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Abstract
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Keywords
Long-term care, China, Italy, Older adults, Governance, Social policies, Welfare systems

JEL Codes
H51, H53, I18, I38, J14, J18, Z18

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ABSTRACT

This paper comparatively analyzes the long-term care (LTC) systems in China and Italy, two countries experiencing profound demographic shifts with rapidly aging populations. While both nations face the common challenge of providing sustainable and adequate care for an increasing number of older adults, their regulations and policy responses diverge significantly, shaped by distinct socio-economic contexts, welfare regimes, and cultural norms. Italy, representing a Southern European welfare model, has historically relied on a fragmented system characterized by familial support, supplemented by cash-for-care benefits and a significant influx of migrant care workers. In contrast, China is in the process of constructing its LTC system, moving from a tradition of family-based care towards a state-led, multi-pillar framework that includes social insurance experiments, private sector engagement, and the integration of health and social care. This paper examines the evolution of LTC policies in both countries, analyzing the drivers behind their different strategic choices. By contrasting the Italian model of "familism by default" with China's top-down, experimental approach, we highlight the respective strengths and weaknesses of each system. The analysis concludes that while no single model is universally applicable, a cross-national comparison offers valuable insights for policymakers grappling with the global challenge of providing sustainable and equitable long-term care in an aging world.

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1. Introduction: The Context of Demographic Change and Long-Term Care

Population aging has emerged as a defining trend in 21st-century global demographic shifts. The consequent surge in long-term care demand, transcending developmental stages and cultural differences, has evolved into a systemic challenge confronting social security systems and public governance worldwide. According to the United Nations' World Population Prospects 2024, the global share of population aged 65 and above has increased from 6.2% in 1990 to 9.8% in 2024, with projections indicating this figure will exceed 16% by 2050. Pioneering aging societies like Japan already report nearly 30% of their population being aged 65 or above, qualifying as "super-aged societies"[1]. Italy, from a socio-demographic perspective, can be considered a unique case; its population aged 65 or above accounts for 24.6%, with one of the lowest fertility rates in the world (see Tab. 1). China, hosting the world's largest older population, documented 280 million people aged 60 and above in 2022 (including 18.3% with impaired or semi-impaired functional capacity), while projections suggest the number of functionally impaired older population will approach 100 million by 2050 (Zhou Ming et al. 2025). Against the backdrop of advancing age structure, nuclear family transformation, and globalization forces, long-term care demand has transitioned from being an "individual household risk" to a "global public agenda", with the underlying challenges demonstrating remarkable universality and complexity.

Tab. 1 – China and Italy. Socio-demographic indicators at-a-glance.

Indicator	**China**	**Italy**
Total population (2024)	1,408.28 million	58.99 million
Population aged 65+ (absolute)	280 million	14.57 million
% of population aged 65+	15.6%	24.6%
% of population aged 80+	≈ 2.8%	≈ 7.7%
Median age (years)	≈ 39.6	48.4
Life expectancy	79.0 years	83.4 years
Old-age dependency ratio (65+/15-64)	≈ 22.8%	≈ 37-38%
Median household/personal income (disposable)	4,822 USD	31,200 USD
Number of older persons (aged 65+) with severe/functional impairment (absolute)	43.75 million	4 million

Long-term care (LTC) refers to the continuum of services required by individuals—primarily older persons, though not exclusively—who have lost the capacity for self-care due to aging, chronic illness, or disability, and who need assistance with daily living or basic medical attention, whether at home or in residential care settings. The World Health Organization defines LTC as a system designed to ensure that "people who lack full self-care capacity can

[1] Population ages 65 and above (% of total population). https://data.worldbank.org/indicator/SP.POP.65UP.TO.ZS?locations=1W (access 17 November 2025)

maintain a quality of life consistent with their preferences, achieve the highest possible level of independence, and retain their autonomy, participation, personal fulfillment, and dignity" (2025). These services, delivered in homes, communities, assisted living facilities, and nursing institutions, include both medical and non-medical support, provided through formal and informal channels. Closely linked to LTC is long-term care insurance (LTCI), which offers financial compensation and coverage for essential services—chiefly basic daily care and medically necessary nursing—to those with long-term functional impairments. Although the older adults constitute the primary recipients, individuals of any age with ongoing care needs may require LTC. As the WHO emphasizes, "All countries in the 21st century need an integrated and well-coordinated long-term care system" (Li, L. 2024).

The "inexorable growth" in long-term care demand, coupled with a supply side characterized by "inadequate capacity and structural misalignment," constitutes a primary global challenge, creating a pervasive "care gap" that proves difficult to bridge.

From the Demand Side, global long-term care needs are characterized by an expanding scale and increasing dimensions. On one hand, population aging directly elevates the risk of functional impairment—the disability rate among the global population aged 80 and above generally exceeds 50%. The care needs of this group extend beyond basic daily living assistance, such as bathing, dressing, and eating, to include specialized medical services like chronic disease management, post-operative rehabilitation, and dementia care, often required for years or even decades. For instance, when Japan introduced its Long-Term Care Insurance system in 2000, there were only 3 million functionally impaired older persons; by 2024, this number had surpassed 7 million. In Italy, data from the 2019 ISTAT report indicate that approximately 4 million people aged 65 and over experience severe difficulties with activities of daily living, resulting in a substantial need for assistance[2]. In China, the impaired older population reached 43.75 million in 2022, an increase of over 10 million since 2010. Among these needs, the gap in "non-basic care services"—such as rehabilitation support and cognitive intervention—is particularly pronounced. These services are critical to the quality of life for impaired older adults but remain in short supply due to their specialized nature and high costs (Huo Shanshan et al. 2024).

On the other hand, the global weakening of family caregiving capacity is intensifying demand pressures. In Japan, nuclear families account for over 70% of households, while Germany's female labor force participation rate has reached 75%. In Italy, the family caregiving has weakened because demographic and social shifts have reduced available informal carers at the same time demand for care has risen: an ageing population with longer life expectancy and more chronic, multi-morbid older adults increases care needs; smaller, more often single-person or geographically dispersed families shrink the pool of potential family carers; substantial emigration of younger adults and internal migration separate older parents from children and shortages in formal home-care services and paid caregivers (exacerbated by regulatory limits and reliance on migrant labour) leave families shouldering more, often unsustainable, care

[2] This estimate comes from ISTAT's analysis of the European Health Interview Survey / AVQ data for 2019 (ISTAT reports also that about 1.4 million older people — 10.1% of 65+ — have a severe reduction of autonomy both in personal care and in domestic life). ISTAT, Le condizioni di salute della popolazione anziana in Italia (Report "Anziani", based on EHIS/Indagine Aspetti della vita quotidiana, 2019). PDF (ISTAT): https://www.istat.it/it/files/2021/07/Report-anziani-2019.pdf

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responsibilities (Melchiorre, Lamura, & Socci (2022). In China, the prevalence of the "4-2-1 family structure" (four grandparents, two parents, one child) means that young and middle-aged adults are simultaneously bearing dual burdens of work and elder care. As a result, the traditional model of "care by children and co-residence" is becoming increasingly unsustainable. Informal care resources—provided by family members, relatives, or friends—are continuously shrinking, leading to an exponentially widening gap in formal care needs, which encompass institutional, community-based, and in-home professional services (Pan Shiyue et al. 2025).

From the Supply Side, countries worldwide are generally confronted with a dual challenge of "infrastructure shortages and service inadequacies." In terms of physical infrastructure, the supply of institutional facilities and beds falls significantly short of demand. In Japan, although the vacancy rate for beds in care institutions reaches 20%, high-quality resources are concentrated in major cities such as Tokyo and Osaka, leaving remote areas struggling with severe bed shortages. In Germany, approximately 30% of nursing institutions face bed shortages, and medical care beds account for less than 25% of the total, failing to address the complex needs of the functionally impaired older people.

Italy's supply of institutional long-term care for older adults with impairments comprised 12,363 active residential *presidi* (Institutional facilities), with 407,957 available beds and 362,850 residents (approximately three-quarters of whom are aged 65 and above). Roughly 78% of beds (≈319,000) are in socio-sanitary units (higher-care) and 22% (≈89,200) in socio-assistential units. Compared with the immediately preceding reporting year, the number of Institutional facilities and total beds showed a small decline (from 12,576 *presidi* and ≈414,000 beds at end-2021 to the 2023 counts) while total residents rose modestly (an increase of ~1.8% to 362,850), underscoring pressure on capacity and persistent regional inequities (ISTAT 2025).

In China's long-term care insurance pilot cities, only about 8,000 designated nursing institutions are available, with bed capacity meeting merely 15% of the needs of the severely impaired older people (Dai Weidong 2024).

Regarding service structure, a widespread global imbalance persists—prioritizing basic living assistance over medical care and favoring institutional care over home- and community-based services. In China's pilot cities, only 30% of care services include medical components such as chronic disease rehabilitation and cognitive impairment care (Huo Shanshan et al. 2024). In the United States, home care service coverage remains below 40%, and many functionally impaired older adults are compelled to choose institutional care due to poor accessibility of home-based services, which costs three to five times more than home care (Zhang Wenjuan & Mei Zhen 2024). Although the Netherlands adheres to the principle of "home care first," a shortage of professional nursing staff in rural areas forces approximately 20% of impaired older persons to seek services across regions, further escalating care costs (Yang Minjun et al. 2024).

The fragmented planning, management, and coordination of long-term care systems—coupled with limited coverage and weak policy integration—represent a second major challenge common across nations, directly exacerbating disparities in protection among different demographic groups and geographic regions.

From the perspective of integrated planning, management, and coordination, regional fragmentation significantly constrains systemic effectiveness. Among China's 49 pilot cities for long-term care insurance, only 12 provide universal coverage to both employed and residential medical insurance enrollees, while the majority remain limited to employed groups.

Contribution standards vary widely—ranging from 15 RMB per person per year (e.g., Jingmen, Hubei) to 240 RMB (e.g., Shanghai) (Yu Ziyi 2023)—with reimbursement rates differing by 30 to 50 percentage points across regions. In the absence of comprehensive provincial-level system planning, the portability of long-term care benefits for older adults moving across regions remains difficult to ensure (Hu Hongwei et al. 2024). In Italy, there is a marked North–South imbalance in provision (North-East ≈ 10 beds per 1,000 population vs South ≈ 3 beds per 1,000), and the provision targeted to non-self-sufficient older people is far denser in the North (≈ 28–31 beds per 1,000 older residents in North-West/North-East) versus the South (≈ 6 beds per 1,000) (ISTAT 2025).

In terms of population coverage, the provision of "selective protections" has exacerbated issues of social equity. In China, the enrollment rate among functionally impaired older people in rural areas remains below 20%, significantly lower than the 65% observed in urban areas. This urban–rural disparity is particularly stark given that over 20% of the rural older population is functionally impaired—a proportion higher than that in cities—yet these individuals face a triple challenge of inadequate care personnel, high costs, and poor service quality. As a result, rural communities have become an institutional "weak link" in the system's coverage (Sun Yanxia & Yu Haiping 2021).

Common financing challenges, including overreliance on single funding sources, generational imbalances, and market failures universally threaten the sustainability of long-term care systems. Italy's LTC financing mixes national transfers, regional budgets, local social spending and out-of-pocket payments; there is no single, comprehensive national LTC insurance. This patchwork produces weak risk pooling and variable coverage: some services are publicly funded (health-related LTC), whereas domiciliary support and allowances often depend on regional policy and municipal capacity, creating gaps and unpredictable household burdens. Recent estimates place public LTC expenditure at a relatively modest share of GDP compared with projected needs, while a meaningful share of costs falls on families[3].

In China, the social insurance model exhibits notable dependence on a single channel and lacks financial autonomy. Across pilot cities, 82% of long-term care funding is redirected from the basic medical insurance pool, with only 18% originating from individual and employer contributions. The absence of an independent, growth-oriented financing mechanism raises concerns that rising long-term care demands could increasingly strain—and potentially crowd out—essential medical insurance funds as the population ages (Zhang Na. 2024).

The "professionalism" and "human-centeredness" of long-term care services are fundamental to the effective implementation of the system. However, these are severely constrained by a "workforce crisis" and "inadequate regulatory oversight", which directly undermine service effectiveness. From the perspective of workforce supply, common challenges include inadequate numbers, high turnover rates, and low professional competency. China has fewer than 300,000 care workers, with only 6.7 caregivers per 1,000 functionally impaired older adults—far below the ratios in Germany (52) and Japan (48) (Xie Bingqing 2019) Moreover, the rural-to-urban migration of care workers in China is exacerbating a "supply vacuum" in rural long-term care services (Sun Yanxia & Yu Haiping 2021).

From the perspective of quality oversight, significant issues persist in the form of "inadequate

[3] Long Term Care System Profile: Italy, The Global Observatory of Long-Term Care, https://goltc.org/system-profile/italy/ (access 17 November 2025).

standards, lax enforcement, and unreliable assessments." In China's pilot cities, only 10% have established a unified service quality evaluation system, while some institutions engage in practices such as "falsifying service hours" and "compromising service standards" (Yang Lei & Zhang Hangkong 2024). Furthermore, the entry of multinational care corporations in an increasingly globalized landscape has compounded regulatory complexity. Differences in how nations define "quality of care"—for instance, China's emphasis on "emotional support" versus the focus in Europe and the U.S. on "functional recovery"—hinder the development of consistent international regulatory standards for cross-border services (Yang Lei & Zhang Hangkong 2024).

In sum, the global surge in long-term care demand reflects a confluence of structural demographic pressures, declining family caregiving capacity, and widening mismatches between care needs and available formal services. These dynamics reveal that long-term care is no longer a peripheral social concern but a central pillar of modern welfare governance, requiring sustained policy attention, institutional redesign, and innovative financing strategies. The persistence of care gaps—especially in medically oriented and community-based services—demonstrates that most countries remain ill-prepared for the scale and complexity of functional impairment associated with population aging. At the same time, the fragmentation of planning, uneven coverage, and persistent regional disparities illustrate the limits of existing governance models in ensuring equitable and efficient LTC provision. As demand accelerates and supply constraints deepen, the long-term sustainability of LTC systems will hinge on the ability of states to integrate services, stabilize financing, professionalize the workforce, and rebalance responsibilities among families, markets, and public institutions.

Against this global backdrop, the following two sections examine how these challenges materialize within specific national contexts. The Italian case illustrates how an advanced-aging, low-fertility society grapples with structural service shortages, regional inequities, and fragmented financing arrangements despite high levels of family involvement. The Chinese case, by contrast, highlights the pressures faced by a rapidly aging, large-scale society undergoing profound social transformation, where pilot long-term care insurance schemes, shifting family structures, and vast urban–rural divides shape both opportunities and constraints. Together, these cases illuminate the diverse pathways—and shared dilemmas—confronting countries as they seek to build sustainable, resilient long-term care systems in the 21st century.

2. The Long-Term Care System in Italy: The new Reform between ambition and reality

The Italian long-term care (LTC) system offers a compelling case study of a Southern European welfare model grappling with the profound pressures of a rapidly ageing demographic (Pavolini, Ranci 2015). Publicly provided care is highly fragmented, with significant mismatches in coverage and generosity across Italian regions (Brugiavini et al. 2023, 2025). Characterized by a path-dependent structure, its evolution has been shaped more by incremental adjustments and reactive measures than by comprehensive, forward-looking reforms.

The cornerstone of this system is an implicit reliance on the family as the primary locus of care, a principle often described as "familism by default." This is not merely a reflection of cultural tradition but a structural outcome of a welfare state that has historically prioritized pension expenditure over the direct provision of social services. Consequently, the responsibility for

providing daily, intensive support to the older adults and those with disabilities falls overwhelmingly on the shoulders of their relatives, predominantly women, who are expected to absorb the physical, emotional, and financial costs of caregiving with limited institutional support. This deep-seated reliance on familial solidarity forms the bedrock of the entire Italian LTC framework.

State intervention, where it exists, has predominantly taken the form of cash-for-care benefits rather than in-kind services. The most significant of these is the *indennità di accompagnamento* (attendance allowance), a flat-rate, non-means-tested monthly cash allowance provided to individuals certified as totally dependent and requiring continuous assistance. While this policy provides a degree of financial relief and user choice, allowing recipients to purchase care on the open market, it simultaneously reinforces the privatization of care responsibilities. Instead of developing a robust public infrastructure of residential facilities or professional home-care services, the state effectively outsources care provision to families and the market. This approach has been instrumental in fostering a vast and largely unregulated market for personal care, creating a direct nexus between state subsidies and the employment of private carers.

This dynamic has, in turn, been sustained by a significant influx of migrant domestic care workers, colloquially known as *badanti*[4]. These workers, primarily women from Eastern Europe and other regions, have become an indispensable pillar of the Italian LTC system, filling the care gap that families, even with cash support, cannot manage alone. They provide round-the-clock assistance, enabling older individuals to age in place, a strongly preferred option in Italian society. Furthermore, qualitative and policy-oriented research supports this depiction of Italy's long-term care landscape: Melchiorre, Lamura & Socci (2022) show how frail older adults living alone in Italy increasingly rely on both public monetary transfers and the informal (and often irregular) labour market of care workers. Their analysis points to the central role of cash benefits in enabling the hiring of caregivers (including migrant 'badanti'), and to the interplay between family responsibilities and public services.

However, this reliance creates a de facto two-tiered system: one where care is informally managed within the home, often under precarious employment conditions, and another, much smaller, public system of residential and home care that is often over-subscribed and difficult to access. The fragmentation of the system is therefore evident in the division of responsibilities between the family (the default provider), the state (the cash provider), and the market (the service provider, heavily reliant on migrant labour). This patchwork arrangement results in significant geographical and social inequalities, with access to and quality of care being highly dependent on a family's economic resources, social capital, and geographical location (Arlotti, Parma, & Ranci 2020). In essence, the Italian model represents a system that has adapted to

[4] The strong informality surrounding this care arrangement, combined with the reliance on migrant labour—especially that of women—plays a key role in the social and occupational devaluation of domestic care work. The widespread Italian term *badante*, used for paid caregivers of older adults, is itself a product of these dynamics. Etymologically stemming from *badare*, meaning "to watch over" or "to keep an eye on," the term originally referred to someone responsible for tending livestock in fifteenth-century Italy. Its modern use in elder care signifies a symbolic reduction of the role: it simplifies a complex set of relational, physical, and household activities into a basic function of "surveillance." This semantic compression is sociologically important. It reflects and reproduces moral hierarchies of care that prioritise supervision and risk management over emotional labour, embodied skills, and domestic tasks—those that are feminised, taken for granted, and thus undervalued. Simultaneously, the term captures a broader social expectation that migrant women will offer ongoing, quasi-familial monitoring, independently managing minor issues while acting as the first response in emergencies. In this way, *badante* functions not only as a descriptor but also as a linguistic tool that legitimises the marginalisation of vital care responsibilities to a precarious, gendered, and racialised segment of the workforce (Ambrosini, 2020).

demographic ageing by externalizing the costs and labour of care onto families and a migrant workforce, a stark contrast to the state-led, top-down construction of a formal LTC framework being pursued in other contexts like China.

Italy's LTC system revolves around an implicit family-centered model that historically relied on multigenerational households and traditional gender roles. The core assumption is that families—primarily women—will provide continuous daily care for dependent older relatives. Legislative frameworks such as Law 104/1992 and subsequent reforms formally recognize the role of family caregivers yet offer limited structural support in terms of services or financial compensation.

The system's central benefit, the attendance allowance (*indennità di accompagnamento*), represents more than half of public LTC expenditure. Its universal and unconditional design supports freedom of choice but also sustains unregulated market arrangements. Unlike the structured, insurance-based models developed in countries like Germany or the emerging system in China, Italy offers no standardized entitlement to home-care services or nursing care. Access to public services remains highly uneven, often depending on regional capacity and municipal investment.

The widespread use of migrant care workers is a defining characteristic of Italian LTC. Estimates suggest that several hundred thousand migrant women provide live-in care, effectively substituting the lack of formal services. While this arrangement allows dependent individuals to remain at home, it also exposes migrant workers to precarious employment conditions and families to the responsibilities of informal employment.

Territorial fragmentation is another systemic issue. Regions exercise significant autonomy in organizing social services, leading to pronounced disparities in availability, quality, and affordability of LTC. Northern regions tend to provide more structured services, while southern regions depend disproportionately on informal and migrant care (Arlotti, Ranci 2021). Italy's LTC system has therefore evolved into a hybrid model combining extensive informal care, cash benefits, and a private care labor market, with limited formal public service provision.

As Da Roit (2017; 2021) and Albertini and Pavolini (2017) have documented, this has created a quasi-market highly stratified by class. Families with sufficient resources "purchase" care by hiring a *badante*, while lower-income families are left with insufficient public support. This model, often termed "migrant-in-the-family," solves the immediate care need for individual families but poses significant societal problems:

- It creates a "care drain" from Eastern European and other countries.
- It operates in a "grey market" with limited labour protections.
- It absolves the state of its responsibility to build a robust public service infrastructure.

The policy and governance failures of Italian Long-Term Care (LTC) cannot be understood without first analyzing their sociological foundation. Italy is the archetypal example of a "familistic" (or "family-based") welfare regime (Ferrera, 1993), where the state has historically operated on the implicit assumption that the family—specifically, its female members—will act as the primary caregiver for social risks, including old-age dependency. We argue that this traditional pillar is now sociologically "exhausted." The resulting "care vacuum" has not been filled by a universal public system, but by a vast, privatized, and highly stratified quasi-market,

creating new forms of inequality.

The structural reliance on the family as the default provider of LTC has placed an immense and well-documented strain on informal caregivers. This "caregiver burden" is the defining feature of the Italian model. The burden is not gender-neutral; it is overwhelmingly female. The role of "primary caregiver" is disproportionately filled by daughters, daughters-in-law, or older spouses. For women caring simultaneously for aging parents and their own children, this obligation often forces a reduction in working hours or a complete exit from the labour market, reinforcing traditional gender roles and contributing to Italy's low female employment rate.

Research, such as the longitudinal studies by Carrino et al. (2018), Brugiavini et al. (2017), provide clear evidence of the multidimensional costs. Informal caregivers report significantly worse health outcomes, including higher rates of depression, social isolation, and physical exhaustion. Furthermore, the financial burden is substantial, encompassing high out-of-pocket expenses for medical supplies and assistive devices, alongside the significant opportunity cost of lost income. This model is clearly no longer sustainable. Its erosion is driven by macro-social trends that have fundamentally weakened the family's capacity to provide intensive, round-the-clock care:

1. Demographic Shifts: Smaller family sizes mean the "burden" is shared among fewer (if any) siblings.
2. Labour Market Changes: Increased female education and labour market participation mean women are less available—and less willing—to serve as a full-time, unpaid care workforce.
3. Social Mobility: Greater geographical mobility means adult children are less likely to live near their aging parents.

The result is a structural "care deficit": the demand for care is rising exponentially while the traditional, informal supply is collapsing. The Italian state did not respond to this growing care deficit with a robust expansion of public services (like home care or residential facilities). Instead, the gap has been filled by the market, specifically through the mass employment of migrant care workers (*badanti*).

This is the central sociological phenomenon in Italian LTC: the "privatisation of care" that is highly stratified by social class (Da Roit 2017; 2021). This model sees individual families using their own resources—often relying on the state's cash transfer, the indennità di accompagnamento (IA; attendance allowance) —to privately hire a *badante*. This worker is frequently co-resident, providing 24/7 coverage. This solution, born from necessity, creates a "quasi-market" for care. This quasi-market is deeply unequal. It creates a two-tier (or multi-tier) system of care access. High-Income Families can afford to hire legally contracted (or multiple) *badanti* to provide high-intensity care, while middle/low-income families can only afford this care by relying on the "grey market" (*lavoro grigio*), hiring workers irregularly, often with limited protections and uncertain quality. Lastly, the poorest families who cannot afford a *badante*, are left to rely on the exhausted family system or the (often minimal) public services available in their area. Sociologically, the *badante* phenomenon has acted as a crucial safety valve. It "solves" the immediate, day-to-day care crisis for thousands of families, thereby reducing popular pressure on the state to build a comprehensive and expensive public system.

The state, in effect, delegates its public responsibility to the private resources of families and the labour of migrant women, all while containing public expenditure. This sociological equilibrium—based on exhausted families and a stratified private market—is not only unequal but also legally and socially precarious. It is this precariousness that forms the backdrop for the fragmented governance and halting reform efforts detailed in the subsequent sections.

2.1 The Governance of Fragmentation: Policy Silos and Territorial Divides

The governance architecture of Italian Long-Term Care (LTC) is perhaps its most defining and problematic feature. It is not a "system" in the coherent sense of the word, but rather, as much scholarship has demonstrated, a fragmented patchwork of policies, funding streams, and institutional responsibilities that have co-evolved without a central design (Bertin, et al., 2020; Brugiavini et al. 2023, 2025). This "structured fragmentation" is the primary obstacle to reform and the key driver of inefficiency and inequality.
This section deconstructs this governance failure by analysing its three core components: (1) the dominance of "cash-for-care" and its policy crowding-out effect; (2) the institutional "silos" of health and social policy; and (3) the profound territorial disparities entrenched by Italy's "lame federalism" (Pavolini & Ranci, 2019).

2.1.1. The Dominance of "Cash-for-Care": The Indennità di Accompagnamento (attendance allowance)

The centrepiece of Italian LTC policy is not a service, but a cash transfer: the indennità di accompagnamento (IA). Established in 1980, the IA is a universal, non-means-tested, flat-rate cash benefit provided by the central state (via INPS, the National Social Security Institute) to any citizen certified as 100% dependent and unable to ambulate or perform basic daily tasks.
From a governance perspective, this instrument is deeply problematic and creates a powerful "path dependency" that stifles reform.

- Fiscal Dominance and "Crowding-Out": The IA dominates public LTC expenditure. Recent analyses (e.g., NNA Network, 2023) show that the IA accounts for over €13-14 billion annually, representing the largest single component of Italy's total public LTC spending (which is estimated to be around €25-28 billion). This leaves comparatively little public funding for the development and provision of in-kind services, such as public home care (ADI/SAD) or residential facilities. As Brugiavini and Bertin (2020) have argued, the IA effectively "crowds out" investment in services, locking Italy into a low-service, cash-based model.
- Policy Incoherence: The IA is disconnected from any care plan. It is an unconstrained transfer; families can use it for any purpose, not necessarily to purchase care. This contrasts sharply with systems in other countries (like Germany's) where cash benefits are part of a structured care insurance scheme. In Italy, the IA's design reflects its original 1980s logic: to monetarily compensate for a disability and support the family, not to build a system of care services (Da Roit, 2021).
- Inequitable Design: Being non-means-tested, the IA is highly regressive. It provides

the same (in-itself insufficient) amount to a low-income household struggling with care costs as it does to a high-income household. This design fails to target resources where the need is greatest.

2.1.2. Institutional Fragmentation: The Health vs. Social "Silos"

LTC is a quintessential "cross-cutting" issue, requiring seamless integration between medical and social support. The Italian governance framework, however, institutionalizes a deep-seated division between these two worlds.

- Health (Sanità): This is the responsibility of the Servizio Sanitario Nazionale (SSN), which is funded by the central state but planned and delivered by the Regions (Regioni) via local health authorities (Aziende Sanarie Locali - ASL). This silo controls services like nursing home care (ADI), rehabilitation, and the health component of residential care (RSA).
- Social (Sociale): This is the responsibility of the Municipalities (Comuni), often grouped into local districts (Ambiti Territoriali Sociali - ATS). This silo manages services like home help (SAD - e.g., cleaning, meal preparation), and social work.

For a non-self-sufficient person and their family, who need both a nurse to manage medication and a helper to assist with bathing, this division is a bureaucratic nightmare. They must navigate two separate access points (Punti Unici di Accesso - PUA), two assessment procedures (e.g., Unità di Valutazione Multidimensionale - UVM), and two different funding/co-payment systems. Integration, while a constant refrain in policy documents, is rarely achieved in practice due to divergent professional cultures, separate budgets, and misaligned political incentives (Bertin, 2020).

2.1.3. Territorial Divides: "Lame Federalism" and the Failure of LEPS

The final layer of governance failure stems from Italy's multi-level structure. The 2001 constitutional reform (Title V) devolved significant autonomy in health and social policy to the 21 Regions, without first establishing a strong central framework for essential rights. This has been described by scholars like Pavolini and Ranci (2019) as a "lame" or "unfinished" federalism. Without robust, nationally-funded and enforced standards, this devolution has transformed socio-economic gaps into institutional gaps. The result is not one Italian LTC system, but 21 different systems.

An emblematic failure is the implementation of LEPS (Livelli Essenziali delle Prestazioni Sociali - Essential Levels of Social Services). While the concept of Livelli Essenziali (for health, LEA) was intended to guarantee a basic floor of rights for all citizens, the LEPS for social care have remained largely unfunded and unenforced for decades.

This creates vast disparities (NNA Network, 2023):

- Service Availability: A citizen in the South (e.g., Calabria, Sicilia) has access to far fewer hours of public home care, fewer day centres, and fewer subsidized residential care beds than a citizen in the North (e.g., Emilia-Romagna, Lombardia).
- Public Spending: Regions in the North spend significantly more per capita on social services for the older adults and disabled than those in the South.

This fragmented, unequal, and cash-dominated landscape is the governance reality that

any reform must confront. It is a system "stuck" in a sub-optimal equilibrium, one that the recent PNRR and the Legge Delega 33/2023 are now, for the first time, attempting to systematically address by creating a unified national governance structure (the Sistema Nazionale Assistenza Anziani - SNANA).

2.2. Crisis and Reform: The PNRR and the "Legge Delega" (Law 33/2023)

The long-standing, "frozen" equilibrium of Italian LTC, characterized by family reliance, market-based *badanti*, and governance fragmentation, was catastrophically destabilized by the COVID-19 pandemic. The crisis, which disproportionately affected the older adults, particularly those in Residential Care Homes (RSA), served as a "focusing event" (Kingdon, 1984), creating an unprecedented policy window for reform.
This window was further forced open by the European Union's response, the NextGenerationEU plan, and its Italian implementation, the *Piano Nazionale di Ripresa e Resilienza* (PNRR). This section analyzes the dual-track reform momentum driven by the PNRR and the subsequent landmark legislation, *Legge Delega 33/2023*.

The PNRR (Mission 5 and 6) earmarked substantial funding for healthcare reform, which, while not exclusively focused on LTC, provided the critical financial and political leverage to address parts of the system. The PNRR's primary contributions relevant to LTC are: 1) Strengthening Territorial and Home Care: The plan allocates funds for "Community Houses" (*Case della Comunità*) and to strengthen Integrated Home Care (ADI - *Assistenza Domiciliare Integrata*); 2) Digitalization and Telemedicine: Investments aimed at modernizing health infrastructure.
However, from a governance perspective, the PNRR's impact on LTC is inherently limited. Its focus is overwhelmingly health-centric (*ambito sanitario*), reinforcing the existing institutional silo. It does little to address the corresponding weakness in the social care (*ambito sociale*) silo, which remains the responsibility of municipalities and is the system's most underdeveloped component.
Critically, the PNRR also introduced strict *conditionality*: Italy was required to legislate a comprehensive reform of LTC to ensure this new infrastructure would be effective. This conditionality was the direct political impetus for Law 33/2023. Passed in March 2023, the "*Legge Delega in materia di politiche in favore delle persone anziane*" (Enabling Act on policies in favor of older persons, Law 33/2023) is the most significant legislative attempt in Italian history to create a coherent national LTC framework. It is the direct product of years of advocacy from civil society and academic coalitions, most notably the "Patto per un nuovo welfare sulla non autosufficienza[5],"
The law's primary objective is to overcome the fragmentation of the Italian system for LTC. Its key pillars, subsequently detailed in the implementing decree (D.Lgs. 29/2024), are:

[5] The Pact for a New Welfare System for Non-Self-Sufficient Individuals (Patto per un nuovo welfare sulla non autosufficienza), signed in July 2021 by a broad social coalition, aims to develop operational proposals for reforming the care system for non-self-sufficient older people. The Pact brings together most of the civil society organizations involved in the care and protection of non-self-sufficient people in Italy: it represents the older adults, their families, pensioners, professional associations, and service providers. https://www.pattononautosufficienza.it/ (access 17 November 2025).

1. Unified (National) Governance (SNANA-Sistema Nazionale Assistenza Anziani):
The law establishes, for the first time, a National Long-Term Care System (Sistema Nazionale Assistenza Anziani, SNANA). This new governance architecture is designed to integrate the fragmented actors: a central coordinating committee (CIPPA - *Comitato interministeriale per le politiche in favore della popolazione anziana*) is established to provide national direction and its explicitly aims to link the national level (INPS, Ministry of Health, Ministry of Labour) with the Regions (health care services) and the Municipalities (social care services), mandating unified access points (PUA) and assessment procedures (UVM).

2. Addressing the Cash-vs-Service Imbalance (Prestazione Universale):
This is the reform's most innovative and controversial element. The law pilots a new "Universal Benefit" (Prestazione Universale) for the most severely non-self-sufficient. This benefit introduces a choice-based model designed to "convert" cash into services:

- Option A (Status Quo): The person can continue to receive the traditional, unconditional *indennità di accompagnamento* (IA).
- Option B (The Reform): The person can "opt-in" to a new, more valuable benefit. This new benefit is a *copertura* that combines the value of the IA *plus* an additional service budget. However, this benefit is conditional: it must be used to purchase certified services, either from public providers or from qualified private sources (including, importantly, legally employed *badanti*).

This mechanism is a direct attempt to tackle the "crowding out" effect of the IA identified by Brugiavini and Bertin (2020), incentivizing a move from the "grey market" of informal care to a regulated system of services. While historic in its ambition, the reform is fraught with challenges that reflect deep-seated political and fiscal constraints. The reform does not abolish or reform the *indennità di accompagnamento* itself. The new benefit is an optional, experimental "add-on" for a limited (and initially, very small) portion of the dependent population. The political cost of "touching" the IA—a benefit received by nearly 3 million people—was deemed too high. This "dual track" system risks creating more complexity rather than solving the core problem. The most significant critique, leveled by the NNA Network and others, concerns funding. The initial allocations for both the *Prestazione Universale* and the LEPS are considered by most analysts to be "manifestly insufficient" to meet the law's stated goals. Without a massive fiscal reinvestment, the reform's promise to rebalance the system toward services cannot be fulfilled. Finally, the success of the SNANA hinges on the willingness of powerful Regions to cede control to a national framework and for under-resourced Municipalities to build complex social service systems.
In conclusion, Law 33/2023 represents a fundamental paradigm shift in *intent,* moving from a patchwork of compensatory cash benefits to the idea of a comprehensive "system". However, its *implementation* thus far appears to be a timid, underfunded compromise, deeply constrained by the very path dependencies it seeks to overcome.

The Italian Long-Term Care system is nowadays a crossroads. Its sociological foundation—the family—is overburdened, and its governance structure is fragmented and inefficient. The long-standing reliance on informal female care, supplemented by a precarious market of migrant labour and funded by an undifferentiated cash allowance, is no longer sustainable demographically, economically, or socially.

The recent reform efforts, culminating in Law 33/2023, represent the most coherent attempt in Italian history to design a system. By establishing the SNANA (National Long-Term Care System) and piloting a "universal benefit" that incentivizes the shift from unconditional cash to regulated services, the reform correctly diagnoses the core problems of the Italian model. It explicitly seeks to overcome the fragmentation, rebalance the cash/service ratio, and address the "grey market" of badanti.

However, the analysis also reveals a fundamental gap between ambition and reality. The reform, in its current implementation, remains a compromise. The political reluctance to reform the IA for the general population, coupled with manifestly insufficient funding for the new "opt-in" benefit and the LEPS, suggests a "path dependency" that is difficult to break. The risk is that Law 33/2023, while symbolically historic, will remain a pilot project rather than a structural transformation.

In conclusion, Italy's LTC system is no longer "frozen." A new paradigm, based on integration and services, has been articulated (Casanova 2020). But its transition from a fragmented, familistic, and cash-based model to a truly universal and equitable public system is far from guaranteed. It remains an unfinished, and critically underfunded, project.

3. The Long-Term Care System in China: A National Strategic Priority.

China is undergoing a profound demographic transition, grappling with mounting pressure on long-term care service provision driven by rapid population aging. The central challenge it confronts is how to deliver "sustainable and adequate" care services to its growing older population.

China's long-term care system is deeply rooted in a cultural tradition that emphasizes family-based support, traditionally centered on family care underpinned by the ethics of filial piety. However, shaped by socioeconomic conditions and the underlying logic of its welfare system, a distinctive pathway has gradually emerged—one that reflects Chinese characteristics. The country is now transitioning from a traditional family-centric model toward a state-led, top-down multi-pillar framework, which includes social insurance pilots, public–private collaboration, and the integration of medical and care services (Kang Rui 2025). This developmental trajectory, shaped by national conditions, offers a valuable analytical lens—"cultural tradition versus institutional choice"—for comparative research, illuminating how the interplay between culture and institutional design leads to divergent systemic paths.

While population aging presents a universal challenge, no single long-term care model offers a globally applicable solution. Analyzing China's experience reveals how distinct institutional logics—such as "family-oriented" versus "state-led" approaches—respond to demographic aging. This comparative insight provides valuable lessons for policymakers worldwide confronting similar challenges, underscoring the vital role of academic research in informing global governance and evidence-based policy making.

Current domestic research on international long-term care comparisons remains relatively limited. Further investigation in this field would substantially enrich China's scholarly landscape in this domain. Moreover, compared to the well-established body of research on Western long-term care systems, a significant academic gap persists in China's "in-depth comparative analysis between its own long-term care system and those of other nations" (Xu Yi & Li Liang 2024). Through international comparative research, we aim not only to deepen the understanding of foreign models but also to gain clearer insights into the distinctive characteristics, advantages, and potential improvements of China's state-led approach, thereby advancing both academic accumulation and theoretical development in domestic long-term care research.

3.1 Demographic Change and the Context of Long-Term Care

China entered an aging society in 2000. China not only has the world’s largest older population but is also aging at an accelerating pace. Structurally, Chinese society is transitioning from “rapid aging” to “deep aging,” against a backdrop of shrinking family sizes and mounting pressure on labor supply. Population aging represents not merely a shift in demographic structure, but a comprehensive challenge to social governance, healthcare systems, and old-age service provisions. With the proportion of older persons steadily increasing and the number of functionally impaired and semi-impaired older people rising sharply, establishing a well-functioning, accessible, and sustainable long-term care system has become an urgent imperative for both China and the global community.

China's long-term care system is deeply rooted in a tradition of family-based older adults support, with the family historically serving as the primary provider of elder care under the profound influence of Confucian filial piety ethics (Yang et al. 2020). The social preference for "aging in place" remains an integral part of China's cultural fabric, leading most older adults to choose home-based care. In the early years of the People's Republic, family caregiving was further reinforced through legal instruments and policy directives, notably through the Law on the Protection of the Rights and Interests of the Elderly, which codifies children's statutory obligation to support their parents (2023). This model traditionally relied on multigenerational household structures, emphasizing children's dual responsibility to provide both material assistance and emotional comfort to aging parents. However, alongside socioeconomic transformation, diminishing family sizes and increased population mobility have progressively eroded traditional family care capacity (Shi et al. 2024). National data reveal that by 2019, 47.2% of rural older adults either lived alone or with equally aged spouses—a striking increase of 17.6 percentage points since 2010—highlighting the accelerating trend of "empty nesting" in family-based elder care.

China's one-child policy, implemented from 1979 until its termination in 2015, has significantly reduced average family size and simplified family structures, giving rise to the "4-2-1" household pattern (four grandparents, two parents, and one child). This demographic shift has substantially increased the eldercare burden on the younger generation (2023). Research confirms that single-child families experience greater pressure when facing the risk of older adults functional impairment, with family resource allocation increasingly skewed toward the younger generation, thereby objectively undermining the practical foundation of traditional

filial piety (Chen, X., & Han, Y. 2022). This structural tension has exacerbated systemic gaps in long-term care demand, serving as a key driver for developing socialized care services. As the first generation of single-child parents enters old age, China's old-age dependency ratio has reached 22.8%, meaning approximately every five working-age individuals support one older person. The combined economic burden and care pressure continue to intensify, making traditional intergenerational support mechanisms increasingly unsustainable (Yin Zhigang 2009).

China's long-term care resources demonstrate a pronounced urban-rural divide (Liu, J., & Zhang, Y. 2023). Rural areas, affected by the out-migration of working-age adults and scarce medical resources, maintain persistently low coverage of older people care services. In 2020, the number of hospital beds per 1,000 people in rural areas stood at 3.34, significantly lower than the 6.28 beds in urban areas, highlighting a substantial imbalance in healthcare resource distribution (Zhou, Y., & Li, C. 2024). Meanwhile, although rural older adults are more dependent on family care, the progressive weakening of family support structures places them at higher risk of functional impairment (Shi et al. 2024). Regarding pension benefits, the average monthly pension for rural residents in 2022 was merely 204 yuan, compared to 3,326 yuan for urban retirees—a more than 16-fold disparity. This institutional gap severely undermines the overall equity of the long-term care system (Huang Zongye & Zhao Jingjing 2022). Notably, the proportion of the population aged 60 and above in rural China has reached 23.81%, exceeding the urban rate by 7.99 percentage points. While rural China has entered a phase of moderate aging ahead of urban areas, the provision of older adults care resources remains critically inadequate, creating a stark contrast (Zhao Xin 2023).

In line with the national strategy on proactive response to population aging and to address gaps in the social security system, China has established a Long-Term Care Insurance (LTCI) system. Building on the "Seven **Errore. Il segnalibro non è definito.** Essential Guarantees" outlined in the report to the 20th National Congress of the Communist Party of China—covering childcare, education, employment, medical care, older people care, housing, and support for the vulnerable—the system further introduces "protection for the disabled." This expansion is intended to strengthen the social security safety net and enhance the public's sense of benefit, happiness, and security.

China initiated the exploration of a long-term care insurance system in 2016, expanded the pilot[6] program in 2020, and officially affirmed the goal to "establish a long-term care insurance system" in the report to the 20th National Congress of the Communist Party of China in October 2022. This signals that LTCI will be a key focus of China’s eldercare policy framework in the years ahead. The 2016 Guiding Opinions on Implementing the Long-Term Care Insurance Pilot

[6] In June 2016, the Ministry of Human Resources and Social Security of China issued the Guiding Opinions on the Pilot of the Long-term Care Insurance System and launched the pilot work of the long-term care insurance system in 15 cities in 14 provinces (districts and cities). These pilots include: Chengde City, Hebei Province, Changchun City, Jilin Province, Qiqihar City, Heilongjiang Province, Shanghai City, Nantong City, Jiangsu Province, Suzhou City, Ningbo City, Zhejiang Province, Anqing City, Anhui Province, Shangrao City, Jiangxi Province, Qingdao City, Shandong Province, Jingmen City, Hubei Province, Guangzhou City, Guangdong Province, Chongqing City, Chengdu City, Sichuan Province and Shihezi City, Xinjiang Uygur Autonomous Region.
The pilot aims to explore the establishment of a social insurance system to provide basic living and medical care security for the disabled through social mutual assistance, and to form a policy framework suitable for national conditions during the 13th Five-Year Plan. The main tasks include: designing coverage, financing and treatment policies; formulating standards for disability assessment and qualification; establishing service evaluation, agreement management and cost settlement mechanisms; and improving the insurance operation and supervision system.

outlined the system's foundational principles: it is to be a social insurance program financed through social mutual aid, providing funding or services for basic daily care and medically necessary nursing to individuals with long-term functional impairments (Zhang, Y. 2025). This defines China's LTCI as a social insurance model based on contribution-based financing and the principle of rights corresponding to obligations. While social insurance forms the core of the system, it is intended to be complemented by other models—such as social assistance and commercial insurance—to form a multi-tiered long-term care security framework.

China has adopted a social insurance model to establish its Long-Term Care Insurance system. This model operates on the principle of mutual aid among members of society, where enrollees secure coverage entitlements through contributions, and the pooled funds are used to provide benefits for eligible individuals with functional impairments. In terms of financing, the contribution level for LTCI is relatively modest, yet the system is designed to address the need for open-ended care coverage for people with long-term disabilities. Pilot programs show that annual contributions in most regions range between 100 and 200 yuan per person, with financing drawn from multiple sources and individuals bearing only a portion of the cost. Benefit levels are linked to the financing capacity: regions with higher contribution standards generally offer more generous benefits. Following an assessment of disability level, eligible individuals may receive monthly reimbursements ranging from several hundred to several thousand yuan for covered long-term care services (Zhao Man & Han Li 2015).

The Long-Term Care Insurance system focuses on covering essential daily living assistance and closely related medical care, operating on the principle of "covering basic needs." Pilot areas provide guarantees for the most essential services required by functionally impaired individuals, primarily including daily living assistance, medical care, family caregiver training, and assistive devices, etc.

These services are itemized in a standardized benefit catalogue, allowing care-dependent individuals or their families to select options according to their specific needs. While the insurance fund primarily covers the cost of basic care services, beneficiaries may choose to purchase higher-level care at their own expense.

To ensure the accurate allocation of support resources to care-dependent individuals, the state has established national unified assessment standards and an administrative framework, which primarily includes disability level assessment, assessment agency management, service agency management.

The establishment of the Long-Term Care Insurance system has provided the long-term care service market with a stable payer, thereby significantly accelerating the development of the care industry. By 2024, approximately 8,000 designated service institutions were operating across 49 pilot regions, employing over 300,000 care service personnel. Concurrently, capacity building within the professional care workforce has been strengthened. The occupation of "Long-Term Care Practitioner" has been formally included in the National Occupational Classification, and its National Occupational Standard was released in 2024, defining three competency levels—primary, intermediate, and advanced—with professional functions spanning daily living assistance, basic nursing, emergency response, functional maintenance, and psychological support. Professionally trained Long-Term Care Practitioners are now capable of delivering specialized services to individuals with functional impairments (2024).

After nine years of pilot implementation, China's Long-Term Care Insurance system has

established effective mechanisms for fund mobilization through social insurance contributions, service oversight via designated-provider agreement management, and cost reimbursement through centralized fund settlement. This socially-pooled mutual aid framework has made systematic long-term care protection feasible, providing timely support to families in severe caregiving distress and enabling millions of individuals with long-term disabilities to live with dignity. Today, there are growing calls across society for the nationwide implementation of the Long-Term Care Insurance system, building on the pilot experience to further strengthen China's social security framework.

3.2 Government Priorities: Developing a Standardized Older adults Care System

In response to the challenges posed by rapid population aging, the Chinese government has elevated the development of its long-term care system to a national strategic priority (2023). The report to the 20th National Congress of the Communist Party of China explicitly called for "establishing a long-term care insurance system" and "ensuring access to basic older adults care services for all older persons," highlighting the foresight embedded in its top-level planning (Chen, X., & Han, Y. 2022). In recent years, the government has advanced this agenda through a dual approach of policy-guided pilot initiatives, accelerating the establishment of an older adults care service system that is home-based, community-supported, and institution-supplemented. This reflects a broader transition from a family-dominated model toward a state-society collaborative framework (Lu et al. 2017). The central government has allocated 296 million yuan (approximately US$41 million) to support 59 regions in launching innovative county-level older adults care service pilots, adopting a point-to-area approach to drive comprehensive improvements in rural older adults care (2024). These measures underscore the government's strategic commitment to perfecting a social security system that covers all citizens and developing a distinctive Chinese model of older adults care (Nie Aixia & Guo Shujing 2023).

3.3 Social Insurance Pilot (LTCI)

China launched its pilot Long-Term Care Insurance (LTCI) system in 15 cities in 2016, aiming to provide coverage for basic daily living assistance and medical care to individuals with functional impairments (Lu et al. 2017). Qingdao, as a pioneering city, began exploring long-term care medical insurance as early as 2012, innovatively extending coverage to include medical services and home-based care, with funding primarily drawn from transfers out of the basic medical insurance fund (Zhang Yanfang et al. 2022). By 2023, the pilot program had expanded to 49 cities, covering approximately 240 million people; however, the actual coverage rate remains at just 6%, indicating significant challenges in scaling up the system (Zhou, Y., & Li, C. 2024). Pilot cities have pursued varying approaches in financing mechanisms, benefit package design, and reimbursement rates. For instance, the Shanghai model emphasizes the provision of home care services, whereas Qingdao's system incorporates a diversified integration of institutional and community-based care (Zheng Shuwen 2024). In 2025, the National Healthcare Security Administration, in conjunction with the Ministry of Finance, added 14 new pilot cities, carefully controlling the scope of expansion to reflect the central

government's consolidated management of the pilot initiative (Mo Yumeng 2023). Kunming, representing the second batch of pilot cities, has established a "1+4+N" service network, creating an operational model that integrates end-to-end systemic control with manual, on-site supervision (2025).

The government plays a leading role in China's long-term care system, advancing institutional care development through a dual approach of policy guidance and financial subsidies (2023). For instance, the *14th Five-Year Plan for Civil Affairs Development* explicitly encourages non-governmental actors to participate in older adults care services and supports private providers through a "publicly-supported, privately-run" operational model (Chen, X., & Han, Y. 2022). Concurrently, by relaxing market access requirements, the government has fostered diversification in the eldercare sector. By the end of 2024, China hosted 406,000 older adults care institutions and facilities, providing 7.993 million care beds in total (2021). In market regulation, the state has established baseline service standards—such as the Basic Specifications for Home-Based Care Bed Services—reflecting a state-led, standardized governance approach (2024). However, private sector involvement remains inadequate, particularly in rural areas, constrained mainly by unclear profitability models and an underdeveloped regulatory framework (Shi et al. 2024). Although 77,600 enterprises related to senior products and services were registered in 2024, indicating initial vitality in the silver economy, a scaled industrial effect has yet to materialize (2023).

China is advancing the systematic integration of healthcare and social services to achieve its vision of holistic, person-centered care (Lu et al. 2017). Qingdao's innovative "whole-person, whole-responsibility" model effectively combines professional medical nursing with daily living assistance, extending services through family doctor contracts and community health centers (Zhang Yanfang et al. 2022). In 2018, the National Health Commission issued the Guiding Opinions on Promoting the Reform and Development of the Nursing Service Industry, emphasizing the establishment of a "continuous care service" system and fostering collaboration between tertiary hospitals and primary institutions (Chen, X., & Han, Y. 2022). By the end of 2024, over 85,000 partnership agreements had been signed between medical institutions and aged care facilities across China, with more than 8,400 integrated medical-care institutions providing over 2.1 million beds in total (Feng, Z., & Wang, L. 2020). The development of home care beds has become an important vehicle for integrated service delivery, with national initiatives supporting the establishment of 358,000 such beds across 184 regions, effectively combining in-home care with remote support and intelligent assistance (2024). Nevertheless, implementation still faces challenges including insufficient inter-departmental coordination and fragmented service delivery (Zhou, Y., & Li, C. 2024).

3.4 Institutional design and policy framework

Strategic Top-Level Design. The Chinese government has elevated long-term care to a national strategic level, establishing a comprehensive institutional framework through policy documents such as the *14th Five-Year Plan for Civil Affairs Development* (Nie Aixia & Guo Shujing. 2023). The report to the 20th National Congress of the Communist Party of China explicitly set the goal of "establishing a long-term care insurance system," providing clear strategic

direction for its development (2023).Steady Advancement of Pilot Initiatives. Adopting a gradual reform path of "pilot first, then promotion," the program was launched in 15 cities in 2016 and progressively expanded to 49 cities, amassing substantial local implementation experience (Mo Yumeng. 2023). This prudent, evidence-based approach has effectively mitigated the risks associated with systemic transition. A Collaborative Modern Governance Framework. A modern governance system has been established, characterized by multi-stakeholder involvement and coordinated action. It fosters a governance pattern led by the government with market participation and societal coordination, invigorating non-governmental forces through models like "publicly-supported, privately-run" operations to form a multi-tiered service system (Chen, X., & Han, Y. 2022).

The legal safeguard system remains incomplete, with a lack of dedicated legislation for long-term care. Existing provisions are scattered across various policy documents, resulting in limited authority and binding force (Nie Aixia & Guo Shujing 2023). Moreover, cross-departmental responsibilities are ambiguously defined, and coordination mechanisms require strengthening. Overlapping mandates between healthcare and older people care service management departments have led to noticeable policy fragmentation (Zhou, Y., & Li, C. 2024). Additionally, the development of standardization lags behind; a nationally unified disability assessment framework, service specifications, and quality supervision system have yet to be fully established, hampering service standardization and comparability (2024).

In terms of service provision, China is breaking away from conventional service models by exploring diversified and personalized approaches. The household-based care bed model extends professional services directly into families—the 16,000 such beds established in Guangzhou, for instance, provide capacity equivalent to 100 traditional nursing homes, markedly improving resource utilization efficiency (Chen, X., & Han, Y. 2022). Furthermore, a new type of service system integrating "medical and wellness" care is being systematically developed. Nationally, over 85,000 cooperative agreements have been signed between medical institutions and older people care service providers, with more than 8,400 integrated medical-care institutions effectively addressing the historical challenge of segregated medical and care services (Feng, Z., & Wang, L. 2020). Concurrently, technological advances are enabling smarter eldercare solutions, leveraging information technology to develop intelligent products that enhance service accessibility and precision (2023). However, the absence of standardized and unified service protocols has led to significant disparities in service quality between urban and rural areas, as well as across different regions. Rural services exhibit particularly low standardization and insufficient professionalism (Shi et al. 2024). Service resources remain fragmented with inadequate integration, and the lack of effective coordination among different providers hinders the delivery of continuous, seamless care (Zhou, Y., & Li, C. 2024). Furthermore, the level of specialization requires enhancement—nursing staff often lack advanced professional skills, particularly in specialized areas such as dementia care, which adversely impacts overall service quality (2025).

Strong fiscal support from the central government has been instrumental, with special allocations dedicated to innovation pilots in county-level older people care systems, effectively guiding local governments to increase investment in care services (2024). Continuous infrastructure development is evident—by the end of 2024, China had established 406,000 older people care institutions and facilities providing 7.993 million care beds, forming a

comprehensive service network (2021). Furthermore, a scientific and efficient governance system for talent development has taken shape, with over 770 specialized older adults care programs launched in higher education institutions nationwide, progressively strengthening the professional training ecosystem (2024). However, mounting financial pressure is becoming evident, as long-term care insurance remains overly dependent on transfers from the basic medical insurance pool, with no independent financing mechanism yet established—raising concerns about its long-term financial sustainability (Lu et al. 2017). Furthermore, there is a pronounced shortage of professional care personnel, with a gap of 14 million older adults care practitioners and consistently high turnover rates, severely constraining service provision (Shi et al. 2024). Moreover, resource allocation is imbalanced—high-quality resources are concentrated in urban areas and large-scale institutions, while rural and community-based services remain under-resourced, highlighting the need for greater equity (Liu, J., & Zhang, Y. 2023).

In terms of cultural adaptation, China promotes the evolution of traditional culture through innovation. Policy design consciously aligns with filial piety traditions, reinforcing the foundational role of family care through legislation like the Law on the Protection of the Rights and Interests of the Elderly, thereby respecting the widespread preference among older adults for "aging in place" (2023). The ethos of supporting and respecting the older adults is gaining broader acceptance, steering society toward an age-friendly environment and helping to build a strong social consensus. As population aging intensifies, a shared recognition of the necessity to establish a long-term care system has emerged, creating a favorable environment for its institutional development (2023). However, cultural barriers persist: Deep-seated traditional attitudes remain influential, with some older adults resistant to institutional care, indicating that acceptance of socialized services needs further cultivation (Chen, X., & Han, Y. 2022). Intergenerational family support has weakened amid trends toward smaller household sizes, reducing children's capacity to provide care—a reality not yet fully acknowledged by society (Guo Yongfang et al. 2020). Furthermore, a clear sense of shared responsibility is lacking, with ambiguous boundaries between the roles of the government, market, families, and individuals, which impedes the system's consolidation and long-term development (Nie Aixia & Guo Shujing 2023).

In summary, China has made substantial progress in developing its long-term care system, with the institutional framework largely in place and a service network now taking shape. Nevertheless, challenges persist in areas including institutional completeness, equitable service delivery, resource adequacy, and cultural alignment. Moving forward, deepening reforms will be essential—particularly in strengthening legal frameworks, refining financing mechanisms, enhancing quality oversight, and promoting balanced resource allocation—to advance the system toward high-quality development.

3.5 Relevant issues and policy path for LTC in China

Funding issues

While China has explored diversified financing mechanisms through its Long-Term Care Insurance (LTCI) pilot program, the system remains predominantly reliant on medical

insurance fund transfers and government subsidies, with individual contribution mechanisms still underdeveloped (Lu et al. 2017). Taking Qingdao as an example, 74% of its long-term care medical insurance funding originates from the basic medical insurance pool, while individual contributions account for only 14%, indicating a financing structure requiring urgent optimization (Zhang Yanfang et al. 2022). Compared to the independent premium models adopted by Germany and Japan, China needs to incorporate commercial insurance and social capital to enhance the system's sustainability (Zhou, Y., & Li, C. 2024). To bolster its financial reserves, China has steadily advanced the investment operations of the basic pension insurance fund, which has reached 2.6 trillion yuan (approximately US$358 billion), while the national social security fund—serving as a long-term reserve—has grown to 3.22 trillion yuan (approximately US$444 billion), providing a crucial buffer to address the upcoming peak in aging population demands (Nie Aixia & Guo Shujing 2023).

Quality control

China has yet to establish a nationally unified system for disability assessment and care standards, with different regions employing varied assessment tools—such as the Barthel Index—leading to substantial disparities in service quality (Chen, X., & Han, Y. 2022). While the government is actively promoting standardization, exemplified by the Ministry of Civil Affairs' release of the industry standard Basic Specifications for Home-Based Elderly Care Bed Services, enforcement remains inadequate (2024). In an innovative approach, Kunming City has implemented a "full-process system control complemented by manual offline supervision" model. By establishing a dedicated fund supervision working group, the city achieves comprehensive oversight of designated service providers. It also employs a settlement mechanism featuring monthly disbursements, quarterly evaluations, and annual reviews, linking assessment results directly to service quality assurance deposits. This model offers a practical reference for enhancing quality supervision (2025).

Shortage of caregivers

China faces a severe shortage of older adults care workers, with a deficit reaching 14 million while only 40,000 qualified personnel are currently available (Shi et al. 2024). The government attempts to attract workers through training subsidies and relaxed entry requirements, yet unclear career progression paths and low social recognition continue to hinder professional workforce development (Yang et al. 2020). Nationwide, higher education institutions have established over 770 specialized programs in nursing science and older people care management to strengthen professional training. Simultaneously, authorities are promoting "volunteer older people care services," exploring incentive and evaluation mechanisms for care volunteering, and developing mutual support models for rural aging populations (2024). In Kunming, multifaceted approaches including increased training frequency for assessors, expanded hands-on practice opportunities, and the development of standardized disability assessment tools are being implemented to enhance professional capacity (Pan Shiyue et al. 2025).

3.6 Policy path

Welfare System (Top-down, State-led Model)

China's long-term care system operates under a characteristic state-led welfare model, where policy formulation and implementation are centrally driven by the national government, while local authorities are tasked with pilot execution and regional innovation (2023). This top-down approach facilitates rapid system expansion and resource integration, yet it may also result in limited local adaptability and resource misallocation (Chen, X., & Han, Y. 2022). For instance, significant variations in benefit package design among long-term care insurance pilot cities have impacted the system's overall equity (Lu et al. 2017). The Chinese government has adopted a "pilot first, then gradual scaling" strategy for systemic development: the Long-Term Care Insurance (LTCI) program was initially tested in 15 cities, subsequently expanded to 49, with 14 additional cities joining the pilot in 2025, demonstrating the central government's comprehensive planning and cautious advancement approach (Mo Yumeng 2023). Furthermore, the State Council's issuance of the Social Insurance Administration Regulations mandates that administrative agencies establish robust internal control systems covering operations, finance, security, and risk management, thereby strengthening institutional operational standardization (Nie Aixia & Guo Shujing 2023).

Cultural and Social Norms (Filial Piety and Family Roles)

The traditional cultural value of filial piety continues to profoundly influence policy design, emphasizing family responsibility in elder care, as exemplified by the statutory support obligations for children codified in the Law on the Protection of the Rights and Interests of the Elderly (2023). However, ongoing urbanization and social transformation are progressively weakening traditional family structures, leading to a policy shift toward socialized services, although cultural expectations continue to shape older adults' acceptance of institutional care (Shi et al. 2024). Research indicates that over 60% of older adults individuals prefer aging in place, demonstrating the enduring influence of traditional cultural norms (Chen, X., & Han, Y. 2022). In response, the Chinese government is strengthening home-based care capacity through policy guidance and service support. The Ministry of Civil Affairs' issuance of the Basic Specifications for Home Care Bed Services exemplifies this approach, extending professional care services directly to seniors' homes while supporting the traditional preference for "aging in place" (2024). Simultaneously, the government is actively promoting modernization in eldercare concepts, working to establish a new framework for older adults support where "all participate, all contribute, and all benefit," thereby balancing traditional cultural values with contemporary needs (2023).

The role of the market and the state

The government guides private sector participation in older adults care service provision through institutional design, standard setting, and financial subsidies (Chen, X., & Han, Y. 2022). For instance, the home-based care bed model integrates social resources while the

government provides both construction subsidies and operational support (2024). Through reforms focused on "streamlining administration, delegating power, and improving services," the government has optimized the business environment for older adults care, effectively encouraging non-governmental participation. In 2024, 77,600 enterprises related to senior products and services were registered, and 34 national standards for age-appropriate design were issued, demonstrating initial market vitality (2023). Regarding public-private collaboration, Kunming has adopted government procurement of services to designate commercial insurance companies as authorized handling agencies, implementing long-term care insurance operations through zonal administration. This approach maintains government leadership while leveraging the professional efficiency of market institutions (2025). However, the market mechanism remains underdeveloped, with private providers facing profitability challenges—particularly in remote areas. Future efforts should strengthen public-private partnerships to advance the "silver economy" toward more mature development (Zhou, Y., & Li, C. 2024).

4. Discussion

The universal and increasing demand for Long-Term Care (LTC), driven by demographic aging, represents a systemic global challenge. The distinct welfare models of Italy and China approach this challenge with divergent strategic responses and institutional tools, shaped by vastly different socio-economic contexts, welfare regimes, and cultural norms. Below is a comparison of how the two countries address this universal demand, drawing exclusively on the sources

The Italian Model: "Familism by Default" and Cash Transfers

Italy, representing a Southern European welfare model, addresses the increasing demand by implicitly relying on the family as the central pillar of care. This approach is often described as "familism by default". The response to care demand can be summarized as follows:

- Reliance on Cash-for-Care: State intervention predominantly takes the form of cash-for-care benefits. The most significant benefit is the *indennità di accompagnamento* (attendance allowance). This is a universal, flat-rate, non-means-tested monthly cash allowance provided by the central state (via INPS) to individuals certified as totally dependent and requiring continuous assistance.
- Privatization and the Market (*Badanti*): The IA allows recipients to purchase care on the open market, reinforcing the privatization of care responsibilities. This mechanism has sustained a vast and largely unregulated market for personal care, supported by a significant influx of migrant domestic care workers, known as *badanti*. These workers have become an indispensable pillar, often enabling the older adults to age in place.
- Fragmentation of Governance: The Italian system is characterized by a path-dependent and fragmented structure. LTC is institutionally divided into "silos" between Health (*Sanità*), which is the responsibility of the Regions/ASL and covers nursing home care, and Social (*Sociale*), which is managed by the Municipalities (Comuni) and local

districts (ATS) and covers services like home help (SAD). Navigating this requires families to confront a bureaucratic nightmare of separate access points and assessment procedures.

- Territorial Disparities: Regional autonomy leads to pronounced North–South imbalances in the availability, quality, and affordability of LTC. For instance, Northern regions tend to provide more structured services, while Southern regions depend disproportionately on informal and migrant care. In terms of residential beds per 1,000 population, the North-East has approximately 10, compared to about 3 in the South.
- Recent Reform Strategy (Law 33/2023): The reform effort, culminating in Law 33/2023 (the Enabling Act), represents the most significant legislative attempt to create a coherent national LTC framework. It aims to overcome fragmentation by establishing the National Long-Term Care System (SNANA). The most innovative element is the piloting of a "Universal Benefit" (*Prestazione Universale*). This new benefit incentivizes the conversion of cash into certified services by offering a more valuable benefit (IA plus an additional service budget) if it is used to purchase certified care. This directly attempts to tackle the "crowding out" effect that the traditional, unconditional IA exerts on public service investment. However, the implementation is often seen as a "timid, underfunded compromise," constrained by political reluctance to reform the IA for the general population.

The Chinese Model: National Strategic Priority and Social Insurance (LTCI)

China, while rooted in a tradition emphasizing family-based older adults support and the ethics of filial piety, is rapidly transitioning toward a state-led, top-down multi-pillar framework in response to mounting demographic pressure. The development of LTC has been elevated to a national strategic priority. The response to care demand can be summarized as follows:

- Establishment of Social Insurance (LTCI): The central mechanism is the Long-Term Care Insurance (LTCI) system. This model operates on the principle of social mutual aid, providing funding or services for basic daily care and medically necessary nursing to individuals with long-term functional impairments.
- Financing Challenges: LTCI relies significantly on social insurance contributions. However, in pilot cities, 82% of long-term care funding is redirected from the basic medical insurance pool, indicating a notable reliance on a single channel and raising concerns about long-term financial sustainability and the potential to strain medical insurance funds.
- Experimental and Phased Approach: China adopts a gradual reform path of "pilot first, then promotion". The LTCI program was launched in 15 cities in 2016 and expanded to 49 cities by 2023, covering approximately 240 million people. The central government plans to expand the initiative to cover 63 cities by 2025.
- Integration of Health and Social Services: There is a systemic effort to advance the integration of healthcare and social services (medically-integrated). By the end of 2024, China had established over 8,400 integrated medical-care institutions and 358,000 home-based care beds.

- Workforce and Infrastructure: By 2024, China had established 406,000 older people care institutions and facilities providing 7.993 million care beds. Despite training initiatives, the country faces a pronounced shortage of professional care personnel, with a deficit reaching 14 million older people care practitioners.
- Disparities: The system still exhibits substantial urban-rural divides. Enrollment rates among the functionally impaired older people in rural areas remain below 20%, significantly lower than the 65% observed in urban areas, despite the rural older people population facing a higher risk of functional impairment.

The two models demonstrate different institutional choices in addressing the "universal challenge" of rising care demand (tab. 2).

Tab. 2 – China and Italy. LTC: Regulatory frameworks and Governance.

Dimension	**Italy** *Familistic/Cash-Based Model*	**China** *State-Led/Social Insurance Model*
Welfare Model & Strategy	Southern European model; relies on implicit family support ("familism by default").	State-led, top-down approach; LTC is a national strategic priority.
Primary Tool	*Indennità di accompagnamento* (IA, Attendance Allowance): unconditional cash transfer.	Long-Term Care Insurance: contribution-based social insurance for regulated services.
Financing Structure	Fragmented financing mixing national transfers, regional budgets, and out-of-pocket payments. Cash transfers (IA) dominate public expenditure.	Social mutual aid; relies heavily (82%) on transfers from the basic medical insurance pool in pilot cities.
Service Provision	Highly dependent on the migrant labor market (*badanti,* migrant female domestic workers) hired privately using IA funds, solving care gaps for families but leading to a two-tiered system.	Focus on building standardized, formal institutional and home-based service infrastructure (e.g., 8,400 integrated medical-care institutions by 2024).
Governance Challenge	Institutional fragmentation (silos) between health and social care, and severe territorial disparities (North-South imbalance).	System development lags standardization, and faces significant urban-rural disparities and ambiguous cross-departmental responsibilities.

In sum, Italy's approach to solving the care demand crisis is akin to providing individuals with money to hire private contractors (*badanti*) to perform the necessary work on their specific properties (families/homes), a system relying on individual purchasing power and market supply. Conversely, China's strategy is like establishing a centralized, government-mandated utility company (LTCI) to systematically plan, standardize, and finance the delivery of essential services across the entire nation, moving cautiously from pilot cities to ensure a standardized entitlement framework. For policymakers worldwide, several overarching lessons emerge. Firstly, no single LTC model is universally transferable; systems must be grounded in cultural traditions, demographic realities and fiscal capacity. China's rapid institutionalization through national pilots illustrates the efficiency gains of central coordination, while Italy's persistent regional disparities reveal the risks of excessive decentralization without binding national standards. Secondly, sustainable funding remains the central challenge: both countries illustrate how overreliance—whether on medical insurance funds, as in China, or on cash allowances, as in Italy—can distort system development and undermine long-term sustainability. These policy challenges mirror concerns raised in the international literature about sustainability. According to Mosca et al. (2017), cash-based benefits (such as those in Italy) play a dual role: they can support informal caregiving but also require careful design to avoid unintended consequences, such as under-provision of formal care or insufficient coordination across levels of government. Besides this, the professionalization of the care workforce is indispensable. China's severe worker shortage and Italy's dependence on migrant labour both demonstrate that without a stable, well-trained and valued workforce, reforms to financing and governance cannot achieve their intended impact. Finally, the global trajectory of ageing underscores the need for integrated health–social governance, with both the Chinese model of medical–care integration and the Italian ambition to unify assessment pathways offering complementary insights for how to build person-centred systems in ageing societies.

5. Conclusion

The comparative challenge that China and Italy face in providing LTC is strikingly similar in its contours—sustaining financing, assuring service quality, and securing a competent care workforce—but the two countries have pursued markedly different institutional responses shaped by welfare legacies, political capacity and demographic trajectories. Italy's system has long been defined by "familism by default": a cash-dominant, fragmented model in which the *indennità di accompagnamento* (attendance allowance) channels a large share of public LTC spending to households, effectively outsourcing care to families and a market of largely migrant carers. This path dependency has produced weak risk-pooling, regional disparities and a quasi-market that substitutes informal and often precarious labour for public services. The recent Law 33/2023 and the creation of a National Long-Term Care System represent a paradigmatic attempt to reorient the balance from unconditional cash toward regulated in-kind services, but the reform remains optional, partially piloted and underfunded—so far unlikely to overturn the structural crowding-out effect of the attendance allowance. These dynamics leave Italy attempting reform from within an entrenched, cash-based equilibrium that favours private provision and regional autonomy.

China, by contrast, has adopted a state-led, top-down experiment in social insurance and service

standardization. The Long-Term Care Insurance (LTCI) pilot initiated in 2016 and progressively expanded to dozens of cities embodies an explicit strategy to establish public, pooled financing and designated-provider arrangements that pay for basic daily and medically necessary care. The central government has prioritized LTC as a national strategic goal, combining pilots, statutory guidance, and targeted fiscal transfers to spur infrastructure, promote integrated medical-care institutions and professionalize the occupation of "long-term care practitioner." This approach has mobilized sizeable public resources for capacity building and standard setting, and it has created an emergent purchaser–provider architecture intended to anchor a multi-pillar system.

Despite these divergent paths, the two systems confront analogous funding dilemmas. Italy's fragmentation concentrates public expenditure in an unconditional cash transfer that limits service expansion and weakens targeting; regional and municipal variation further fragment access and leave households exposed to unpredictable out-of-pocket burdens. Law 33/2023 seeks to convert cash into service budgets for selected beneficiaries, but its pilot scope and limited allocations mean the underlying fiscal architecture remains unchanged. China's LTCI has made more progress in creating a pooled revenue stream, yet its pilots rely heavily on transfers from basic medical insurance and central subsidies rather than on an independent, actuarially calibrated LTC fund. The dependence on a single channel raises the spectre of crowding-out health budgets and of brittle sustainability as demographic pressures intensify. Both countries therefore face the same structural trade-off: how to construct reliable, equitable and politically sustainable revenue bases without precipitating fiscal strain on other social programmes.

Quality control and standardization likewise reveal convergent problems implemented differently. Italy's highly decentralised governance and the health–social siloing produce uneven integration of care and variable monitoring across regions; quality oversight is undermined by multiple access points, separate assessment procedures and the persistence of an informal, largely unregulated market for migrant carers. In China, authorities have promulgated national assessment standards and industry specifications and have linked designated-provider agreements to quality supervision, yet enforcement and standard development lag and substantial inter-regional heterogeneity persists. Notably, some Chinese pilots report only limited implementation of unified quality evaluation systems and occasional provider malpractice, while Italy's long-standing territorial divides produce stark North–South differences in service density and quality. Thus, China's strength—central standard-setting and purchaser arrangements—has yet to translate fully into consistent enforcement; Italy's weakness—fragmentation—continues to preclude national quality floors.

The caregiver shortage is perhaps the most intractable shared problem. Italy has relied historically on migrant care workers to fill household care needs, generating a large informal labour market with precarious conditions and limited pathways for upskilling. This supply strategy has masked, rather than resolved, the structural shortage of professionalized care workers and has entrenched inequalities between households able to purchase private care and those depending on insufficient public services. China faces an acute numerical gap—estimates point to millions of missing practitioners—and has prioritized rapid workforce expansion through training subsidies, occupational classification and expanded higher education programmes. Nevertheless, career paths, wages, social recognition and retention remain weak

in China as in Italy, and both countries struggle to attract and retain staff for demanding, low-reward jobs. The difference is that China's centralized policy toolkit allows for coordinated supply-side interventions (training pipelines, occupational standards), whereas Italy's reform efforts must negotiate regional autonomy and long-standing informal labour arrangements to create legal, decent employment and professionalization paths.

The comparison between Italy and China yields several policy-relevant insights that speak not only to their respective reform trajectories but also to the broader global debate on long-term care (LTC). Italy can draw significant lessons from China's top-down, state-led approach, particularly the benefits of coherent national planning, unified assessment systems, and the deliberate construction of institutional and home-based services. China's model shows that large-scale piloting, central standard-setting, and the gradual consolidation of financing streams can accelerate system-building and reduce fragmentation—areas where Italy continues to struggle due to its multi-level governance structure and entrenched patchwork of cash benefits and informal arrangements. Italy's reliance on unconditional cash transfers and a migrant-dominated care market has produced a sub-optimal equilibrium that reforms such as Law 33/2023 aim to overcome, yet their limited funding and optional implementation highlight the difficulty of redirecting a mature but incoherent welfare regime toward integrated services.
At the same time, China can learn from Italy's longstanding experience with user autonomy, ageing-in-place preferences, and the societal value placed on relational care. Italy's history of familial involvement, strengthened by cultural expectations and supported through cash allowances, underscores the importance of aligning LTC systems with local preferences for home-based care and maintaining user choice—principles that China is now increasingly incorporating through home-based care bed models and community-level integration. Moreover, Italy's experience cautions China against over-reliance on a single financing channel. The Chinese pilot system currently depends heavily on transfers from basic medical insurance, raising concerns about sustainability and the potential crowding-out of essential health services. The Italian case demonstrates that diversified financing and transparent national guarantees, despite their imperfections, remain essential for long-term equity and system resilience.

In conclusion, China and Italy address common LTC problems through different institutional logics. Italy attempts reform within a familistic, cash-oriented equilibrium that has relied on market and migrant labour solutions and now seeks incremental rebalancing via Law 33/2023 and EU recovery funds. China, on the other hand, pursues a state-led path of pooled insurance pilots, standard setting, and supply expansion. Both trajectories exhibit complementary lessons: Italy's experience warns that cash transfers can crowd out service provision and entrench informal labour markets, undermining quality and equity; China's experience shows that centralized financing and standards can accelerate system building but require robust enforcement, diversified revenue sources and stronger incentives for workforce retention to ensure fiscal and service sustainability.
For policymakers, the comparative lesson is not convergence on a single model but the joint imperative to secure diversified, sustainable financing, to bind quality standards to enforcement and purchaser incentives, and to professionalise and fairly remunerate caregiving so that demographic ageing does not translate into a chronic care deficit for future generations.

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