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Gaps and pathways in long-term care systems in South-East Asia: a comparative analysis of India, Sri Lanka and Thailand

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Abstract

Background

Population ageing in the South-East Asia Region is increasing demand for long-term care (LTC), yet evidence on how to design and scale LTC systems in resource-constrained settings remains limited. This study examines system-level factors shaping the development of LTC and identifies policy-relevant pathways to strengthen LTC systems.

Methods

We conducted a rapid comparative policy analysis of India, Sri Lanka and Thailand, purposively selected to represent different stages of LTC system development. Peer-reviewed and grey literature published between 2013 and 2025 were identified through structured searches of PubMed and the WHO Institutional Repository for Information Sharing (IRIS), supplemented by policy and programme documents. Data from 68 sources were extracted and analysed using a structured framework covering governance, financing, workforce, service delivery and accountability. A comparative thematic approach was applied to identify cross-country patterns, enabling factors and system constraints.

Results

LTC systems across the Region remain underdeveloped and heavily reliant on informal care, with limited cross-sectoral coordination. Cross-country differences were associated with institutional stewardship, pooled financing, workforce formalization and implementation capacity. Thailand demonstrates a more integrated model, embedding LTC within universal health coverage through decentralised governance, structured caregiver support and community-based service delivery. India and Sri Lanka show partial progress but continue to face inconsistent governance, limited financing mechanisms and constrained workforce capacity.

Conclusions

Strengthening LTC systems in low- and middle-income countries requires phased reforms anchored in primary health care, supported by clear governance arrangements, sustainable financing and expanded caregiver support. Embedding LTC within existing health system platforms may offer a feasible and scalable pathway for advancing equitable and person-centred care in ageing societies.

Introduction

Longevity is a major human achievement, with people today living nearly twice as long as those born in 1900. In the World Health Organisation (WHO) South-East Asia Region (SEAR), life expectancy at birth

has increased from around 40 years in 1950 to approximately 70 years in recent years (1, 2). However, longer lives are not always lived in good health. At age 60 years, healthy life expectancy remains substantially lower than total life expectancy, indicating that many older people spend a considerable share of later life in poor health, often with care dependency (3, 5).

Long-term care (LTC) systems are national arrangements that provide integrated support for people with, or at risk of, significant and ongoing loss of intrinsic capacity, enabling them to maintain functional ability, dignity and well-being. Grounded in the life-course and healthy ageing approach, LTC spans prevention, early identification of care needs, rehabilitation and ongoing support. It emphasises person-centred, community-based care delivered through primary health care systems (4–7).

Most LTC policy literature has focused on high-income insurance-based systems in Europe and East Asia. Far less is known about how lower- and middle-income countries can build LTC systems as they age rapidly under fiscal, workforce, and institutional constraints. The South-East Asia Region serves as an important policy laboratory because countries face common demographic pressures yet have adopted different policies and institutional responses.

The ten Member States of the WHO South-East Asia Region—Bangladesh, Bhutan, Democratic People's Republic of Korea, India, Maldives, Myanmar, Nepal, Sri Lanka, Thailand and Timor-Leste—are at different stages of demographic transition and readiness for LTC (3, 5).

This study addresses two policy questions: (i) what factors explain differing levels of LTC system development across countries in the Region; and (ii) what reform pathways can help countries strengthen LTC systems progressively and equitably? We examine these questions through a comparative analysis of India, Sri Lanka and Thailand.

This study contributes to the limited comparative evidence on the development of long-term care systems in low- and middle-income countries by identifying key system-level drivers of progress and constraints across diverse policy contexts. It further proposes a phased, policy-relevant pathway to strengthen LTC systems in resource-constrained settings, with potential applicability beyond the WHO South-East Asia Region.

Methods

We undertook a rapid comparative policy review to generate timely, policy-relevant evidence in a field where formal comparative research remains limited. Given the rapid-review design, the findings were interpreted as a policy-oriented synthesis rather than a comprehensive systematic assessment.

India, Sri Lanka and Thailand were purposively selected using maximum-variation sampling to reflect contrasting institutional and financing pathways for LTC development: India as a large federal system with emerging LTC arrangements; Sri Lanka as a middle-income setting with stronger social indicators

but limited formal LTC institutionalisation; and Thailand as a more mature system with established community-based LTC integrated within universal health coverage (UHC).

PubMed and the WHO Institutional Repository for Information Sharing (IRIS) were searched for peer-reviewed and grey literature published between 2013 and 2025 using terms including “long-term care”, “older people”, “healthy ageing” and “South-East Asia”. Additional reports from international agencies, governments and civil society organisations were identified through targeted searches. Searches were conducted in January 2026.

Studies were included if they: (i) focused on people aged 60 years and above; (ii) addressed at least one LTC system component (governance, financing, workforce, service delivery, information systems or enabling environment); and (iii) were relevant to countries in the South-East Asia Region. Studies not available in English or not directly related to LTC systems were excluded.

Titles and abstracts were screened for relevance by one reviewer, followed by full-text screening of eligible records. Uncertainties regarding inclusion were resolved through discussion among the authors. A total of 68 documents were included in the final synthesis.

Data was extracted using a standardised framework based on the WHO LTC system building blocks: governance, financing, workforce, service delivery and information systems. Findings were then synthesised using a conceptual framework linking long-term care needs, system responses and outcomes.

A structured analytical framework was applied to enable systematic cross-country comparison. Data were coded deductively across predefined domains and patterns were identified using comparative thematic synthesis. This approach enabled the identification of common system constraints, enabling factors, and transferable policy lessons across different stages of LTC system development.

Results

A conceptual framework was developed to synthesise findings and guide the interpretation of LTC systems in the South-East Asia Region, building on the WHO LTC system components (Fig. 1). The framework maps the pathway from demographic and epidemiological transitions to rising LTC needs, system responses and implementation mechanisms. It highlights how integrated, person-centred approaches delivered through primary health care and aligned with UHC can support functional ability, equity and well-being among older people.

Emerging long-term care needs and system gaps

In 2024, the WHO South-East Asia Region was home to approximately 1.8 billion people, including an estimated 207 million people aged 60 years and above. The proportion of older people is projected to rise from 11.3% in 2024 to 20.9% by 2050, reaching around 441 million people (1).

Around two-thirds of people in later life are likely to require assistance with activities of daily living at some stage (7). The growing burden of chronic disease, multimorbidity, frailty and cognitive decline is increasing functional limitations and care dependency (12, 13, 17). Dementia affected an estimated 9.6 million people in the Region in 2019 and is projected to double by 2050 (18).

Social determinants, including gender, economic insecurity and rural residence, shape care needs and access to services (6, 15, 16). In several countries, more than 70% of older people live in rural or remote areas with limited health and social infrastructure, while migration and changing household structures are reducing the availability of traditional family care (19–21). LTC services therefore remain underdeveloped and unevenly coordinated, with many initiatives operating at pilot scale and with limited coordination between formal and informal providers (1–5, 7).

System responses for long-term care

Countries across the Region are introducing policy and programme responses to address rising LTC needs, including new ageing policies, service delivery innovations and efforts to integrate LTC within primary health care and UHC platforms (3–7). However, progress varies substantially across countries.

Institutional stewardship and governance

Most countries lack dedicated national LTC legislation or standalone policies. Responsibilities are often divided among ministries of health, social welfare and local government, contributing to weak accountability, inconsistent standards and limited coordination (5–8). Countries with clearer stewardship arrangements and defined implementation responsibilities appeared to demonstrate more consistent progress in translating policy intent to service delivery. Thailand represents a comparatively more developed example, with LTC embedded within decentralised governance structures and aligned with UHC (36–40).

Financing arrangements and entitlement design

LTC financing remains limited and heavily dependent on out-of-pocket spending (17, 19, 21). No country in the Region operates a fully comprehensive national LTC financing system and support is piecemeal across health insurance, pensions and social welfare schemes (1,2,17,20–23). Where financing remained discretionary and split across sectors, coverage was narrower and less equitable. Thailand’s pooled financing through UHC and local government funding appeared to support broader scale-up and clearer entitlements (38–40).

Workforce formalisation and caregiver support

Shortages of trained geriatricians, rehabilitation professionals, and community caregivers were reported across the Region (6–8, 14, 17). Most countries continue to rely heavily on unpaid family caregivers, predominantly women, many of whom experience physical, emotional and economic strain (9, 17, 30). Heavy reliance on unpaid care can mask unmet needs and shift costs to households. Structured caregiver training and supervision systems exist in some settings, particularly in Thailand, but are not yet widely institutionalised elsewhere (10–12, 36–39).

Integration of services through primary health care

Home- and community-based care were consistently identified as preferred models of LTC but remain underdeveloped and weakly connected to formal systems in many countries (17, 19). Institutional care is expanding, but remains constrained by cost, regulation and social acceptability (4, 14, 22). Primary health care platforms may provide the most feasible entry point for scaling LTC services in many resource-constrained settings. Thailand has institutionalised community-based LTC through home visits, day care, and intermediary care models linked to primary health care and UHC platforms (10–12, 36–40).

Monitoring, quality and accountability

Information systems remain weak in most settings, with limited routine data on functional status, caregiver burden, service utilisation, and quality of care (16). Weak data systems constrain planning, purchasing and quality assurance. Thailand provides a notable example of routine monitoring through national databases linked to LTC programmes (8, 38, 40). Innovation is emerging through telehealth, assistive technologies and community-based initiatives, although many programmes remain small-scale and lack robust evaluation (13, 19, 21, 27).

Outcomes and system implications

Differences in system capacity and implementation influence access, quality and equity in LTC. Stronger systems are associated with improved functional ability, dignity and well-being among older people (4–7). Persistent gaps in availability, accessibility, affordability, quality and accountability continue to disproportionately affect rural and underserved populations (6, 15, 16).

Comparative analysis of India, Sri Lanka and Thailand

A comparative analysis of LTC systems in India, Sri Lanka and Thailand across governance, financing, workforce, service delivery, information systems and enabling-environment domains is presented in Table 1.

Table 1

Comparative analysis of long-term care systems in India, Sri Lanka and Thailand informed by the WHO integrated continuum of LTC framework

Domain	India	Sri Lanka	Thailand
Governance	Divided among health and social sectors, including National Programme for Health Care of Elderly (NPHCE) and social welfare programmes, implementation remains variable and LTC is not fully mainstreamed into national planning; limited regulation of residential care facilities raises concerns about care quality (14, 24, 25).	Policies and legislation exist (e.g. Elders Act, national ageing policy), but implementation capacity and coordination remain limited; LTC is not fully mainstreamed into national health planning (22, 31–33).	Integrated governance with LTC embedded in UHC, clear stewardship by MoPH and NHSO and decentralised implementation through local administrative organisations (36, 38–40).
Financing	No comprehensive LTC financing system; high out-of-pocket spending and scattered support through NGO- and CSR-driven initiatives; pensions and social assistance are not linked to LTC entitlements; PM-JAY covers inpatient care but not LTC services (20, 21, 23–26).	No dedicated LTC financing system; reliance on social protection schemes with general allowances but no LTC entitlements; continued dependence on NGOs and limited government outreach (22, 31–35).	Publicly financed LTC is integrated within UHC through NHSO and local health funds, with more stable pooled financing and defined service entitlements (38–40).
Workforce and caregivers	Heavy reliance on informal family caregivers; shortages of trained geriatric and LTC workforce; significant caregiver burden and unmet support needs (20, 21, 26–30).	Predominantly family-based care that is increasingly strained; limited initiatives to develop and train a formal care workforce (31–35).	Structured multilevel LTC workforce including village health volunteers, care managers and community caregivers, with formal training and supervision systems (9–12, 36–41).
Service delivery	Services delivered through NPHCE and CSO-led community and home-based pilots; rapid expansion of largely unregulated private residential care homes; limited access to formal LTC as indicated by LASI (20, 26–29).	Predominantly hospital-based services with some NGO-led community care; weak integration between health and social care systems (22, 31–33).	Established community-based LTC system integrated within PHC and UHC platforms, home visits, day care and intermediary care models operational (9–12, 36–41).
Information systems	NPHCE lacks routine monitoring of LTC outcomes; limited use of functional assessments; LTC indicators not integrated into routine health information systems; LASI provides the strongest national evidence base but is	Limited data on LTC needs, caregiver burden and service utilisation; gradual but inconsistent efforts to strengthen health information systems (22, 31–33).	Routine monitoring through NHSO-linked databases; inclusion of LTC indicators and use of data for programme management (38–40).

Domain	India	Sri Lanka	Thailand
	not institutionalised for programme monitoring (20, 23).		

Discussion

This analysis suggests that LTC system development in low- and middle-income countries is not determined by demographic ageing alone, but by the extent to which countries establish clear institutional stewardship, align financing mechanisms and integrate LTC within existing health system platforms. Countries that embedded LTC within primary health care and universal health coverage frameworks appeared to demonstrate consistent progress towards integrated LTC development. These findings highlight the importance of system integration and governance coherence as key drivers of LTC development (36–40).

The South-East Asia Region remains highly heterogeneous in demographic transition, fiscal capacity and health system development, which may influence the transferability of findings across settings.

The South-East Asia Region is experiencing rapid population ageing, generating increasing demand for LTC that supports functional ability and well-being in later life (1–5). Traditional family-based care arrangements remain central but are increasingly strained by urbanisation, migration, declining fertility and changing household structures (2,17,21).

Consistent with the findings of this review, LTC systems across the Region remain poorly coordinated, with persistent gaps across core system domains. Governance responsibilities are often distributed across multiple sectors with limited coordination, reflecting the absence of unified policy frameworks in many countries (3–8). Financing remains insufficient and heavily reliant on out-of-pocket expenditure, limiting access and financial protection (5, 7, 17, 20–23). Workforce shortages, combined with dependence on informal caregivers, constrain service availability and quality (9, 17, 19, 30). Information systems are frequently weak or uneven, limiting planning and monitoring, while gaps in accountability mechanisms, quality assurance and care standards further undermine service delivery (8, 16).

LTC is often politically under-prioritised because costs are immediate, benefits are diffuse and unpaid family care can obscure unmet need. As fertility declines and migration increases, reliance on informal care becomes less sustainable, creating pressure for formal policy responses (2, 17, 21).

These systemic constraints pose significant risks to older people, including unmet care needs, functional decline, social isolation, and financial hardship (3–7). Gaps vary across countries, reflecting different stages of LTC system development, ranging from segmented arrangements to more integrated models (22, 26, 36). Without coordinated policy responses, these disparities may widen inequities and undermine progress towards universal health coverage (2, 5).

Taken together, these findings reinforce the need for system-wide approaches that align population needs, policy responses and implementation mechanisms. At the same time, important opportunities exist. Cultural preferences for ageing in place align with WHO frameworks that emphasise home- and community-based care (6–8). Primary health care platforms and community networks provide a strong foundation for scaling up integrated LTC services (4–8). Leveraging these platforms can enable earlier identification of functional decline and delivery of preventive and rehabilitative interventions.

Strengthening an integrated continuum of LTC requires coordinated action across prevention, promotion, rehabilitation, acute and palliative care, ensuring continuity and person-centred care across home, community and facility settings (7, 8). Services must uphold dignity, autonomy and quality of life by aligning care with what matters most to individuals. Anchoring LTC within primary health care is critical to shift systems towards prevention-oriented approaches that delay or slow functional decline, rather than focus solely on advanced disability. Supporting family caregivers through training, respite services and social protection—and recognising caregiving as skilled work—is essential to improving care quality and sustainability (9, 17, 30).

Persistent gaps in availability, accessibility, affordability, quality and accountability underscore the need for more coherent and coordinated system responses. Countries may adopt a phased, progressive approach to LTC system development, beginning with foundational components, strengthening cross-sectoral integration, and scaling services sustainably over time. Prioritising LTC within national health agendas may become increasingly important to sustain health system performance in ageing societies (3–8).

Policy implications for countries in the South-East Asia Region Short-term

develop national LTC strategies, assign stewardship, adopt minimum standards and begin caregiver training and support.

Medium-term

integrate LTC into primary health care, establish pooled financing, introduce functional assessment, expand caregiver support and strengthen multisectoral coordination.

Long-term

develop sustainable financing models, regulate mixed-provider markets, strengthen LTC information systems and scale up community-based care.

Limitations

This study has several limitations. First, the rapid review methodology prioritised timely synthesis of policy-relevant evidence and may not have captured all relevant literature. Second, only English-language sources were included, potentially excluding nationally published evidence. Third, the analysis focused

on three purposively selected countries and may not fully represent the diversity of LTC system development across the South-East Asia Region. Finally, much of the available evidence consisted of policy reports and grey literature, reflecting the limited peer-reviewed evidence base on LTC systems in low- and middle-income countries. The quality and methodological rigour of included sources varied substantially, and findings should therefore be interpreted as indicative rather than definitive assessments of LTC system performance.

Conclusion

Population ageing in the South-East Asia Region is advancing rapidly, yet LTC systems remain underdeveloped and unevenly coordinated. Without coordinated action, persistent gaps in governance, financing, workforce, service delivery, information systems and quality will continue to limit access and exacerbate inequities among older people.

This analysis highlights the potential value of shifting from unevenly developed, reactive models to integrated, person-centred LTC systems anchored in primary health care. Strengthening prevention, expanding community-based services and supporting family caregivers may be important for maintaining functional ability and well-being in later life.

A phased, context-sensitive reform pathway may help countries progressively strengthen LTC systems and move beyond family-dependent, weakly institutionalised LTC arrangements towards resilient, equitable LTC systems aligned with universal health coverage and healthy ageing goals. Comparative lessons from South-East Asia may also inform other low- and middle-income countries undergoing rapid population ageing.

Abbreviations

CSR, Corporate Social Responsibility; LASI, Longitudinal Ageing Study in India; LTC, long-term care; MoPH, Ministry of Public Health; NGO, Non-Government Organisation; NHSO, National Health Security Office; NPHCE, National Programme for Health Care of the Elderly; PHC, primary health care; PM-JAY, Pradhan Mantri Jan Arogya Yojana; SEAR, South-East Asia Region; UHC, universal health coverage; WHO, World Health Organization

Declarations

Ethics approval and consent to participate

Ethical approval was not required for this study because it was based on analysis of publicly available literature, policy documents and secondary sources.

Consent for publication

Not applicable**.**

Clinical trial number

Not applicable.

Availability of data and materials

All data analysed during this study are included in this published article and its references. No additional datasets were generated or analysed during the current study.

Competing interests

The authors declare no competing interests.

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Authors' contributions

AK and HJ conceptualised the study. PO, SH and PW contributed to the literature review, data extraction and analysis. AK drafted the initial manuscript. MC, PW, and HJ contributed to the interpretation of findings, critical revision of the manuscript and overall technical guidance. All authors reviewed and approved the final manuscript.

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Disclaimer

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Figures

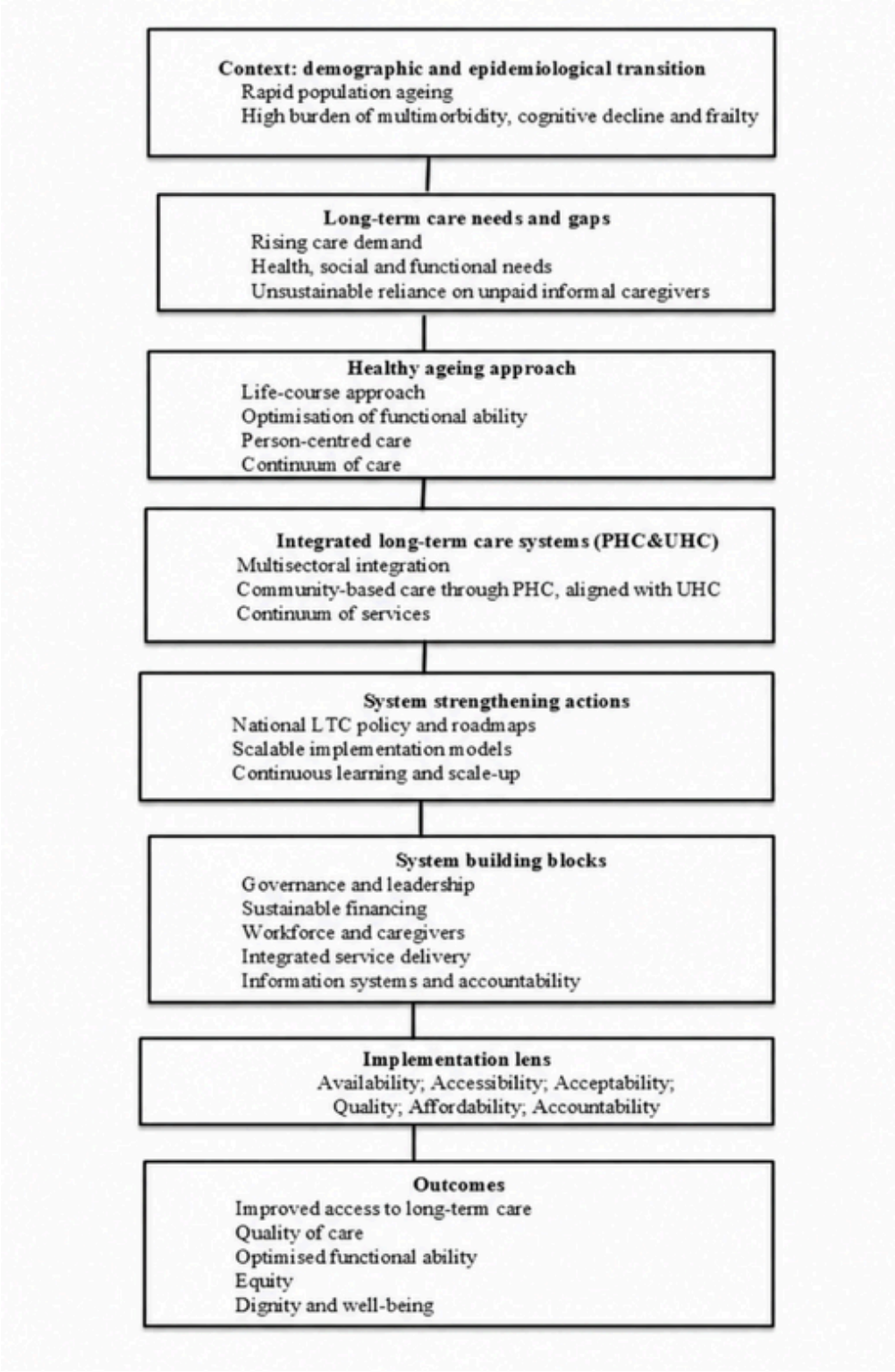


Figure 1

Conceptual framework for strengthening long-term care systems in the South-East Asia Region