the computerized user file, remains gradual and marked by still heterogeneous uses, which currently limits their full potential in terms of co-ordination.

In addition to the Digital ESSMS, CNSA manages three data platforms:

- ESMS Pricing is a web-based data entry platform for prices and tariffs of EHPADs and independent living residences.
- The SI-APA is the information system that will equip all departmental teams responsible for managing the APA at home and will allow seniors to submit their applications.

- SIDOBA (*système d'information de l'offre de la branche autonomie*) aims to enhance knowledge and management of the branch through data (e.g., financial, activities). SIDOBA is based on a technical platform designed to simplify and enrich data collection and centralization on the activity of home nursing care services (*services de soins infirmiers à domicile*, SSIADs), comprehensive home care and support services (*services polyvalents d'aide et de soins à domicile*, SPASADs) and EHPADs.

Finally, the regulation of Home Care Services (*Services Autonomie à Domicile*, SAD) sets the use of a single tool to track interventions carried out at the home of the person receiving support. This information resource can be used by all professionals involved in the person's care. When digital, it complies with the interoperability framework for health information systems. The service provider defines the rules for accessing the tool - which they own - according to the profile of each professional and by the person receiving support. Access to its content by the person receiving support is permitted, while access by the person's family and friends is subject to the person's consent[11].

4.5 France has also advanced in the support to informal caregivers

In October 2019, the French government introduced a comprehensive national strategy to support informal carers, called Agir pour les aidants 2020-2022. With a budget of 400 million EUR over three years, including 105 million EUR specifically for respite care, this initiative was the result of extensive consultations with caregivers, representative organisations and various stakeholders. In October 2023, the government launched a follow-up strategy for 2023-2027.

New measures proposed include the creation of a form of insurance for caregivers (*Assurance vieillesse des aidants*, AVA) and access for informal caregivers to certification for acquired experience (*Validation des Acquis de l'Expérience*, VAE). The AVA, part of France's 2023 pension reform, ensures the continuity of pension rights for those who stop or reduce their professional activity to care for a child, or an ill or disabled person (optional free insurance). The VAE procedure allows individuals to have their professional experience validated to obtain professional certification, regardless of their age, education level or status.

4.6 A new system in place to monitor quality of residential care providers in France

The quality scale for the ESSMS is a summary indicator of the level of quality achieved by a structure during its evaluation within the framework of the system managed by the French National Authority for Health (*Haute Autorité de Santé*, HAS). The evaluation by an independent organization translates into a publicly reported quality level between A and D, allowing the people receiving support, their families and professionals identify the degree of continuous quality improvement of the ESSMS. As of September 2025, the results of the evaluation of ESSMS are available in the public domain (https://www.has-sante.fr/jcms/c_1725555/fr/qualiscope).The quality scale is based on 4 classes:

A – Advanced: the ESSMS proactively commits, in continuous collaboration with professionals and the individuals they support, to developing adapted and personalized support methods according to the evolving needs of the individuals

[11] Décret n° 2023-608 du 13 juillet 2023 relatif aux services autonomie à domicile : Cahier des charges définissant les conditions techniques minimales d'organisation et de fonctionnement des services autonomie à domicile mentionnés à l'article L. 313-1-3 du code de l'action sociale et des familles.

B – Structured: the ESSMS develops, in conjunction with professionals and the individuals they support, structured and generally adapted support methods, but not systematically readjusted to evolving needs

C – Partial: the ESSMS has begun reflecting on the organization of support, with partially structured methods and an uneven impact on the quality of support provided to individuals

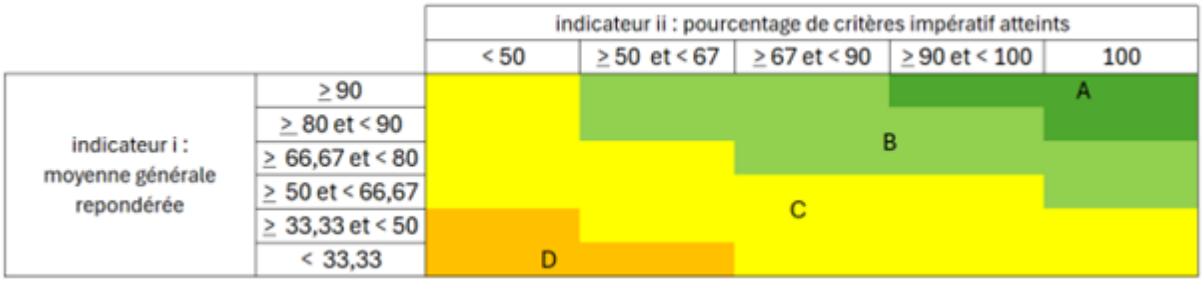
D – Insufficient: the ESSMS has not clearly defined the support methods, these are poorly or not at all followed by professionals, with a weak impact on the quality of support provided to individuals.

The evaluation is based on:

- standard criteria (129) and specific criteria (28) depending on the type of ESSMS, distributed across 42 objectives (*indicateur i)*
- mandatory criteria, which are considered essential and must be fully mastered by ESSMS (*indicateur ii)*. Depending on the type of establishment, the number of mandatory criteria varies from 16 to 18

A quality class is assigned to the ESSMS based on those two types of criteria (Figure 4.1).

Figure 4.1. Criteria for the positioning of social and medico-social establishments and services (ESSMS) on the quality scale



Source: (Haute Autorité de Santé, 2025[77])

The quality assessment mechanisms supported by the French National Authority for Health (*Haute Autorité de Santé)* represent a significant progress in terms of transparency and quality of care monitoring, even if their primary purpose is not to measure co-ordination between actors.

4.7 Recent changes in governance arrangements have strengthened care co-ordination in France

Departmental public service for autonomy (service public départemental de l'autonomie)

The law « *Batir la societe du bien vieillir et de l'autonomie* » (2024) establishes the "Departmental public service for autonomy", managed by the department in close co-ordination with ARSs, and with the involvement of all appropriate stakeholders. The creation of this departmental service aims to overcome the silos too often encountered by older people, people with disabilities, and their caregivers in the effective implementation of their rights. This "one-stop shop," officially launched in May 2024, is designed to simplify the user experience by facilitating pathways through the construction of a truly local public service that guarantees the same quality of service for all, regardless of the region or individual situation. The complexity inherent in public policies that contribute to people's autonomy must therefore be reduced and managed by organizations and professionals. The service aims to align the various stakeholders in the field, enabling them to work more effectively together to provide individuals with a comprehensive and co-

ordinated response. This ensures continuity of care, facilitates rapid and concrete access to solutions, and supports their independence in various areas of their lives (e.g., housing, health, education, employment, cultural life, leisure).

In each department, a Territorial conference on autonomy is responsible for:

- Co-ordinating the actions of the members of the departmental public service for autonomy. To this end, it develops an annual action plan that outlines, according to the needs of the territory, the resources and respective contributions of the members.
- Allocating funding, considering the guidelines defined by the national conference on autonomy, to prevent loss of autonomy and to support the development of inclusive housing.

To allocate funding, the territorial conference on autonomy meets as a commission called the “Commission of funders for the prevention of loss of autonomy.” The commission is chaired by the president of the departmental council or by the president of the local authority exercising the powers of the departments. The director general of the ARS serves as vice-chair. Based on an assessment of the needs of people aged 60 and over residing in the area and an inventory of local initiatives, the commission establishes a three-year plan defining priority funding areas. Each year, it defines a co-ordinated funding program for individual actions and prevention, respecting the priority areas defined in the three-year plan.

The program defined by this commission focuses on:

- Improving access to equipment and individual assistive devices that promote independent living at home through the establishment of rental platforms and the promotion of innovative purchasing and distribution methods;
- The allocation of APA;
- The co-ordination and support of prevention actions implemented by home-based support services for the older people;
- Support for initiatives to assist caregivers of older adults experiencing a loss of autonomy;
- The development of other collective prevention initiatives;
- The development of initiatives to combat social isolation among the older persons.

The Departmental council for citizenship and autonomy ensures the participation of older people and people with disabilities in the development and implementation of policies concerning autonomy within the department. It is responsible for preventing loss of autonomy, providing medical and social support, and ensuring access to healthcare and human or technical assistance. It is also responsible for accessibility, housing, shared living arrangements, urban planning, transportation, education, social and professional integration, and access to physical activity, leisure, community life, culture, and tourism.

Home Care Services (Services Autonomie à Domicile, SAD)

The home care sector has been restructured by consolidating existing services: Home Help and Support Services (SAAD), Home Nursing Services (SSIAD), and Multipurpose Home Help and Care Services (SPASAD) to form a single category of services, the Home Care Services (*Services Autonomie à Domicile*, SAD). The new SAD will:

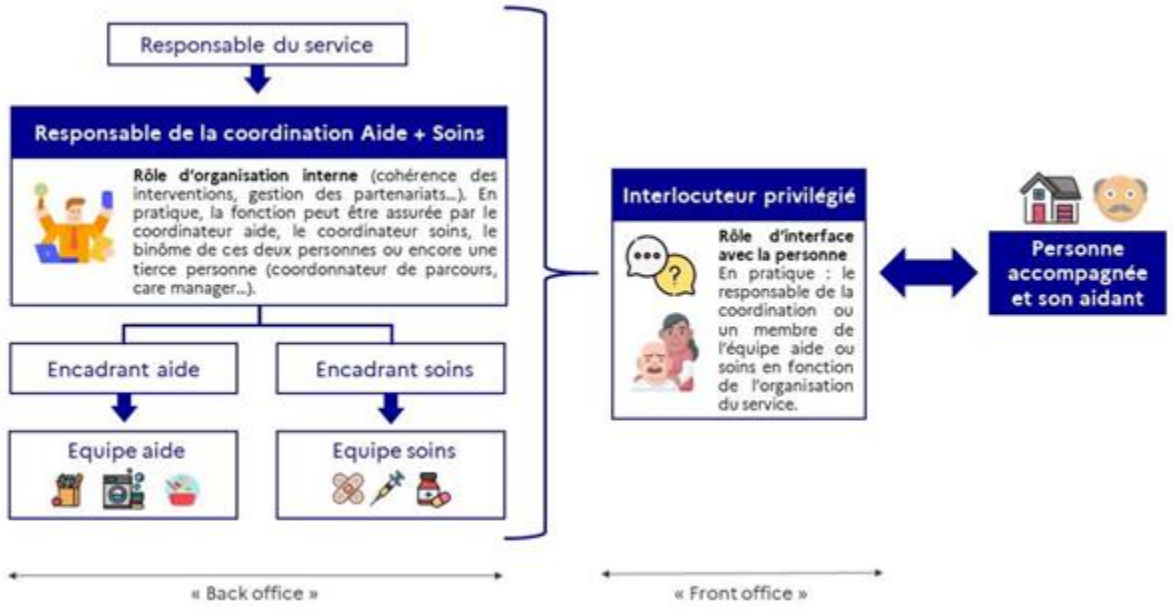
- Simplify daily procedures with a single point of contact responsible for organizing the response to individuals' assistance and care needs;
- Strengthen co-ordination between assistance and care professionals to improve the quality of support;
- A more comprehensive response to individuals' needs: prevention, identification of vulnerabilities, support for caregivers, and identification and combating abuse.

The new SADs will be divided into two different categories:

- "Mixed SADs", providing both assistance and care
- "Assistance SADs", providing only assistance

The new SADs should adopt an integrated approach when offering assistance and care services. In particular, the service must establish co-ordination between professionals by adapting its organization (Figure 4.2).

Figure 4.2. Integrated organisation model of "mixed SADs



Source: (Ministères chargés des affaires sociales, 2023[78]).

SADs providing assistance, support, and care services, like any social and medico-social establishment or service, are managed by a legal entity that holds an authorization issued jointly by the ARS and the departmental council. This legal entity may be an association, a public institution, a company, or a social or medico-social cooperative.

4.8 Recent changed in payment mechanisms in France incentivise care co-ordination

New payment mechanisms for EHPAD and USLDs

EHPADs and USLDs offer three types of services to their residents:

- Accommodation: meals (full board), room rental, maintenance of private and common areas
- Support: trained staff assist residents, for example, with assistance with washing and mobility
- Daily medical and paramedical care: healthcare staff – such as co-ordinating physicians, nurses, nursing assistants – is responsible for the daily medical care of residents, including distributing medications, applying dressings.

Each of these three services has a daily rate:

- an accommodation rate paid by the resident,
- a dependency rate paid by the resident, which may be partially covered by the department through APA,
- a care rate payable by Social Security

From July 1, 2025, to simplify the mechanism and reduce geographical inequalities, 23 departments experiment with a new payment mechanism based on a single comprehensive care and dependency rate set by ARS and paid by Social Security. Furthermore, there is a single flat-rate resident contribution (6.1 Euro per day), and the funding of APA in institutions by departments is discontinued. This pilot will be conducted over a period of 18 months, from July 1, 2025 to December 31, 2027.

These experiments are still in the preparatory stage and their effects on territorial equity and incentives for co-ordination will need to be thoroughly assessed.

New payment mechanisms for SSIAD and SAD mixte

"Home care" covers all nursing care:

- hygiene and comfort care, such as washing, provided in cases of loss of autonomy, which may be provided by nurses or nursing assistants under the supervision of a registered nurse
- and nursing procedures (e.g., dressings, injections)

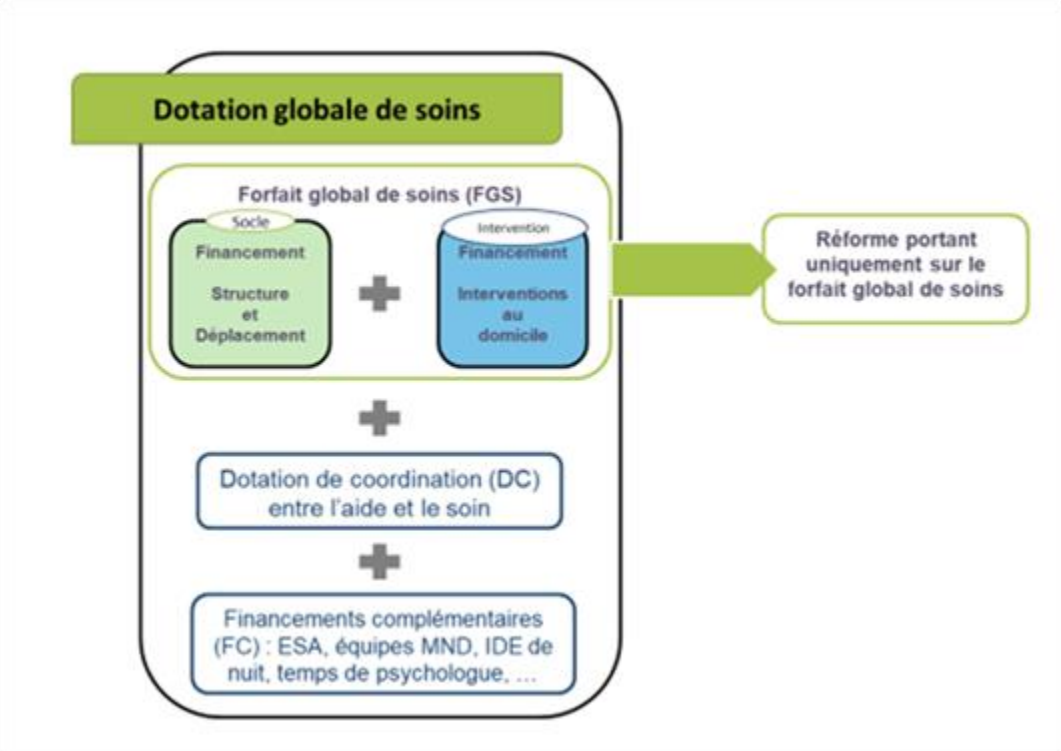
It is the attending physician or a hospital doctor (in the case of hospitalization) who determines whether the care the person requires qualifies as home care. If this is the case, a medical prescription will be issued. For this care, a beneficiary can use a home care service (*SAD mixte*) or a SSIAD (home nursing service), a nursing health center, a private nurse, or HAD (home hospitalization).

A reform of the payment mechanisms of SSIAD and SAD *mixte* (for the care component) came into force in 2023. Till then, the financing of those services was not adjusted based on the needs and characteristics of the non-self-sufficient individuals.

The reform is being implemented gradually between 2023 and 2027, when the overall care package will be fully calculated according to the new funding arrangements. A five-year convergence period is planned for the calculation of the overall care package so that each service gradually converges towards its "projected" overall care package. The overall funding for SSIADs and SAD *mixte* is composed of three components (Figure 4.3):

- the overall care package (*forfeit global de soins*, FGS)
- the co-ordination grant (*dotation de co-ordination*, DC)
- additional funding (*financements complémentaires*, FC)

Figure 4.3. New payment mechanism for SSIAD and mixed SADs



Source. Caisse Nationale de Solidarité pour l'Autonomie, CNSA Réforme du financement des SSIAD et des SAD mixtes | CNSA.fr.

The "basic" component (structure and travel) is calculated based on the number of authorized places as of December 31 of the year preceding the pricing (year N-1) and an annual "structure" flat rate. The amount of this flat rate is set annually by ministerial decree (8 751 Euro for 2025).

As for the "intervention" component, a weekly intervention flat rate (*forfeit intervention*, FI) is calculated for each user profile based on their characteristics – GIR, weekend and public holiday care, and nurse (*Infermier en soins généraux*, IDE) intervention. There are nine weekly intervention flat rates, the amounts of which are also determined annually by ministerial decree. Increases may apply to 4 of them (FI4, FI5, FI8 and FI9) in the following cases: GIR 3 and 1, simultaneous team care by several professionals such as nurses and nursing assistants (*prise en charge conjointe*, PECC), and intervention for insulin-treated diabetic patients (CNSA, 2025[79]).

For each beneficiary, a user flat rate is calculated by multiplying the flat intervention rate assigned to that person – including add-ons as appropriate - by the number of "user weeks" – that is the number of actual weeks of care provided by the service. Annex reports the payment rates for 2025.

The *dotation de co-ordination* was defined by Decree No. 2021-1932 of December 30, 2021, relating to the minimum rate applicable to home help hours and the allocation aimed at ensuring the integrated operation of help and care within a home independent living service. This allocation, which benefits the facility's help and care activities, covers the cost of actions ensuring the integrated operation of the facility and the consistency of interventions with the characteristics of the person being supported. The amount of this allocation is determined by the ARS, considering the number of people supported by the service and the volume of the facility's help and care activities. The 2022 budget campaign instruction (first phase) provided further details on this allocation:

"The allocation may, in particular, be used to finance the time of the co-ordinating nurse (IDEC) necessary for the establishment of co-ordination meetings, partnerships, and time for sharing best practices. It is estimated that at least one-third of the time of an IDEC should be financed for every 80 places."

The financial incentives dedicated to coordination, particularly the coordination grant, are still in the scale-up phase and are not intended, at this stage, to cover all the coordination needs identified in the territories.

Article 44 of the Social Security Financing Act for 2022 provides for a comprehensive reform of the SAAD financing model, with the aim of improving the quality of services provided to users while providing guarantees regarding financial solvency. This reform, effective September 1, 2022, consists of the introduction of a supplementary grant (*financements complémentaire*) to finance initiatives aimed at improving the quality of services provided to beneficiaries. Article L. 314-2-2 of the CASF defines the actions that can be funded by the additional allocation, divided into six objectives:

- Support individuals whose care needs present specific needs
- Provide services over a period that includes evenings, weekends, and public holidays
- Contribute to meeting needs across the country
- Provide support to caregivers of those receiving support
- Improve the quality of life at work for those receiving support
- Combat the isolation of those receiving support

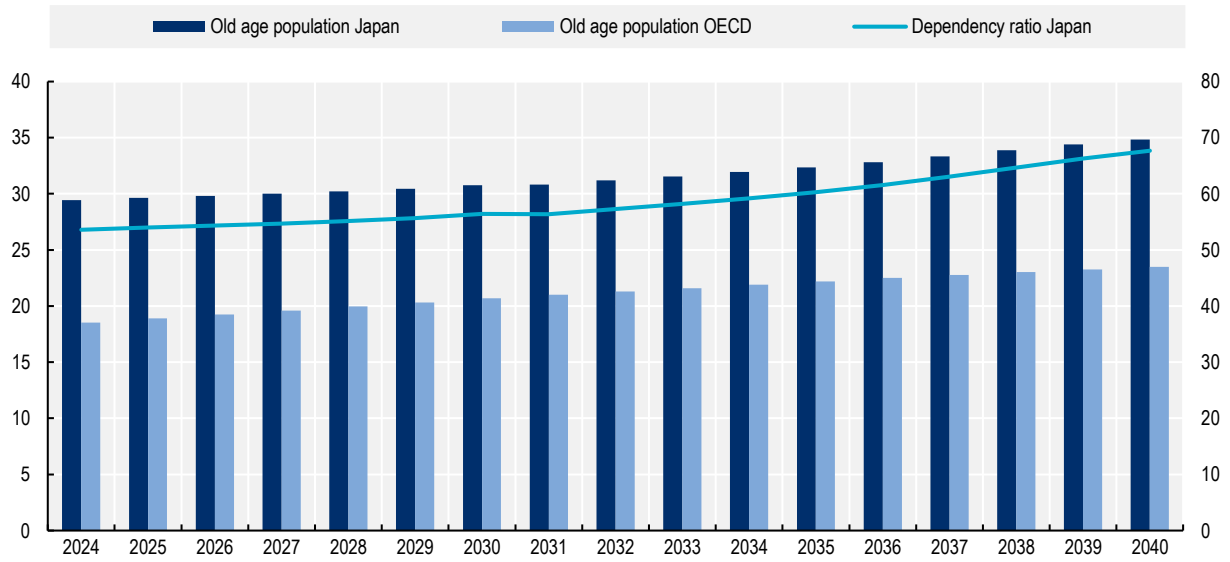
The total amount of credits paid by the CNSA was 241 million Euro in 2023, mainly to finance actions aimed at improving the quality of working life of home care workers (35 % of the total).

5 How Japan promotes co-ordination in long-term care

5.1 Overview: Japan has an insurance-based long-term care system, covering a large share of costs

Japan is currently the most aged OECD country with the largest share of population aged 65+ and 80+ in the OECD. In 2023, 29.1% of the overall population was aged 65 and over, well above the OECD average of 18.5% and will reach 37.7% in 2050, nearly 1.5 times the OECD average of 26.4% (OECD, 2025[11]). Simultaneously, Japan's declining birth rates have remained below the OECD average for decades, marking 1.3 in 2022 (OECD, 2024[43]). Combined with the low fertility and the decline of the younger population, the old age dependency ratio, or the number of individuals aged 65 or older per 100 people of working age, is expected to increase from 54.0% in 2025 to 67.6% in 2050 (OECD, 2025[12]).

Figure 5.1. The share of older adults and old age dependency ratio is expected to increase



Note: Old age population rate is the share of people aged 65 and over to the total population. Old age dependency ratio is the number of individuals aged 65 or older per 100 people of the working age population aged 20-64. Primary axis on the left is for the old age population rate and the secondary axis on the right is for the old age dependency ratio.
Source: OECD Data Explorer Population Projections (2025[12]).

As a result of its aged population, long-term care (LTC) needs are high in Japan. Currently, OECD estimates suggest that more than one-third of those aged 65+ have long-term care needs compared with

the OECD average of one in four (OECD, 2024[75]). A total of 7.2 million people were certified as needing support or care under the LTCI system in 2024, which accounts for about 19.8% of those aged 65 and over (MHLW, 2024[80]). In 2023, 15% of older people aged 65 and over were receiving LTC, higher than the OECD average of 12%, and a majority (78%) received care at home (OECD, 2025[11]). The share of people receiving LTC at home has increased by 4.2 times (0.97 million in 2000 to 4.07 million in 2022), which is a greater increase than the increase in the number of service users overall by 3.5 times (1.49 million to 5.16 million) (MHLW, 2023[81]).

Japan's LTC expenditures have doubled over the past two decades, making up approximately 20% of total healthcare spending in 2023 (OECD, 2025[2]). Home-based LTC costs remain considerable at over 400% of median income for severe needs, above the OECD average of about 300% (OECD, 2025[11]). At the same time, Japan has a relatively generous system with 80% of the LTC expenses covered by public services at home and 60% for institutional care, limiting out-of-pocket costs to below 40% of the median income for severe needs. As the population ages, related expenditures are projected to rise by 3.5% per annum, slightly below the OECD's average (OECD, 2024[75]).

Japan established an LTC Insurance system (LTCI) in 2000 under the principles of being a person-centred service that supports the independence of daily life for older adults. It is a contributory insurance based on the mandatory enrolment of all residents aged 40 or over. People aged 65 and over are eligible for LTCI services regardless of disease, while those aged 40-64 are eligible if diagnosed with age-related diseases such as rheumatoid arthritis. Japan's LTCI system is funded through a tripartite structure involving insurance premiums (50%) and public funding (50%). The insurance premiums are collected from the Category 1 insured (aged 65 and over) and the Category 2 insured (aged 40-64).[12] The public funding consists of support from the national government (25%[13] of total LTCI costs), prefectural governments (12.5%), and municipal governments (12.5%). The insured are assessed into seven levels under a standardised criteria on their degree of care and support needs.

The responsibilities for the LTCI systems are shared among the national and subnational governments. The national government formulates laws and regulations, outlines health and welfare policy measures for older people, sets the fee schedule and provides financial support to municipalities for long-term care services (Japan International Cooperation Agency, 2022[82]). Prefectural governments are responsible for overseeing healthcare services and reviewing individual LTCI claims, as well as designating service providers for LTCI alongside municipalities. Municipal governments[14] are responsible for collecting the insurance premiums, legally mandated by the *Long-term Care Insurance Act (*1997, Act No. 123), reimbursing the service providers, and overseeing needs assessment.

The LTCI covers home help, day care, institutional care, and preventive services, which are defined into three types of benefits. First, the *LTC Benefits* provide facility services, in-home services and community-based services for those with assessed care needs 1 to 5. Second, the *Preventative LTC Benefits* provide LTC prevention services and community-based LTC prevention services to those with assessed support needs 1 and 2. Lastly, the *Comprehensive Services for Long-term Care Prevention/Daily Life Support* can be used for both people with assessed support needs and those without. Care in or close to home has been prioritised as an objective of LTC since 2005.

[12] Category 1 contributions are collected by the municipality and deducted automatically from pension contributions. Category 2 contributions are collected by the Social Health Insurance and pooled nationally and redistributed.

[13] 20% of the contribution is mechanically fixed, while 5% is allocated as a grant to local municipalities, depending on the share of the older population and income levels.

[14] Municipalities include special city wards (特別区)

5.2 Governance: Japan has clear vertical and horizontal co-ordination mechanisms for LTC

Prefectures and service plans are important for vertical co-ordination

The national government outlines the broad principles of LTCI system and revises the fee schedule for LTCI every three years by the Ministry of Health, Labour and Welfare (MHLW). While the fee schedule specifies the charges for individual services, the global revision rate is initially decided based on various factors, including the financial condition of the service providers, expected demands due to population ageing and the need for salary increases. This is announced by the prime minister (MHLW, 2023[83]; OECD/WHO, 2021[84]).

The prefectural government oversees health care planning and ensures co-ordination between health and LTC strategies by aligning the home care component in its Medical Care Plans with municipal LTCI plans every three years, following the LTCI fee revision cycle. All prefectures have councils which discuss the LTCI Service Support Plan, consisting of academics, healthcare professionals (such as the prefectural Medical Association representing physicians) and social welfare professionals (such as the prefectural Care Workers Association and prefectural social welfare council), beneficiary representatives and municipalities within (MHLW, 2025[85]). Prefectures are also responsible for developing wide-area service infrastructure through the co-ordination and support of cross-municipal initiatives, such as medical-LTC collaborations and dementia care networks, and contributing financially. Additionally, they supervise LTC service quality by approving LTC facilities and issuing certifications for certified care workers (see below). Prefectures have the right to inspect LTC facilities to ensure compliance and can even revoke business permits while being responsible for staffing planning regarding the workforce.

As the primary administrator of Japanese LTC services, the municipal government sets out their Municipal LTCI Service Plans according to the Basic Guidelines from the MHLW. These Basic Guidelines prescribe the types of services municipalities and prefectures should include in their plans and the standards each municipality should refer to when setting the expected volume of service demand. The municipal plans estimate and set LTCI premiums based on the MHLW estimation tools. They also define the Daily Living Areas within the municipality, estimate the volume of each type of LTCI service, the capacity required for each area, and describe the measures and goals for LTC prevention. Municipalities are obliged to assess their LTC service performance and the outcome indicators recommended by the Basic Guidelines by the LTCI Act revised in 2017. These indicators are referenced for additional grants for municipalities, giving a financial incentive for the effective and efficient provision of LTC services and LTC prevention (JMA Research Inc., 2022[86]).

The community-based integrated care model enables horizontal co-ordination across sectors

Japan has promoted a community-based integrated care system since 2015.[15] This approach supports older people ageing in place by respecting community resources and networks. It combines healthcare, long-term care, preventive services, daily living support, and housing, backed by government and community cooperation (Ping and Salehi, 2024[87]). While rehabilitation and nursing care, both at home and in the community, are covered by the LTCI, medical care is provided by the healthcare system linked to the Social Health Insurance (SHI). The social welfare system also provides support for housing for older people who require a living situation with care due to economic reasons. The social benefit can be given concurrently with LTCI. Social housing also plays a role in providing housing to older adults who are not

[15] The community-based integrated care approach was initiated in the 2000s; however, it was stipulated in 2013 (MHLW, 2024[106]).

yet eligible for LTCI benefits due to their low support need. Municipalities take the central role, with the support of prefectural governments and health centres and in close cooperation with local medical associations, in building a system for regional collaboration so that related organisations can work together in providing an integrated in-home health care and long-term care through multi-professional cooperation (Kitahara, 2019[88]).

Within the integrated care model, intersectoral governance and decision-making are achieved both at the macro level (through the formulation of three-year plans) and at the individual level (through care planning and multi-professional co-ordination). Prefectures formulate the "Support Plan for Long-term Care Insurance Implementation" and "Regional Medical Care Plan" tailored to each prefecture's circumstances and issues, and present policy measures and medium- to long-term strategies (Japan International Cooperation Agency, 2022[82]). They also provide technical advice and training for municipalities and implement pilot projects in the region, which is particularly important for small municipalities with limited resources. Consistent with the prefectural LTCI and welfare implementation plans, municipalities are required to create Community-based Integrated Care Plans and establish Community-based Integrated Support Centres to operate them either directly or through outsourcing. These centres are responsible for creating a cooperative system among relevant parties and institutions by supporting community care meetings and providing comprehensive, ongoing care management support for care managers. The Community-based Integrated Support Centres also offer extensive consultations and advocacy for older people in the community and carry out long-term care prevention activities. Public health nurses, social workers, and chief care managers are present at the centres, with the care managers being the key co-ordination mechanism (see below). With each municipality determining the number and target areas of these centres based on local living areas, as of April 2020, there were 5 221 community-based support centres nationwide (Japan International Cooperation Agency, 2022[82]).

Responding to the upcoming wave of population ageing in 2040, the government has outlined future directions to further enhance service delivery towards 2040, when the need for both medical and long-term care is expected to surge (MHLW, 2022[89]). The 2040 plan broadens the scope of the integrated care from older people, particularly with dementia, to at-risk populations (e.g., people with a disability, single-parent households, and low-income groups). In care co-ordination, the prefectural role will be strengthened in planning and resource allocation to reduce regional disparities. Task-shifting and task-sharing between healthcare and LTC staff will be allowed to address workforce shortages (MHLW, 2025[90]). LTC services will put greater emphasis on preventive care and health promotion than post-illness care and increase flexibility to respond to demand surges in urban areas and service sustainability in depopulated areas. The long-term care prevention support centres are to offer community-based rehabilitation, preventive care, integrated delivery, community meeting places, and combined services and support (MHLW, 2025[91]). Digital platforms for data-sharing, telehealth, and predictive analytics for care planning will be introduced to improve integrated long-term care delivery and productivity.

5.3 Financing and payment: Redistribution mechanisms, pooling and financial incentives are present in the Japanese LTC system

The pooled national LTCI fund is redistributed to municipalities (insurers) based on their old-age population ratios, regional cost adjustments, and service demand forecasts. The premium calculation is based on income level and region, and municipalities set the premium rates every three years. The average premium between 2024 and 2026 is JPY 6 225 per month (MHLW, n.d.[92]). Municipalities with higher-than-average older populations or lower fiscal capacity receive additional subsidy, the Long-Term Care Financial Stabilisation Fund, established in 2000. The fund supports premium stabilisation and provides emergency financial relief during unexpected cost surges. It is financed equally by the national, prefectural, and municipal governments, with municipal government contributions channelled through insurance premiums.

The prefectures manage the fund and make it available to municipalities as grants or loans. Grants are provided every three years (at the end of the LTCI business period) and cover half of the shortfall caused by premium collection deficiencies. Loans are issued annually and cover the entire deficit resulting from premium shortfalls and increased benefit costs (excluding any grant amount). Their repayment should be made in the next business period, funded by insurance premiums (MHLW, 2004[93]).

Facility-based services are eligible for special support, with the national government covering 15% and prefectures covering 17.5% of the costs. This is a deviation from the standard 20%/12.5% split to reflect higher operational costs in institutional settings.

Under Japan's LTCI system, financial incentives, called Additional Fee Items, are designed to promote horizontal collaboration among health and social care providers for integrated care (MHLW, 2024[94]). These are extra payments added to the standard LTC service fees when providers meet specific conditions that promote quality, co-ordination, and efficiency. For example, the additional fee items include three add-ons to incentivise care co-ordination and collaboration:

- Collaboration between domiciliary nursing and home care providers: “home-visit nursing and home-visit care collaboration add-on” provides additional reimbursement when visiting nurses and home care workers co-ordinate care plans and share information
- Collaboration following hospital discharge for nursing homes: “hospital discharge/transfer collaboration add-on” is paid to facilities (e.g., special nursing homes) that actively co-ordinate with hospitals during discharge planning to ensure smooth transitions
- Care manager’s collaboration with hospitals and primary care physicians: “information collaboration during hospital visits add-on” is granted when a care manager attends the user’s medical or dental examination to provide information on the user’s condition and living environment, receives medical advice, and records it in the LTC Service Plan

These additional fee items are reviewed every three years during the LTCI fee schedule revision.

5.4 Workforce: Key workers, meetings, shared spaces and pathways promote workforce co-ordination and joint work in Japan

The LTC workforce includes in-home care helpers (or assistants), certified care workers, and care managers (Table 5.1). In-home care helpers are qualified assistants who have completed vocational training courses. They provide support with physical care, mainly assisting with daily activities, housework, and travel to medical appointments. Certified care workers are those who have passed the national qualification exam after obtaining eligibility either through graduation from accredited training institutions or through completion at least three years of field experience along with practical training. They can provide not only person-to-person care support but also consultations, grief care, programme planning, and training and management of nursing care staff. Since 2012, certified care workers and personal care workers who have undergone specific training have been authorised to perform suctioning of sputum and other necessary medical procedures for daily living under a physician’s instructions (MHLW, n.d.[95]). Care managers are certified professionals with at least five years of professional experience in the medical, health, or welfare fields, who have passed the national qualification exam and completed statutory training. They are responsible for co-ordinating with municipalities, LTC service providers, and primary care physicians to ensure insured persons receive appropriate services based on their conditions and wishes.

Table 5.1. LTC workforce requirements and roles by occupation

Occupation / Qualification	Main Requirements	Main Roles / Responsibilities	Next Step
Care Assistant	No national qualification required; municipalities or facilities may provide short training	Performs non-care support tasks such as cleaning, meal delivery, and assistance with facility operations; supports certified care staff	Take *Care Worker Entry Training* to begin providing direct care
Care Worker (after *Care Worker Entry Training*)	Completion of *Care Worker Entry Training*(130-hour course)	Provides basic physical and daily living care (bathing, dressing, meals, etc.) at home or in facilities	Take *Practical Care Worker Training* or gain experience toward national certification
Care Worker (after *Living Support Workers Training*)	Completion of *Living Support Workers Training*(59-hour course)	Provides living support such as cleaning, laundry, and meal preparation/cooking.	Take *Care Worker Entry Training* to begin providing direct care
Care Worker(after *Practical Care Worker Training*)	Completion of *Practical Care Worker Training*(450-hour course)	Performs general caregiving plus limited medical-related support (e.g., suctioning, tube feeding); supports team-based care	After 3+ years of experience, eligible for the *Certified Care Worker* national exam
Certified Care Worker	(1) 3+ years of care experience + *Practical Care Worker Training*, or (2) graduation from an accredited care school	A nationally licensed care professional responsible for comprehensive care, record management, mentoring, and co-ordination with nurses and therapists	Advance to home-visit care supervisor or Chief Care Worker
Care Manager	5+ years of professional experience in health, medical, or welfare fields + Care Manager Practical Training Exam + practical training	Designs individual care plans, co-ordinates services and manage benefit use under the LTCI system	Promote to *Chief Care Manager*

Source: Authors' compilation.

Care managers play a central role in co-ordinating care between the health and LTC sectors by creating an intersectoral care plan (referred to as an *LTC Service Plan* or an *LTC Prevention Service Plan)* tailored to individual needs, which is shared and adjusted among the different service providers. After the municipality's LTC need certification, care managers collect information and assess a LTC beneficiary's circumstances, including daily challenges, personal preferences, and physical and mental health status, through consultations with the beneficiary and their family members. Based on the information and assessment results, care managers draft an individualised care plan that includes the overall care policy, care objectives, and the types and volumes of services required. Then, the draft care plan is sent to the Service Representative Meeting, which includes representatives from various service providers in the LTC, healthcare, and social welfare sectors, for review. The care plan is finalised once it is explained and agreed by the beneficiary (MHLW, 2022[96]).

Municipalities will lead in developing human resources who will be the core of cooperation between health care and long-term care, while it is necessary to collaborate with medical associations and other organisations to promote home health care and long-term care integration. Some municipalities establish an agreement with a medical university or institution to open a home health-LTC collaboration hub, operated by the municipal integrated care centre in cooperation with relevant service providers (e.g., Toyoake City and Togo Town). The collaboration hub provides training to promote collaboration between health and LTC professionals and raise awareness of home-based health and LTC services, as well as individual consultations and care services (MHWL, 2025[97]).

Home-based medical and long-term care collaboration promotion

The home-based medical and long-term care collaboration promotion programme is a collaboration between the health and long-term care sectors within the community, based on the LTCI Act. Under the co-ordination of municipalities, a consultation desk is set up at a local doctors' association (or other relevant institution), and a community-based Integrated support centre to collaborate on in-home services for older people. Hospitals and clinics for home-based care, home care nurse providers, pharmacies and long-term care service providers convene to discuss issues in multidisciplinary collaboration and to provide a home-based medical care service capable of responding 24 hours a day.

Co-ordination mechanisms of the community-based integrated care system

The community-based integrated care model involves a broader range of staff from the health and social welfare sectors, in addition to LTC staff. Included are health care workers (doctors, dentists, pharmacists, nurses, health workers, physiotherapists, occupational therapists, speech-hearing therapists, nutritionists, dental hygienists, and other medical professionals), social workers, as well as staff of the integrated care centre in the municipality (MHWL, 2025[97]).

The Daily Living Support System Development Programme aims to establish a provision system for daily life support and LTC prevention services by various stakeholders, and to promote community mutual support led by municipalities. To achieve this, municipalities appoint "living support co-ordinators" and establish "consultative bodies" to promote the development of these community systems. Living support co-ordinators, also known as "community support promoters," work within communities to encourage collaboration among various stakeholders and organisations, and to promote the enhancement of resident-led activities in which older adults participate and other services. More specifically, they develop resources by creating services that are lacking and training support workers, build networks between stakeholders, and match community resources and services with the needs of older adults. For example, living support co-ordinators support the facilitation of social opportunities such as exercise and cooking classes for residents, and train older volunteers to give them a sense of purpose. They also identify community resources such as package delivery and meal delivery providers that watch over older adults and establish an emergency contact system.

The establishment of Consultative Bodies is prescribed as a platform for the collaboration of community residents and related parties to promote community development. These are teams in which stakeholders work together towards community development. Consultative bodies are expected to include living support co-ordinators at their core, with members including local residents, Residents' Association members, local organizations such as senior citizens' clubs and local commerce and industry associations, NPOs and private companies etc. The geographical scope of consultative bodies can be of two, the entire city (layer 1) and daily living areas (layer 2) according to local community conditions. Activities of these consultative bodies vary but can include serving as a platform to unify the awareness and consensus among stakeholders for community development.

The Community Care Meetings held by Community General Support Centres are called "Individual Community Care Meetings," where multiple disciplines, such as medical care and long-term care, collaborate to review support for individual cases and address issues. These meetings help develop the practical skills of care managers through case examination. During these meetings, the focus extends beyond co-ordinating long-term care services; they bring together various stakeholders—including medical and long-term care specialists, social workers, community welfare officers, and residents' association representatives—to consider comprehensive care that includes social engagement and daily living support.

Co-ordination with hospitals

Community collaborative critical pathways are a tool for building cooperative systems across healthcare institutions and medical LTC organisations within the community. They are based on an overall medical care plan from the start of treatment through living at home, to help quickly return home after acute hospitalisation and recovery hospitalisation (rehabilitation hospitals). The community collaborative critical pathways clarify the role of related institutions and professionals in the health and long-term care sectors and serve as a basis for a multidisciplinary team to support patients with consistent and seamless treatment (Japan International Cooperation Agency, 2022[82]).

Hospitalisation discharge Support is incentivised through specific workers and the add-on reimbursement payment for discharge support. Interviews are carried out with patients and their families from the early stages prior to hospitalisation to check living conditions and medical and welfare service use, providing an orientation about hospitalised life and screening patients who may have difficulty with discharge. These information-sharing activities help the patient and their families understand issues with discharge at an early stage and help different professionals develop a systematic response to discharge. Discharge support nurses (staff) can be placed in the ward, collaboration with local medical institutions and care managers, and multidisciplinary conferences are promoted. Also, to support the smooth transition to home care, add-on reimburse payment is made for home visits by nurses immediately after discharge. With these measures, it is expected that discharge can be supported, looking ahead to returning and continuing to live at home (Japan International Cooperation Agency, 2022[82]).

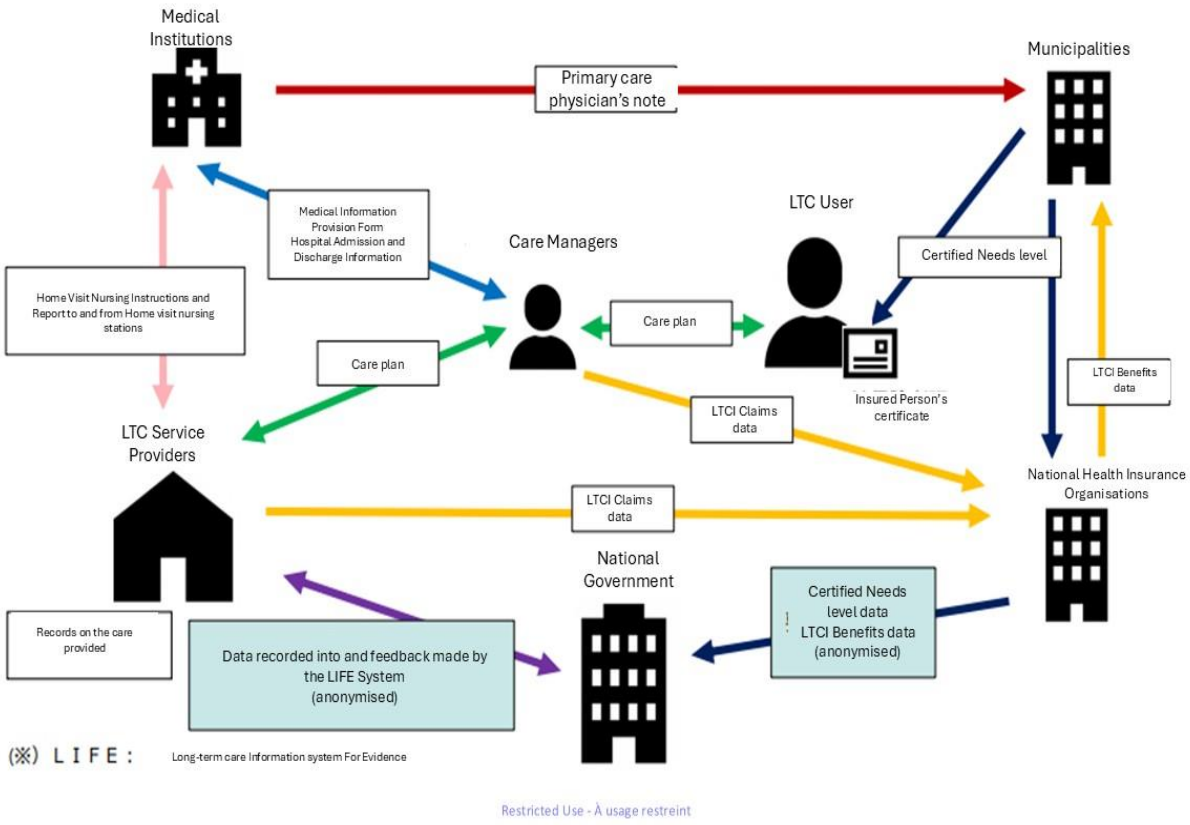
The level and pattern of health-social co-ordination in the continuum of care from hospital admission and discharge, everyday medical support situations, medical emergencies, to end-of-life care may widely vary across the municipalities, under the broad principles for the sectoral collaboration on each occasion (MHWL, 2025[97]). For example, since 2017, Toyoake City has been implementing a "Discharge Support Project". Under this initiative, the city receives information from the government about older people who have applied for new LTC certification while hospitalised. The project staff then calls the applicants directly to assist with their discharge from the hospital and facilitate their transition to LTC services and lifestyle support after discharge. When there is no monitoring structure due to a lack of service co-ordination at the time of discharge or a lack of support persons, the team conducts a phone visit and, if necessary, connects a new support person. After discharge, patients can continue receiving medical treatment at home through appropriate linkages to LTC services and lifestyle support services (MHWL, 2025[97]).

5.5 Data sharing: Efforts have been made for improved data sharing in the Japanese LTC system since 2021

Not all data is initially digital and shared across different workers in LTC

In Japan, various types of LTC data are fragmented across different systems, including municipalities, the NHIO (prefectures), care managers, and LTC providers, in both paper and digital formats (Figure 5.2). Some data lack standardisation and are recorded on paper, while others are recorded digitally and shared through data infrastructures.

Figure 5.2. Data flow in the LTC system



Source: https://www.mhlw.go.jp/content/12301000/001112347.pdf

Translated file : https://portal.oecd.org/eshare/els/pc/Deliverables/LTCcareco-ordination/Deliverables/Japan/figures/Data%20flow%20in%20LTC%20system.pptx?web=1

The needs assessment information is protected. The municipality assesses, creates, and shares the needs assessment information with the LTC beneficiary and the national insurance organisation. However, information about the assessment process and results is not automatically shared with care managers who develop the individual's care plan. To obtain the assessment information, care managers must submit a disclosure request to the municipal offices in person on paper forms. Primary care physicians who issue their medical opinions on the beneficiary's condition for needs assessments also send them to the municipality by post. At the same time, the MHLW receives de-identified data from NHIO, but does not have access to individual beneficiary data.

Care plans are generally created on paper by care managers and shared with the beneficiary and relevant service providers. LTC service providers also keep individual care records, such as home care service plans, weekly service schedules, home care support progress and service usage records. When the beneficiary receives home care visits from nurses, visiting nurse stations receive home visit nursing instruction forms that include the beneficiary's medical conditions and treatment instructions created by a physician. However, LTC claims have been administered digitally since 2019, including all service providers, the NHIO in each prefecture (the claim settlement agency), and the municipality (the insurer/payer) (MHLW, 2024[98]). The MHLW is not involved in the claims process and only receives de-identified data from the NHIO.

Efforts to integrate databases

In 2021, an amendment to the LTCI Act mandated the development of data infrastructure to facilitate information sharing between health and social care systems. This aims to provide seamless care from acute to post-acute stages, reducing unnecessary emergency service use (Ping and Salehi, 2024[87]). As part of the mandate, several initiatives have been undertaken to make LTC data available across the board.

A data collection system was launched in 2021 to collect beneficiaries' ADL and care-related data: the Long-term Care Information System for Evidence (LIFE) system. The LIFE system gathers information on beneficiary health conditions, care activities and other relevant inputs from care facilities and home care service providers. This is a system used to provide feedback to service providers. For example, the system can show the overtime change in an individual beneficiary's BMI or compare one LTC facility's average ADL score to other facilities. The LIFE system currently permits access for service providers (MHLW, 2025[99]).

The Community-based Integrated Care 'Visualization' System was launched by the national government as an analytical tool for municipalities and prefectures to conduct community management. This information system centralises various data related to the building of community-based integrated care systems, including LTCI data, and visualises them in an easy-to-read format using graphs and maps (Japan International Cooperation Agency, 2022[82]). The full-scale operation of this system since July 2025 allows data access by anyone. It is expected to facilitate collaboration between local stakeholders engaged in community-based integrated care (MHLW, n.d.[100]).

Furthermore, the national government is constructing the Nationwide Healthcare Information Platform to enable medical and long-term care data sharing. A data linkage infrastructure, as well as the Long-Term Care Information System, is being built as a part of the Platform. Several Japanese medical and long-term care databases are managed by the MHLW, including the National Database of Health Insurance Claims (NDB), the Diagnosis Procedure Combination Database (DPC DB), and the Japanese Long-Term Care (LTC DB) (Kakinuma, 2025[101]). While these databases have promoted the use and provision of anonymised information, the Act Partially Amending the Medical Care Act and Other Legislation was enacted in December 2025, enabling the use and provision of pseudonymised information moving forward. The government plans to develop a data linkage infrastructure for integrated and secure analyses of data across multiple databases.

The LTC Information Platform, scheduled to be introduced in 2026, will allow individuals, municipalities, LTC facilities, healthcare institutions, and other related stakeholders to share and utilise care-related information about beneficiaries (MHLW, n.d.[102]). For example, through this online platform, primary care physicians will be able to send their notes to the municipality, and care managers can view the progress and results of the needs assessment, including the physician's notes. The introduction of the LTC Information Platform will improve operational efficiency and reduce administrative burden by replacing paper exchanges with electronic procedures (MHLW, 2025[103]; All-Japan Federation of National Health Insurance Organisations, 2025[104]). The National Health Insurance Database (Kokuho Database, KDB) system utilises information related to long-term care and medical insurance to provide statistical data to

municipalities, supporting the implementation of their health projects. Through uniform nationwide aggregation, the system enables municipalities to compare their local data with prefecture-level and national-level values, allowing them to identify their unique characteristics and issues more clearly (All-Japan Federation of National Health Insurance Organizations, n.d.[105]).

Data use in quality monitoring

Japan monitors its LTCI system through a two-tier municipal oversight structure: group guidance, which requires annual training for all providers, and management supervision, which involves on-site audits at least every six years in line with LTCI certification renewal. Inspectors review care quality and operational practices using detailed checklists to verify compliance in areas such as consent procedures, care planning, staff qualifications, infection control, emergency readiness, complaint management, abuse prevention, and incident reporting. When non-compliance is identified, authorities can issue improvement orders, suspend operations, or revoke licenses, based on the enforcement powers defined in the Long-Term Care Insurance Act (MHLW, 1997).

In addition, the publicly accessible LTC provider database, provided by the MHLW, is central to the LTC quality monitoring. Individuals can search for and compare providers and facilities nationwide based on various criteria, including service types, facility characteristics, staffing levels, payment, and beneficiary satisfaction metrics. This platform enables care recipients and their families to make informed choices and compare options, while also promoting accountability among providers and facilities. It also promotes public engagement by allowing users to provide feedback through an online survey designed to improve the platform's usability and ensure that people can easily access the information they need.

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