

Living Longer, Ageing Together? A Qualitative Policy Analysis of Public Health Governance in Japan's Super-Aged Society

Chutikarn Butwiset

Bangmod Aesthetic Hospital, Bangkok, Thailand

Email: bangmodcb@bangmodhos.com

DOI: 10.5281/zenodo.23388291

ABSTRACT

Japan has the oldest population in the world, and its public health system has become a laboratory for how mature welfare states respond to demographic ageing. This article asks how Japanese public health policy has defined the problem of ageing between 2000 and 2026, and what tensions those definitions create. Using a qualitative, interpretive document analysis of national legislation, government white papers, ministry planning documents and secondary scholarship, the study traces four policy frames: the shift from longevity to “healthy longevity” in the Health Japan 21 programme; the socialisation of care through Long-Term Care Insurance; the construction of the local community as public health infrastructure under the Community-Based Integrated Care System; and a recent normative turn toward rights and inclusion, visible in the Basic Act on Dementia and the loneliness and isolation legislation. The analysis finds that Japanese policy has steadily moved responsibility for health in later life from hospitals and families toward individuals and neighbourhoods, while relabelling that move in the language of autonomy and mutual support. This approach has produced real gains in prevention and social participation, but it rests on assumptions about family availability, community capacity and care labour that demographic data increasingly contradict. The article concludes that the sustainability of Japan's model depends less on new programmes than on rebuilding the care workforce and addressing regional and social inequalities in healthy ageing.

KEYWORDS super-aged society; public health governance; community-based integrated care; long-term care insurance; dementia policy; Japan

1. Introduction

Population ageing is usually discussed as an economic or fiscal problem: shrinking labour forces, rising pension bills and pressure on health budgets. For public health, however, ageing raises a different and more fundamental question. When a society succeeds in extending life, what does it then owe its members in the extra years, and who is responsible for making those years healthy? Japan is the clearest case through which to examine this question. The finalised results of the 2025 census

show that people aged 65 and over make up a record 29.4 per cent of the population, while the total population, including foreign residents, fell by 3.17 million between 2020 and 2025 (Kyodo News, 2026). Japan crossed the threshold of a “super-aged society”, conventionally defined as one in which more than 21 per cent of the population is aged 65 or over, well before any other country.

Japan’s post-war public health record has been widely admired. Universal health insurance from 1961, falling stroke mortality and relatively equal access to care helped produce some of the longest life expectancies in the world (Ikeda et al., 2011). Since 2000, however, the policy agenda has moved away from extending life and toward governing the long final stage of it. Long-Term Care Insurance (LTCI), introduced in 2000, made care for frail older people a social rather than purely family obligation (Campbell & Ikegami, 2000). National health promotion plans set the extension of healthy life expectancy as their headline goal. In the 2010s the government promoted a Community-Based Integrated Care System to be in place by 2025, the year in which the post-war baby boom cohort would all reach 75 (Tsutsui, 2014). Most recently, the Basic Act on Dementia to Promote an Inclusive Society and new legislation on loneliness and isolation have introduced the language of rights, dignity and inclusion into ageing policy.

A large literature evaluates individual programmes, especially LTCI financing (Ikegami, 2019) and community interventions (Hikichi et al., 2015). Less attention has been paid to how these programmes fit together as a way of thinking about ageing, and to the assumptions they share. This article therefore asks two questions. First, how have Japanese public health policies framed the “problem” of ageing between 2000 and 2026? Second, what tensions and blind spots do these framings produce under current demographic conditions? The article argues that Japanese policy has progressively relocated responsibility for health in later life from hospitals and families to individuals and local communities, and that this relocation is now under strain because the social resources it depends on are themselves ageing and shrinking.

2. Analytical Framework and Methods

The study adopts a qualitative, interpretive design based on document analysis. Document analysis treats official texts as social products that record how institutions define problems, assign responsibility and justify action (Bowen, 2009). It is appropriate here because the research questions concern policy meaning rather than measured outcomes, and because Japanese ageing policy is extensively documented in legislation, cabinet decisions and ministry explanatory materials. No primary data were collected from human participants.

The analysis is informed by a framing perspective on public policy. Policies do not simply respond to given problems; they define what the problem is, whose problem it is and what kinds of solution are thinkable. Following this perspective, the study reads policy texts for four elements: the way ageing is diagnosed, the actors held responsible, the instruments proposed, and the values invoked to justify them. The welfare-regime literature on East Asia, particularly work on the “care diamond” of state, market, family and community (Ochiai, 2009), provides a second lens for identifying how responsibility is distributed among these sectors.

The corpus was assembled purposively and comprises three groups of material. The first group consists of primary legal and policy texts: the Long-Term Care Insurance Act and its successive revisions, explanatory materials for Health Japan 21 (third term) (Ministry of Health, Labour and

Welfare [MHLW], 2023), the Basic Act on Dementia (Act No. 65 of 2023) and its outline translation, and the Act on the Promotion of Policy on Loneliness and Isolation. The second group consists of official statistics and white papers, including the Cabinet Office's Annual Report on the Ageing Society (2025), MHLW releases on healthy life expectancy and care workforce requirements, and National Police Agency data on solitary deaths. The third group consists of peer-reviewed scholarship and policy commentary in English, Japanese and Korean. Japanese-language sources were read in the original and translated by the author.

Analysis followed the reflexive thematic approach of Braun and Clarke (2006). Documents were read repeatedly, coded inductively for statements about problem definition and responsibility, and the codes were grouped into candidate themes that were then checked against the full corpus and against secondary scholarship. Four themes emerged and structure the findings below. The main limitation of the design is that policy texts express intentions and justifications rather than lived experience; the article therefore uses statistical and secondary evidence to test the claims made in policy documents, but it cannot capture how older people themselves interpret these policies.

3. Demographic and Epidemiological Context

Table 1 summarises the main indicators that frame the policy analysis. Three features stand out. First, ageing is now driven by the oldest age groups. People aged 75 and over numbered 20.78 million in 2024 and had overtaken those aged 65 to 74 (Cabinet Office, 2025). Because need for care and the prevalence of dementia rise steeply after 75, the composition of the older population matters as much as its size.

Table 1

Selected Indicators of Population Ageing and Health in Japan

Indicator	Value	Reference year and source
Population aged 65 and over (share of total)	29.4%	2025 Census, final results (Kyodo News, 2026)
Total population (incl. foreign residents)	122,972,528	Down 3.17 million from 2020 (Kyodo News, 2026)
Population aged 75 and over (share of total)	20.78 million (16.8%)	Cabinet Office (2025)
Healthy life expectancy, men / women	72.57 / 75.45 years	2022 values (MHLW, 2024a)
Years lived with activity limitation, men / women	8.49 / 11.63 years	2022 values (MHLW, 2024a)
Employment rate, aged 65 and over	25.7%	2024 (Statistics Bureau of Japan, 2025)
Care workers employed / required by FY2040	2.13 million / 2.72 million	FY2023 and FY2040 (MHLW, 2024b; Japan News, 2025)
Persons living alone found dead at home (of whom 65+)	76,020 (58,044)	2024 (National Police Agency, 2025)

Note. MHLW = Ministry of Health, Labour and Welfare. FY = fiscal year.

Second, gains in healthy life expectancy have not outpaced gains in life expectancy. In 2022 healthy life expectancy was 72.57 years for men and 75.45 years for women, implying roughly 8.5 years for men and 11.6 years for women lived with limitations in daily activities (MHLW, 2024a). Since 2001, average and healthy life expectancy have moved almost in parallel, so the period of dependency has not substantially shortened (Nippon.com, 2025). The difference between the best- and worst-

performing prefectures in male healthy life expectancy widened slightly to 2.82 years, indicating persistent geographical inequality (MHLW, 2024a).

Third, the social foundations of care are changing. Older people increasingly live alone; the National Institute of Population and Social Security Research projects that the number of older single-person households will reach about 10.8 million by 2050. In 2024 the National Police Agency (2025) published annual national figures on solitary deaths for the first time: 76,020 people living alone were found dead at home, of whom 58,044 were aged 65 or over. At the same time, the long-term care workforce has begun to contract. The number of care workers fell to about 2.13 million in fiscal 2023, the first decline since LTCI began, whereas the government estimates that 2.72 million will be needed by fiscal 2040 (Japan News, 2025; MHLW, 2024b). These trends form the backdrop against which the four policy frames below must be assessed.

4. Findings: Four Frames of Ageing in Japanese Public Health Policy

4.1 From longevity to healthy longevity: Health promotion as lifelong self-management

The first frame redefines success. In national health promotion planning, long life is no longer the goal in itself; the target is the extension of healthy life expectancy and the narrowing of health disparities. This orientation was established in the second term of Health Japan 21 (2013–2023) and was carried forward in the third term, a twelve-year plan beginning in fiscal 2024. The third term adopts the slogan of health promotion that “leaves no one behind”, sets 51 targets, and introduces a life-course approach together with an emphasis on improving the social environment rather than only individual behaviour (MHLW, 2023; Nomura et al., 2022).

The texts reveal a double movement. On the one hand, the third term explicitly acknowledges the social determinants of health and promises environments in which people become healthy “naturally”, without needing exceptional motivation. On the other hand, most measurable targets still concern individual behaviours and biomarkers: diet, physical activity, smoking, oral health and the management of lifestyle-related diseases. Older people are addressed above all as subjects who should prevent frailty, maintain cognitive function and remain economically and socially active. The rising employment of older people supports this framing; 9.3 million people aged 65 and over were in work in 2024, an employment rate of 25.7 per cent (Statistics Bureau of Japan, 2025).

This frame has clear strengths. It shifts public health attention toward function and quality of life rather than mortality alone, and it aligns with the epidemiological reality that non-communicable diseases dominate the burden of disease in later life (Nomura et al., 2017). Yet it also moralises ageing. Where healthy ageing is presented as an achievable personal project, dependency risks being read as a failure of self-management. The persistence of an eight- to twelve-year period of limitation, and the regional gap in healthy life expectancy, suggest that structural factors such as income, occupation and local service capacity are not being addressed by behavioural targets alone.

4.2 Socialising care: Long-Term Care Insurance and its limits

The second frame concerns who pays for and provides care. Before 2000, care for frail older people in Japan was overwhelmingly provided by families, especially daughters-in-law, with residual municipal welfare services and the widespread use of hospital beds for “social admissions” (Campbell & Ikegami,

2000). LTCI changed the definition of the problem: care became a universal social risk, financed by compulsory premiums from everyone aged 40 and over together with taxation, and delivered by a market of certified providers on the basis of standardised need assessment. Policy documents of the period describe this as the “socialisation of care”.

The analysis shows that this frame has been progressively qualified. Successive revisions since 2005 have emphasised prevention, raised co-payments for higher-income users, shifted lighter-need users toward municipal programmes and tightened eligibility for residential care (Ikegami, 2019). The justification has moved from social solidarity toward sustainability: the question is less what older people need than what the system can afford. In this sense, LTCI has evolved from a guarantee of care toward a framework for rationing and redirecting it.

The deeper limit of the frame is labour. LTCI turned care into publicly financed services but did not secure the people who provide them. Care work remains poorly paid relative to the national average, and the first decline in the care workforce in fiscal 2023 marks a turning point (Japan News, 2025). The government’s projected shortfall of roughly 570,000 care workers by fiscal 2040 (MHLW, 2024b) means that the formal right to care may not translate into actual services, particularly in rural areas. Recent responses, including expanded admission of foreign care workers and subsidies for care robotics, treat the shortage as a technical gap to be filled rather than as a question about the social value of care work.

4.3 The community as public health infrastructure

The third frame is the most distinctive feature of Japanese policy since the 2010s. The Community-Based Integrated Care System seeks to ensure that housing, medical care, long-term care, prevention and daily-life support are available within a roughly thirty-minute area, so that older people can continue living in familiar surroundings to the end of life (Tsutsui, 2014). Municipalities are designated as the main coordinators, and the policy vocabulary emphasises four forms of help: self-help (jijo), mutual help (gojo), social-insurance-based help (kyojo) and public help (kojo).

In this frame the local community becomes a form of public health infrastructure. Neighbourhood “places to gather” (kayoi-no-ba), volunteer-run exercise groups and watch-over networks are promoted as preventive interventions. There is credible evidence that such measures matter: the Japan Gerontological Evaluation Study (JAGES) has shown that social participation is associated with lower risks of functional disability, and an evaluation of community salons in Taketoyo town found that participation was associated with reduced incidence of disability (Hikichi et al., 2015; Kondo, 2016). The community frame thus has a stronger empirical basis than critics sometimes allow.

Nevertheless, the ordering of the four forms of help is revealing. Public help appears last, as a residual safety net. The model depends on neighbourhoods having enough active, healthy residents to provide mutual help, yet the same demographic trends that create need also erode that capacity. In depopulating rural municipalities, those expected to volunteer are often themselves in their seventies. The community frame therefore risks reproducing the older reliance on family care in a new form, shifting unpaid work from daughters-in-law to neighbours, most of whom are women and older people (Ochiai, 2009).

4.4 Rights, inclusion and isolation: A normative turn

The fourth frame is the most recent. The Basic Act on Dementia to Promote an Inclusive Society was enacted in June 2023 and took effect on 1 January 2024. It replaces an earlier administrative framework with a statutory basis and states that people with dementia should be able to live with dignity and hope, participate in all areas of society, and be involved in policy-making (Lim, 2024). The Basic Plan adopted under the Act in late 2024 explicitly rejects the assumption that a diagnosis of dementia means the loss of capacity. In parallel, the Act on the Promotion of Policy on Loneliness and Isolation, in force from April 2024, defines loneliness and isolation as social problems requiring public action rather than private misfortunes.

This turn matters because it introduces a rights-based vocabulary into a policy field previously dominated by cost and prevention. It reframes older people, including those with cognitive impairment, as citizens with entitlements to participation, rather than only as objects of care or targets of behavioural change. Civil society organisations have welcomed the inclusion of people with dementia in policy processes as a major change (Health and Global Policy Institute, 2024).

Yet the new frame is largely declaratory. The dementia legislation is a basic act, which sets principles and planning duties but creates few enforceable entitlements or dedicated budgets. The loneliness legislation likewise relies on local platforms and public awareness. The publication of national solitary death statistics makes the scale of isolation visible: in 2024 nearly one in ten such deaths among older people was discovered more than a month later (National Police Agency, 2025). Rights to inclusion are being declared at the moment when the material resources needed to realise them, namely care workers, local services and social networks, are becoming scarcer.

5. Discussion: Responsibility, Capacity and Inequality

Read together, the four frames show a consistent direction of travel. Over 25 years, Japanese public health policy has moved the centre of responsibility for later-life health away from hospitals, which were costly, and away from families, which were overburdened, toward individuals who are expected to manage their own health and toward communities that are expected to support one another. The state's role has shifted from provider to coordinator, standard-setter and promoter of norms. This pattern is consistent with earlier analyses that describe Japan's welfare state as relying heavily on non-state actors to deliver social protection (Estévez-Abe, 2008).

Three tensions follow from this direction. The first is a tension between responsibility and capacity. Each frame assigns responsibility to an actor whose capacity is declining: individuals who will spend about a decade with limitations, families that are becoming smaller and more often single-person households, communities that are depopulating, and a care workforce that has begun to shrink. Policy language that celebrates self-help and mutual help can obscure this mismatch. Precarity in Japanese society more broadly, including weakened workplace and family ties, compounds the problem (Allison, 2013).

The second tension concerns inequality. Health Japan 21 names the reduction of health disparities as a core goal, but the main instruments are universal behavioural targets, and community-based care depends on local resources that vary widely. The widening gap in male healthy life expectancy between prefectures, and the concentration of population in the Tokyo metropolitan area, suggest that

a model built on local capacity will tend to reproduce regional differences. A public health approach to ageing that is serious about equity would need to channel resources toward places and groups with the least capacity, rather than rely on them to mobilise their own.

The third tension lies between the normative and the material. The rights-based turn is significant, and it brings Japan closer to international frameworks such as the WHO's agenda for healthy ageing. But inclusion requires infrastructure: accessible transport, adapted housing, adequately staffed home care and trained professionals. Without investment in the care workforce, declarations of dignity risk remaining symbolic, and the burden of realising them will fall again on families and unpaid community members.

These findings carry lessons for other Asian societies that are ageing rapidly, including China, South Korea and Thailand. Japan shows that social insurance can successfully socialise the financing of care and that community participation can measurably delay disability. It also shows that financing and participation are insufficient if the labour of care is undervalued and if policy assumes community capacity that demographic change is eroding.

6. Conclusion

This article has used qualitative document analysis to examine how Japanese public health policy has framed population ageing from 2000 to 2026. It identified four frames: healthy longevity as personal and lifelong self-management; the socialisation and subsequent rationing of care through Long-Term Care Insurance; the community as public health infrastructure; and a recent turn toward rights, inclusion and the prevention of isolation. Together they reveal a steady relocation of responsibility toward individuals and neighbourhoods, framed in the language of autonomy and mutual support.

Japan's experience is neither a simple success nor a cautionary failure. Its policies have produced high levels of social participation among older people, a functioning universal care insurance scheme and a pioneering statutory commitment to people living with dementia. The central weakness is not a lack of ideas or programmes but a growing gap between what policy asks of individuals, families and communities and what they can realistically provide. Closing that gap will require treating care work as essential public health infrastructure, directing resources toward the regions and groups with the poorest healthy ageing outcomes, and giving enforceable substance to the rights now written into law. Future research should complement this documentary analysis with fieldwork on how older people, family carers and care workers experience these policies in practice, particularly in depopulating regions.

References

- Allison, A. (2013). *Precarious Japan*. Duke University Press.
- Bowen, G. A. (2009). Document analysis as a qualitative research method. *Qualitative Research Journal*, 9(2), 27–40.
- Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, 3(2), 77–101.
- Cabinet Office, Government of Japan. (2025). Annual report on the ageing society: FY2025 [Summary]. <https://www8.cao.go.jp/kourei/english/annualreport/2025/pdf/2025.pdf>
- Campbell, J. C., & Ikegami, N. (2000). Long-term care insurance comes to Japan. *Health Affairs*, 19(3), 26–39.
- Estévez-Abe, M. (2008). *Welfare and capitalism in postwar Japan*. Cambridge University Press.

- Health and Global Policy Institute. (2024). Dementia policy for an inclusive society 2024: HGPI recommendations on the Basic Plan on Dementia to Promote an Inclusive Society (draft). <https://hgpi.org/en/research/dementia-20240813.html>
- Hikichi, H., Kondo, N., Kondo, K., Aida, J., Takeda, T., & Kawachi, I. (2015). Effect of a community intervention programme promoting social interactions on functional disability prevention for older adults: Propensity score matching and instrumental variable analyses, JAGES Taketoyo study. *Journal of Epidemiology and Community Health*, 69(9), 905–910.
- Ikeda, N., Saito, E., Kondo, N., Inoue, M., Ikeda, S., Satoh, T., Wada, K., Stickley, A., Katanoda, K., Mizoue, T., Noda, M., Iso, H., Fujino, Y., Sobue, T., Tsugane, S., Naghavi, M., Ezzati, M., & Shibuya, K. (2011). What has made the population of Japan healthy? *The Lancet*, 378(9796), 1094–1105.
- Ikegami, N. (2019). Financing long-term care: Lessons from Japan. *International Journal of Health Policy and Management*, 8(8), 462–466.
- Japan News. (2025, April). Nursing care workers in Japan fall to 2.13 million; demand growing higher, but pay remains low. Asia News Network. <https://asianews.network/nursing-care-workers-in-japan-fall-to-2-13-million-demand-growing-higher-but-pay-remains-low/>
- Kondo, K. (2016). Progress in aging epidemiology in Japan: The JAGES project. *Journal of Epidemiology*, 26(7), 331–336.
- Kyodo News. (2026, September 29). Japan elderly population hits fresh high at 29.4 per cent: 2025 census. Bernama. <https://bernama.com/en/world/news.php?id=2613292>
- Lim, D. (2024). The establishment of the Dementia Basic Act in Japan: Key contents and implications. *Global Social Security Review*, 30, 57–70. <https://doi.org/10.23063/2024.09.5>
- Ministry of Health, Labour and Welfare. (2023). Kenkō Nippon 21 (dai-sanji) suishin no tame no setsumei shiryō [Explanatory material for the promotion of Health Japan 21 (third term)]. <https://www.mhlw.go.jp/content/001158870.pdf>
- Ministry of Health, Labour and Welfare. (2024a). Kenkō jumyō no Reiwa 4-nen-chi ni tsuite [On the 2022 values of healthy life expectancy]. <https://www.mhlw.go.jp/content/10904750/001363069.pdf>
- Ministry of Health, Labour and Welfare. (2024b). Dai 9-ki kaigo hoken jigyo keikaku ni motozuku kaigo shokuin no hitsuyō-sū ni tsuite [Required number of care workers based on the 9th long-term care insurance business plans]. MHLW.
- National Police Agency. (2025). Keisatsu no toriatsukatta shitai no uchi, jitaku ni oite shibō shita hitori-gurashi no mono [Persons living alone who died at home among deaths handled by the police, 2024]. NPA.
- Nippon.com. (2025). Healthy life expectancy gap remains constant in Japan. <https://www.nippon.com/en/japan-data/h02252/>
- Nomura, S., Sakamoto, H., Ghaznavi, C., & Inoue, M. (2022). Toward a third term of Health Japan 21: Implications from the rise in non-communicable disease burden and highly preventable risk factors. *The Lancet Regional Health – Western Pacific*, 21, 100377.
- Nomura, S., Sakamoto, H., Glenn, S., Tsugawa, Y., Abe, S. K., Rahman, M. M., Brown, J. C., Ezoe, S., Fitzmaurice, C., Inokuchi, T., Kassebaum, N. J., Kawakami, N., Kita, Y., Kondo, N., Lim, S. S., Maruyama, S., Miyata, H., Mooney, M. D., Naghavi, M., ... Shibuya, K. (2017). Population health and regional variations of disease burden in Japan, 1990–2015. *The Lancet*, 390(10101), 1521–1538.
- Ochiai, E. (2009). Care diamonds and welfare regimes in East and South-East Asian societies: Bridging family and welfare sociology. *International Journal of Japanese Sociology*, 18(1), 60–78.
- Statistics Bureau of Japan. (2025). Tōkei kara mita waga kuni no kōreisha [Japan's older population as seen through statistics] (Statistical Topics No. 146). Ministry of Internal Affairs and Communications.
- Tsutsui, T. (2014). Implementation process and challenges for the community-based integrated care system in Japan. *International Journal of Integrated Care*, 14(1), e002.