



Long-Term Care Policies and Social Representations of Dependency in Ageing Societies: A Comparison Between France and Japan

Tara De Condappa

Université de Picardie Jules Verne, France

Abstract

Population ageing raises important questions about how dependency and loss of autonomy among older adults are understood and addressed in public policy. While long-term care policies are often analysed through institutional arrangements and welfare-state configurations, less attention has been paid to the cognitive and normative dimensions that shape these systems. This article proposes an integrated analytical framework combining social representations theory, the cognitive approach to public policy, the sociology of policy instruments and the social care perspective. Drawing on a qualitative documentary comparative analysis of France and Japan, based exclusively on legislative texts, institutional reports and peer-reviewed literature from the 1990s to the present, it examines how institutionalised representations of ageing, dependency and care interact with policy paradigms and welfare-state arrangements. The findings show that France and Japan have developed distinct configurations in response to similar demographic challenges. France institutionalises dependency through a medico-functional framework centred on standardised assessment and universal financial entitlements. Japan, by contrast, has developed a community-based logic grounded in subsidiarity and a quadripartite normative framework articulating individual, community, societal and governmental responsibilities. In both countries, long-term care arrangements tend to render invisible the gendered dimension of care work, which remains disproportionately performed by women. The article also introduces the exploratory concept of a care representational regime as a heuristic device for examining how relatively stable configurations of meaning concerning dependency, autonomy and responsibility for care become embedded in policy paradigms, instruments and institutional arrangements. Empirical validation through methods drawn from social representations research remains a priority for future research.

Keywords: social representations; long-term care policies; care representational regime; comparative gerontology; ageing societies

1. Introduction

1.1 Context and Justification

Population ageing constitutes one of the major structural challenges of contemporary societies. According to the World Health Organization (2025), the number of people aged 60 and over is projected to reach approximately 2.1 billion by 2050, with profound implications for health systems, pension regimes and mechanisms of social solidarity. In response to this transformation, welfare states have developed differentiated institutional responses shaped by their historical configurations, social protection regimes and dominant normative frameworks (Esping-Andersen, 1990; Palier & Martin, 2008). Among the countries most affected, France and Japan constitute two analytically significant cases. Both are post-industrial democracies with developed welfare states and among the highest life expectancies in the world, yet they have constructed substantially different institutional responses to dependency in old age. In 2024, people aged 65 and over represented approximately 22% of the French population, corresponding to around 14.7 million people (INSEE, 2024a), compared with 29.3% of the Japanese population (Statistics Bureau of Japan, 2024).

Japan is ageing in the context of an absolute population decline, after having reached its demographic peak in 2010 at more than 128 million inhabitants, compared with approximately 124 million in 2024. France, by contrast, continues to experience population growth, although the proportion of people aged 75 and over is projected to increase substantially over the coming decades (INSEE, 2024b; Picard, 2023). In both countries, public policies officially prioritise ageing in place as a major policy objective, in line with the expressed preferences of older populations (Picard, 2023). However, this convergence of objectives should not obscure significant differences in institutional modalities, policy instruments and the representations that underpin them (Daly & Lewis, 2000; Lascoumes & Le Galès, 2004).

France has developed a comparatively centralised institutional architecture in which the State guarantees access to social rights through a dense network of national and territorial institutions, whereas Japan has established a more decentralised governance structure in which municipalities and local community actors assume a central operational role (Morikawa, 2014; Picard, 2023). These two architectures reflect distinct configurations of solidarity and responsibility, without either constituting a model that could simply be transferred to the other context. The concept of dependency occupies a central place in public policy discourse in both countries, but its meaning, boundaries and normative implications differ. The ways in which older people and care needs are institutionally represented influence not only the design of care systems but also the policy instruments mobilised and the institutional roles assigned to public authorities, professionals, families and communities (Jodelet, 1984; Lascoumes & Le Galès, 2004). Social representations theory (Jodelet, 1984; Moscovici, 1961/2015), articulated with the cognitive approach to public policy (Hall, 1993; Muller, 2000), the sociology of policy instrumentation (Lascoumes & Le Galès, 2004) and scholarship on social care (Daly & Lewis, 2000), therefore provides a relevant framework for analysing the relationships between collective meanings, normative paradigms, policy instruments and institutional configurations.

This research is situated within this integrated perspective in order to illuminate the logics that underpin long-term care policies in France and Japan. It builds on the work of Picard (2023), which provides an extensive Franco-Japanese comparison of ageing-in-place policies, while differing from that work in three respects. First, whereas Picard (2023) adopts a primarily institutional and organisational perspective, the present article explicitly articulates

social representations (Abric, 1994; Jodelet, 1984; Moscovici, 1961/2015), policy paradigms (Hall, 1993; Jobert & Muller, 1987; Muller, 2000), policy instruments (Lascoumes & Le Galès, 2004) and social care configurations (Daly & Lewis, 2000). Second, the analysis covers a broader temporal spectrum, including French reforms through the creation of the fifth branch of Social Security in 2020 and successive revisions of the Kaigo Hoken through 2018. Third, it introduces the exploratory concept of a care representational regime as a heuristic tool for comparative research in social gerontology. The concept is intended to capture relatively stable configurations of collective meanings concerning dependency, autonomy and responsibility for care that become embedded in policy instruments and institutional arrangements. Beyond the France-Japan comparison itself, the article therefore examines the theoretical conditions under which social representations and public policy analysis may be articulated in the comparative study of ageing.

1.2 Research Objectives

This article pursues four interdependent objectives :

- (1) To describe the main institutional mechanisms and policy instruments of long-term care policies in France and Japan since the 1990s;
- (2) To analyse the social representations and policy paradigms relating to ageing and dependency that are embedded in these arrangements;
- (3) To identify structural convergences and divergences between the two cases through a systematic comparative analysis;
- (4) To propose an integrated analytical framework capable of articulating the representational, normative, instrumental and institutional dimensions of care policies.

1.3 Research Question

How do social representations of dependency and the resulting policy paradigms shape the design of policy instruments and institutional arrangements in long-term care in France and Japan?

This central question is elaborated through three analytical sub-questions:

- (1) Which social representations of dependency and autonomy are encoded in each country's main policy instruments?
- (2) To what extent do national normative paradigms, medico-functional in France and community-based in Japan, translate into distinct institutional architectures?
- (3) What convergences and divergences can be identified through a systematic comparison of the two national configurations?

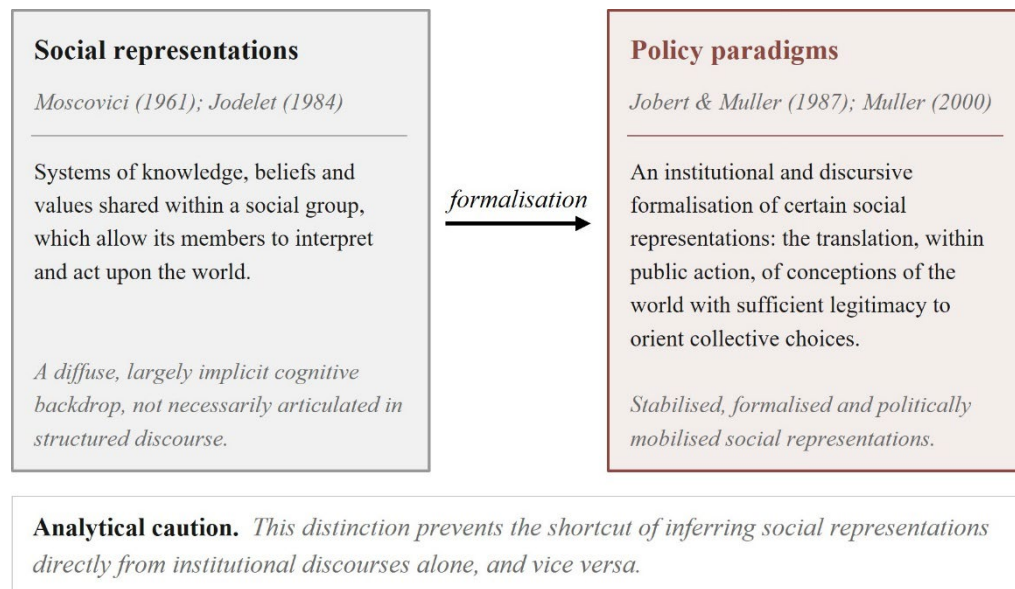
2 Methodology

2.1 Theoretical and Analytical Framework

The objective of this research is to understand how long-term care policies are constructed at the intersection of cognitive, normative, instrumental and institutional dimensions. Before presenting the four theoretical frameworks mobilised, a terminological clarification is necessary between two central notions used in this article which, although complementary, operate at distinct analytical levels. Social representations, in the sense developed by Moscovici (1961/2015) and Jodelet (1984), refer to systems of knowledge, beliefs and values

shared within a social group that enable its members to interpret and act upon the social world. They constitute a diffuse and largely implicit cognitive background that actors do not necessarily articulate in the form of structured discourse. Policy paradigms, in the sense of Jobert and Muller (1987) and Muller (2000), constitute, by contrast, an institutional and discursive formalisation of certain representations of the social world. They refer to stabilised frameworks of norms, values and causal assumptions that acquire sufficient legitimacy to orient collective choices and public intervention.

In this sense, policy paradigms may be understood as institutionally stabilised and politically mobilised structures of meaning. This distinction is analytically important because it avoids directly equating institutional discourse with the social representations actually held by individuals or social groups. To address the research question, the article mobilises four complementary theoretical frameworks drawn from social psychology, the sociology of public action and the comparative analysis of social protection systems. These approaches are considered not as competing explanations but as interdependent levels of analysis through which the complexity of long-term care policies can be examined.



Note. This terminological clarification is presented in section 2.1 of the article.

Figure 1. Social representations and policy paradigms : an analytical distinction

(de Condappa, 2026)

2.1.1 Social Representations

Social representations theory, developed by Moscovici (1961/2015) and elaborated by Jodelet (1984, 2015) and Abric (1994), defines social representations as organised systems of beliefs, values and knowledge shared by members of a social group. Within the structural approach, these representations may be organised around a relatively stable central core and a more flexible peripheral system that is sensitive to contextual variation. Applied to ageing, social representations contribute to organising collective knowledge, orienting social practices and legitimising particular ways of defining older people, dependency and autonomy. Their socio-genetic dimension also underlines that representations of older people and dependency are historically constructed rather than natural or self-evident. In the present study, social representations are not measured directly through individual interviews, free associations or questionnaires. The analysis instead focuses on the institutionalised forms in which particular

conceptions of ageing, autonomy and dependency become stabilised through policy categories, official discourse and policy instruments.

2.1.2 Cognitive and Referential Approach

The cognitive approach to public policy, developed by Jobert and Muller (1987) and Muller (2000), holds that every public policy is organised around a framework of norms, values and causal assumptions through which actors define public problems and legitimate possible solutions. Hall (1993) similarly demonstrates how policy paradigms structure institutional choices and define the boundaries of legitimate policy intervention. His distinction between adjustments to existing instruments and deeper paradigm change is particularly useful for examining long-term care reforms in France and Japan. This perspective also converges with discursive neo-institutionalism. Schmidt (2008) emphasises that institutions rest not only on formal rules but also on ideas, discourses and interpretive frameworks that shape the perception of public problems and legitimate particular solutions. In this article, policy paradigms therefore constitute an intermediate analytical level between broader representations of ageing and concrete institutional choices.

2.1.3 Policy Instrumentation

The sociology of policy instrumentation, developed by Lascoumes and Le Galès (2004) and further elaborated by Halpern et al. (2014), considers policy instruments not as neutral technical devices but as institutions that embody particular values, causal theories and representations of the social world. Applied to the present comparison, this perspective makes it possible to analyse the AGGIR grid, the APA, the Kaigo Hoken and the Community-Based Integrated Care System not only as administrative arrangements but also as instruments through which particular conceptions of dependency, autonomy and legitimate responsibility for care are operationalised and reproduced. The analytical importance of policy instruments therefore lies in their capacity to translate abstract categories into concrete eligibility criteria, benefits, classifications, administrative procedures and organisational arrangements.

2.1.4 Welfare-State Regimes and Social Care

The fourth theoretical anchorage situates the France-Japan comparison within two complementary traditions. The first is Esping-Andersen's (1990) analysis of welfare-state regimes, which demonstrates that welfare states constitute differentiated institutional configurations structured by distinct relations among the State, market and family. France is generally associated with a conservative-corporatist tradition, whereas Japan is more often described as a hybrid configuration combining institutional social protection with comparatively strong family and community responsibilities (Okamoto & Komamura, 2022).

The second is the concept of social care developed by Daly and Lewis (2000), which approaches care as a set of activities and relationships situated at the intersection of the State, market and family. This perspective is particularly useful for moving beyond the analysis of financial benefits alone and examining how care responsibilities are distributed among public authorities, professionals, families and communities. Together, these approaches provide a framework for analysing not only how care is financed and organised but also how responsibility for dependency is socially and institutionally allocated.

2.1.5 Towards an Integrated Analytical Framework for the Comparative Study of Care Policies

The four theoretical perspectives mobilised in this article are often used separately in the literature. However, understanding long-term care policies requires simultaneous attention to the cognitive, normative, instrumental and institutional dimensions that contribute to their

development, implementation and evolution. The integrated analytical framework proposed here therefore articulates four levels.

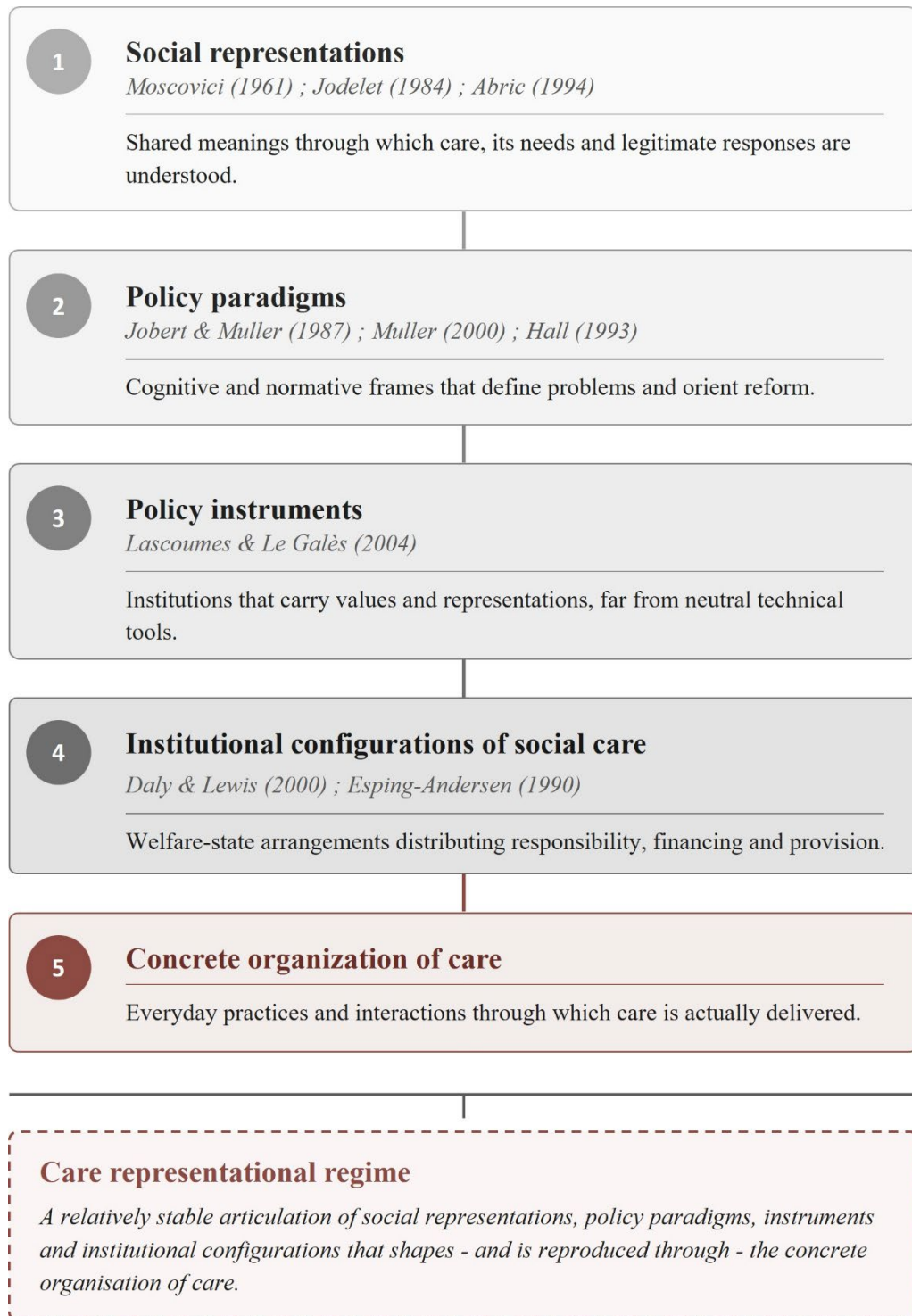
The first level concerns social representations, understood as systems of meaning surrounding ageing, dependency, autonomy and care (Abric, 1994 ; Jodelet, 1984 ; Moscovici, 1961/2015).

The second level concerns policy paradigms, understood as institutionalised normative and cognitive frameworks that define public problems and legitimate forms of intervention (Hall, 1993 ; Jobert & Muller, 1987 ; Muller, 2000).

The third level concerns policy instruments, which translate these paradigms into administrative categories, eligibility criteria, benefits and organisational mechanisms (Halpern et al., 2014 ; Lascoumes & Le Galès, 2004).

The fourth level concerns social care configurations and welfare-state arrangements, through which responsibilities are distributed among the State, market, family and community (Daly & Lewis, 2000 ; Esping-Andersen, 1990).

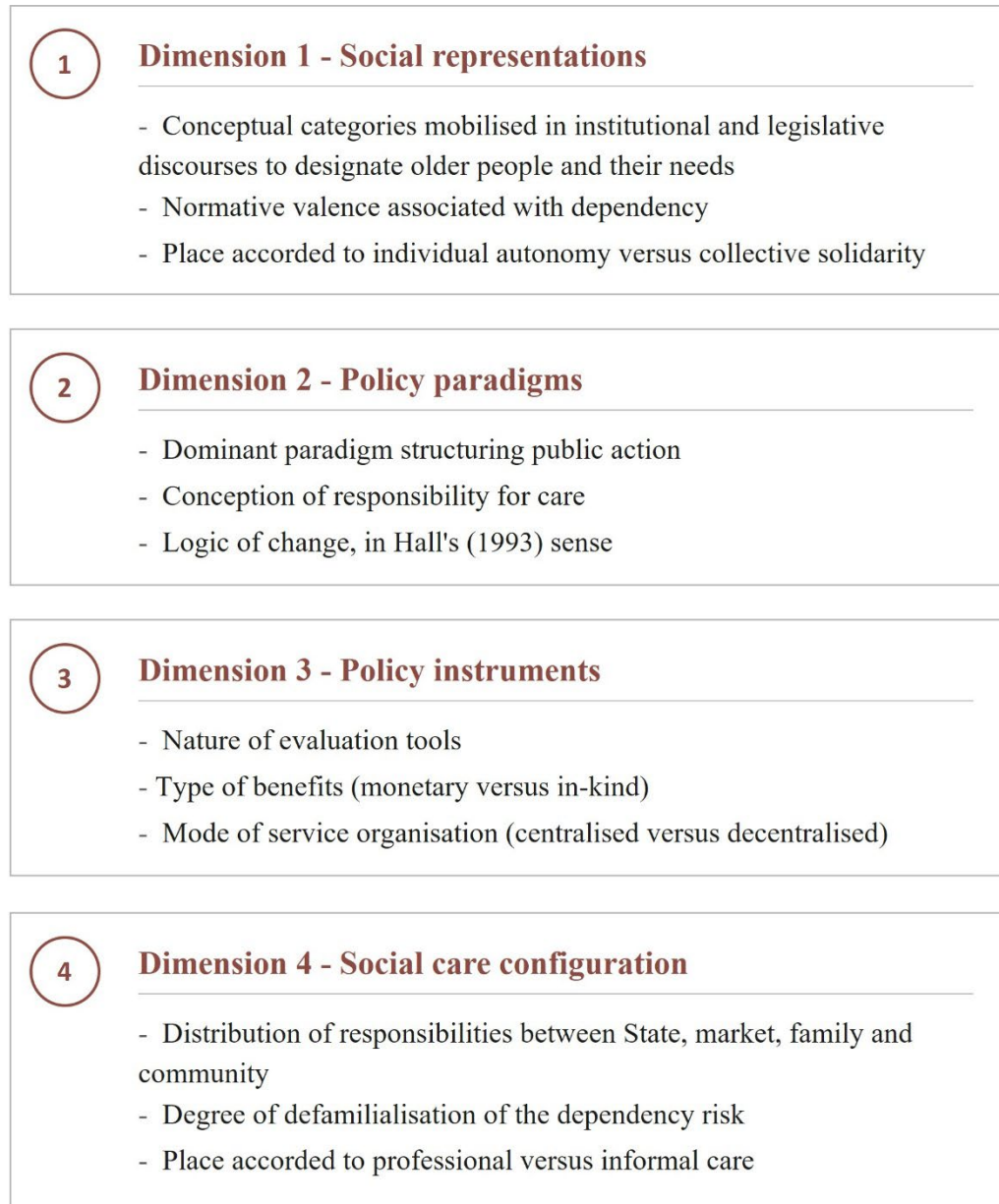
The analytical value of the framework lies in the relationships among these levels rather than in their isolated examination. Representations contribute to shaping normative paradigms; paradigms orient the design of policy instruments ; instruments become embedded in particular institutional configurations ; and these configurations may in turn contribute to stabilising or transforming dominant meanings. The framework also provides the theoretical basis for the exploratory concept of a care representational regime. This concept refers to a relatively stable configuration of meanings concerning dependency, autonomy and responsibility for care that becomes embedded in policy paradigms, instruments and institutional arrangements. It is proposed as an intermediate analytical level between social representations in the strict psychosocial sense and observable welfare-state institutions. The concept is exploratory rather than classificatory. It is intended to capture patterns of institutionalised meaning identified through the comparative analysis rather than to assign national systems to fixed cultural categories.



Note. Each level structures and orients the one below it, from the symbolic register of social representations down to the everyday, concrete practice of care.

Figure 2. Integrated analytical framework for care policies (de Condappa, 2026)

This figure synthesises the analytical framework mobilised in this research. It illustrates the proposition that social representations contribute to structuring policy paradigms, which in turn orient the design of policy instruments and institutional configurations of care. The concept of care representational regime is used to examine the relatively stable articulation of these different levels.



Note. The grid operationalises the integrated analytical framework presented in section 2.1. Each dimension is documented for each country using the indicators listed above.

Figure 3. Four-dimension analytical grid (de Condappa, 2026)

2.2 Nature of the Study

This article adopts a qualitative comparative approach based exclusively on secondary sources. It is an interpretive documentary study that seeks to examine relationships among institutionalised representations, policy paradigms, policy instruments and care configurations in two distinct national contexts. The study does not aim to directly measure the social representations held by citizens, caregivers, professionals or policy-makers. Rather, it analyses how particular conceptions of ageing, dependency, autonomy and responsibility for care are embedded in institutional discourse, administrative categories and public policy instruments. The analysis therefore operates at two complementary levels. The first is institutional and concerns legislation, assessment mechanisms, financing arrangements and service-delivery structures. The second is representational and paradigmatic and concerns the categories, terminology and normative assumptions through which care needs and responsibilities are defined.

2.3 Documentary Sources

The analysis draws on four categories of secondary sources covering the period from the 1990s to the present.

The first category comprises normative and legislative texts. For France, these include the law establishing the APA in 2001, legislation relating to the creation of the Caisse Nationale de Solidarité pour l'Autonomie in 2004, the 2015 law on the adaptation of society to ageing and the creation of the fifth branch of Social Security in 2020. For Japan, the documentary corpus includes texts relating to the introduction of the Kaigo Hoken, successive reforms of the long-term care insurance system and the progressive formalisation of the Community-based integrated care system.

The second category comprises statistical and institutional reports, notably those produced by the Direction de la Recherche, des Études, de l'Évaluation et des Statistiques, the Assemblée nationale, the ministère des Solidarités, the Cabinet Office of Japan and the World Health Organization, as well as the Libault report on old age and autonomy.

The third category consists of peer-reviewed academic literature in social psychology, the sociology of ageing, gerontology, public health and the sociology of public action. Academic publications were identified through PubMed, Cairn.info and Google Scholar.

The fourth category comprises academic works specifically addressing France-Japan comparisons in ageing policies, foremost among which is the doctoral research of Picard (2023), which provides an in-depth analysis of Japanese ageing-in-place policies with comparative reference points to France.

The selection of academic literature followed a theoretical sampling logic aimed at documenting the four dimensions of the analytical framework: social representations, policy paradigms, policy instruments and social care configurations. Search terms combined concepts relating to ageing, dependency, long-term care, social representations, public policy and the France-Japan comparison.

The principal inclusion criteria were:

- (1) peer-reviewed scientific publications published between 1990 and 2024 ;
- (2) publications concerning France, Japan or a comparison including at least one of these two countries ;

- (3) publications making an explicit contribution to at least one of the four analytical dimensions.

Foundational theoretical texts published before 1990 were retained when they constituted major references for the analytical framework.

Where directly comparable statistics were not available for the same reference year, the analysis used the most recent nationally available data for each indicator. The year of observation is therefore reported alongside each quantitative figure, and cross-national comparisons are interpreted cautiously when reference years differ.

2.4 Analytical Strategy

2.4.1 Analytical Procedure and Document Analysis Strategy

The documentary analysis was conducted through a qualitative interpretive procedure informed by public policy analysis and thematic analysis of institutional documents. For each document, relevant textual, institutional and regulatory elements were identified according to the indicators associated with the four dimensions of the analytical framework. These elements included, for example, the terminology used to define ageing, dependency and autonomy; the criteria used to assess care needs and determine eligibility; the type of benefits provided; the allocation of responsibility among public authorities, professionals, families and communities; and the organisation and coordination of care services. The identified elements were then classified within the corresponding analytical dimension and examined within each national case. The analysis focused on recurring associations between categories, normative assumptions, policy instruments and institutional arrangements rather than on the frequency of isolated terms. Comparisons were therefore based on patterns of convergence within each national configuration and on systematic differences between France and Japan across the same analytical dimensions. The inference from documentary evidence to institutionalised representations was based on the convergence of several forms of evidence rather than on individual statements taken in isolation.

In the French case, for example, the recurrent combination of standardised functional assessment through the AGGIR grid, eligibility determined through levels of incapacity and compensation through the APA was interpreted as indicating an institutionalised medico-functional representation of dependency. Dependency is thereby rendered administratively observable, measurable and compensable through public intervention.

In the Japanese case, the combination of needs assessment, predominantly in-kind service provision, municipal coordination, personalised care planning and the formal distribution of responsibilities among individuals, families, communities, social institutions and public authorities was interpreted as indicating an institutionalised community-based representation of care. Care needs are thus framed less exclusively as an individual functional deficit than as a situation requiring coordination among several levels of responsibility and support.

These analytical inferences concern representations that are stabilised and embedded in policy instruments, administrative categories and institutional arrangements. They should not be interpreted as direct measurements of the social representations actually held by citizens, informal caregivers, professionals or policy-makers. The term institutionalised representations is therefore used throughout this article to distinguish this documentary and policy-level analytical object from social representations measured through the empirical methods conventionally used in social psychology.

2.4.2 Comparative Analytical Grid

The comparative analysis is organised around a four-dimension grid derived from the integrated analytical framework presented in Section 2.1.

Dimension 1 - Social représentations : Indicators examined: conceptual categories used to designate older people and care needs; normative valence associated with dependency; representation of autonomy; balance between individual responsibility and collective solidarity.

Dimension 2 - Policy paradigms : Indicators examined: dominant normative framework structuring public action ; conception of responsibility for care ; legitimate forms of intervention ; degree of continuity or change in the sense proposed by Hall (1993).

Dimension 3 - Policy instruments : Indicators examined: nature of assessment tools; eligibility criteria; type of benefits, including monetary and in-kind provision ; degree of standardisation ; mode of service organisation and coordination.

Dimension 4 - Social care configuration : Indicators examined: distribution of responsibilities among the State, market, family and community; degree of defamilialisation; role of professional versus informal care ; territorial organisation of care provision.

Following this document-level coding procedure, the comparative analysis proceeded in two stages.

First, each national long-term care system was reconstructed according to the four analytical dimensions in order to identify the internal relationships among representations, paradigms, instruments and care configurations.

Second, the two national cases were compared dimension by dimension in order to identify convergences, divergences and distinctive configurations of institutionalised meaning.

This procedure makes it possible to move from documentary evidence to comparative interpretation while maintaining a distinction between observable policy arrangements and the analytical inference of institutionalised representations.

The objective of this research is not to directly measure the social representations of citizens, carers or professionals. It consists rather in analysing the way in which certain conceptions of ageing, dependency and care are incorporated into instruments, administrative categories and institutional arrangements. In this perspective, public policies are considered particularly revealing objects of stabilised collective representations, insofar as they translate socially legitimate definitions of public problems and the responses deemed appropriate to address them. The results should therefore be understood as an analysis of institutionalised representations of ageing and dependency rather than as a direct study of individual représentations.

Table 1. Steps of the analytical and comparative process (de Condappa, 2026)

Step	Object analysed	Guiding question
1	Social representations	<i>How is dependency defined and represented ?</i>
2	Policy paradigms	<i>What norms and values orient public action ?</i>
3	Policy instruments	<i>Which arrangements translate these paradigms ?</i>
4	Institutions	<i>How are care responsibilities organized ?</i>
5	Comparison	<i>What convergences and divergences appear between France and Japan ?</i>

3 Results

3.1 France : A Medico-Functional Paradigm of Dependency

3.1.1 Dependency as an Object of Public Action: Historical Construction

France belongs to the conservative-corporatist tradition of social protection identified by Esping-Andersen (1990), characterised by a strong role for social insurance and public institutions in the organisation of social rights. Within this framework, dependency in old age progressively became a specific object of public action from the 1980s onwards, under the combined effects of demographic ageing, changing family structures and growing concern about the financial sustainability of welfare provision. Its construction as a public problem can be analysed through the cognitive approach to public policy developed by Jobert and Muller (1987) and Muller (2000). From this perspective, public intervention is organised around a set of categories, norms and causal assumptions through which a problem and its legitimate solutions are defined. The paradigm that progressively became institutionalised in France may be characterised as predominantly medico-functional. Dependency is primarily represented as a loss of functional or cognitive capacity that can be assessed, classified and compensated through professional and public intervention (Ennuyer, 2013).

This paradigm is also embedded in a longer history of representations of old age. Guillemard (1986) analysed the progressive social construction of old age as a distinct stage associated with withdrawal from productive activity and increasing dependence on collective protection. Caradec (2012) subsequently showed that contemporary representations of ageing remain structured by a tension between old age understood as decline and dependency, on the one hand, and the normative ideal of active and autonomous ageing, on the other. This tension is only partially resolved in French long-term care policy. Although contemporary policy discourse increasingly emphasises autonomy, the principal assessment and allocation instruments remain strongly structured by a functional understanding of dependency.

3.1.2 The AGGIR Grid : Instrument and Representation

The *Grille Autonomie Gérontologie Groupes Iso-Ressources* (AGGIR grid), introduced during the 1980s and progressively formalised as a regulatory assessment tool, constitutes a central instrument of French long-term care policy. In the sense proposed by Lascoumes and Le Galès (2004), the AGGIR grid cannot be understood as a purely neutral technical mechanism. By classifying older people into six Groupes Iso-Ressources, from GIR 1 to GIR

6, according to their capacity to perform activities of daily living, the instrument translates a particular conception of dependency into an administratively operational form. The grid makes dependency observable through standardised functional criteria. It therefore contributes to institutionalising a representation of dependency as a measurable deficit in individual capacities. This does not imply that the AGGIR grid exhausts the lived experience of dependency. Rather, it indicates that access to particular public benefits depends on a standardised administrative representation of care needs. From the perspective of the present analytical framework, the AGGIR grid therefore provides a clear example of the relationship between representation, paradigm and instrument. A medico-functional representation of dependency is translated into a classificatory device that establishes categories of eligibility and contributes to determining the form and level of public intervention.

3.1.3 The APA : Universalisation of Rights and Partial Reconfiguration of the Paradigm

The *Allocation Personnalisée d'Autonomie* (APA), established by the Law of 20 July 2001, represented a significant transformation in French long-term care policy. It replaced the *Prestation Spécifique Dépendance* and expanded access to public support for people aged 60 and over classified in GIR 1 to GIR 4. The APA is not subject to a means-tested eligibility threshold, although beneficiaries' financial contributions vary according to income. It therefore combines a logic of universal social entitlement with an individualised allocation calibrated according to assessed levels of dependency. In 2023, approximately 1.36 million people received the APA in France, corresponding to public expenditure of around EUR 6.5 billion (CNSA, 2024; DREES, 2024). From the perspective of policy instrumentation, the APA constitutes a hybrid instrument. It extends an individual social right while maintaining eligibility within a standardised functional assessment framework. Its terminology is nevertheless significant. The expression *allocation personnalisée d'autonomie* replaces the explicit language of dependency with that of autonomy. This semantic shift reflects a broader evolution in French ageing policy towards an emphasis on individual rights and the preservation of autonomy. However, this discursive reconfiguration has not been accompanied by an equivalent transformation of the underlying assessment mechanism. Eligibility continues to depend primarily on the AGGIR grid. The French trajectory can therefore be interpreted as a partial reconfiguration rather than a complete transformation of the dominant paradigm. The vocabulary of autonomy has become increasingly prominent, while the administrative objectification of dependency through functional assessment remains institutionally central.

3.1.4 The EHPAD and the Institutional Crystallisation of Dependency

Établissements d'Hébergement pour Personnes Âgées Dépendantes (EHPADs) constitute a central component of institutional long-term care provision in France. At the end of 2023, approximately 7,500 EHPADs accommodated around 600,000 residents (CNSA, 2024; DREES, 2024). The importance of this institutional model reflects a social care configuration in which severe dependency is frequently associated with specialised professional provision outside the ordinary home environment. This configuration is consistent with the medico-functional paradigm identified above. When dependency is conceptualised primarily as an objectively assessable loss of functional autonomy, increasing levels of dependency can become associated with increasing levels of specialised professional intervention. However, the formal architecture of long-term care does not capture the full distribution of care responsibilities in France. Informal care remains a substantial component of support for older people living at home and is strongly gendered. Laborde et al. (2021), drawing on French data on informal caregiving, report that women account for approximately 60% of caregivers supporting older people living at home. Gender differences also vary according to the

relationship between the caregiver and the older person: women represent around 60% of non-co-resident caregiving children and approximately 73% of other family caregivers. These figures indicate that the development of professional and publicly financed long-term care has not eliminated the gendered organisation of informal care. Rather, formal and informal provision coexist. This finding is important for the analysis of the French care configuration. The medico-functional paradigm makes professional services, assessment procedures and financial compensation highly visible within public policy, whereas a substantial proportion of unpaid care remains located within family relationships and is less directly represented within formal policy instruments. The French system therefore combines a relatively high degree of institutionalisation of dependency with the continued importance of unpaid family care. This tension qualifies any interpretation of French long-term care as fully defamilialised.

3.1.5 The Fifth Branch: Paradigm Change or Recalibration ?

The creation of the fifth branch of Social Security dedicated to autonomy in 2020 constitutes an important institutional development in French social protection. It established autonomy as a distinct field of social security alongside illness, occupational accidents, family policy and pensions. The reform strengthened the institutional recognition of long-term care as a collective social risk and was consistent with the orientations of the Libault report (2019), which called for a more coherent national response to population ageing and loss of autonomy. From the perspective developed by Hall (1993), however, the creation of the fifth branch raises the question of whether the reform represents a genuine paradigm change or a substantial institutional recalibration within an existing paradigm. Several elements support the second interpretation. The principal functional assessment instrument, the AGGIR grid, remains central to eligibility for the APA, and the organisation of long-term care continues to distinguish strongly between levels of functional dependency. The reform therefore modifies the institutional architecture and strengthens the political status of autonomy without fundamentally replacing the medico-functional logic through which dependency is assessed and administratively classified. Financial sustainability also remains a major constraint on reform trajectories. The Libault report (2019) estimated that substantial additional annual financing would be required by 2030 to meet projected long-term care needs. This tension between expansion of social rights and control of public expenditure is not specific to France and can also be observed in other long-term care systems, including Japan (Tamiya et al., 2011). The French trajectory can consequently be interpreted as a process of institutional strengthening and partial normative reframing rather than as a complete transformation of the underlying care paradigm.

3.2 Japan: A Community-based Care Paradigm

3.2.1 The Japanese Welfare State and the Question of Care

Japan occupies a distinctive position in comparative analyses of welfare-state regimes. Although it was not explicitly included in Esping-Andersen's (1990) original typology, subsequent scholarship has frequently characterised the Japanese welfare state as a hybrid configuration combining institutional social protection with comparatively strong family and community responsibilities (Okamoto & Komamura, 2022). This configuration is particularly visible in the field of social care. As Daly and Lewis (2000) emphasise, care policies are situated at the intersection of the State, market and family, and differences in the distribution of responsibilities among these spheres constitute an important dimension of welfare-state variation. Historically, care for older people in Japan was strongly embedded within the family sphere and associated with norms of intergenerational responsibility. The introduction

and subsequent development of public long-term care insurance represented an important institutional transformation by progressively shifting part of this responsibility from the family towards publicly organised and collectively financed services (Iwagami & Tamiya, 2019). The evolution of Japanese long-term care policy can therefore be interpreted as a process of partial socialisation of care. However, this process has not eliminated the role of family and community actors. Rather, it has contributed to reorganising their position within a broader system of shared responsibilities.

3.2.2 The Kaigo Hoken: Socialisation of Care Need as Instrument

The Kaigo Hoken, Japan's public long-term care insurance system, was introduced in April 2000 and constitutes the central institutional mechanism of contemporary Japanese long-term care policy. The reform aimed to reduce excessive reliance on family caregiving while improving access to formal long-term care services. The system is administered by municipalities and financed through a combination of insurance contributions and public taxation (Iwagami & Tamiya, 2019). Eligibility and service allocation are based on a nationally standardised care-needs certification process. Beneficiaries are classified according to levels of support or care needs, and services are subsequently organised through individual care plans.

Unlike the French APA, which is primarily structured around an individual financial entitlement, the Kaigo Hoken predominantly provides access to in-kind services. These include home-based, community-based and institutional long-term care services organised according to assessed levels of need (Iwagami & Tamiya, 2019). This difference is analytically significant. While both systems rely on standardised assessment, the Japanese instrument places greater emphasis on the coordination of service provision through municipal structures and care planning. The system has undergone repeated reforms since its introduction as a result of rapid population ageing, increasing demand and growing expenditure. These reforms have included greater emphasis on prevention, changes in co-payment arrangements and the development of community-based forms of care (Iwagami & Tamiya, 2019 ; Morikawa, 2014). From the perspective of Hall's (1993) distinction between policy adjustment and paradigm change, these reforms appear primarily as adaptations within the broader principle of universal long-term care insurance rather than a rejection of the underlying system.

The socialisation of care through the Kaigo Hoken has nevertheless not eliminated informal family caregiving. A representative repeated cross-sectional analysis of 12,764 co-resident family caregivers in Japan between 2001 and 2016 found that 73.5% of caregivers were women. This finding indicates that the formal expansion of long-term care services has coexisted with a strongly gendered distribution of unpaid care responsibilities. It therefore qualifies any interpretation of the Japanese system as having fully transferred care responsibility from families to formal services. The persistence of predominantly female caregiving highlights an important tension within the Japanese care configuration. Although the Kaigo Hoken institutionalises collective responsibility for long-term care, its operation remains embedded within social arrangements in which family members continue to provide substantial unpaid support. This finding is particularly important for the present comparative analysis. The socialisation of care through formal insurance has altered the institutional distribution of responsibility, but it has not eliminated the gendered organisation of informal caregiving.

3.2.3 Cultural and Representational Foundations: Ji-jo, Go-jo, Kyo-jo, Ko-jo

The Japanese community-based integrated care system is frequently discussed through four complementary principles: Ji-jo, Go-jo, Kyo-jo and Ko-jo. Sudo et al. (2018) describe these principles as self-help, mutual aid, social solidarity care and governmental care. Together, they articulate different levels of responsibility for health and long-term care, ranging from individual and interpersonal resources to formal collective and governmental support. This framework is useful for understanding the normative architecture of Japanese community-based care. It does not imply that the State withdraws from long-term care provision. Rather, it indicates that public intervention is organised alongside individual, family, community and social insurance responsibilities. The analytical relevance of this framework lies in the way it distributes legitimate responsibility for care across several levels rather than concentrating it exclusively within a central public authority.



Figure 4. The Ji-jo, Go-jo, Kyo-jo, Ko-jo framework adapted from Sudo et al. (2018)
(de Condappa, 2026)

The framework may therefore be interpreted as an institutionalised representation of care as a shared and relational responsibility. In contrast to a model in which dependency is predominantly treated as an individual deficit requiring public compensation, Japanese long-term care policy increasingly emphasises the coordination of multiple sources of support within the person's ordinary living environment. However, the gender dimension discussed above introduces an important qualification. Shared responsibility is not necessarily distributed equally among all social actors. Family and community participation may reproduce unequal care burdens when unpaid care remains disproportionately performed by women.

3.2.4 The community-Based Integrated Care System: Territorialisation of Care

The Community-Based Integrated Care System represents a major development in Japanese long-term care policy. Its objective is to enable older people to continue living within their familiar communities by integrating medical care, long-term care, preventive services, housing and everyday support. Morikawa (2014) shows that the development of community-based integrated care emerged in response to several challenges associated with the expansion of long-term care insurance, including the need for stronger coordination between

medical and social care, cost containment and improved continuity of support. The system therefore extends beyond the provision of formal long-term care services. It also incorporates informal mutual aid and community resources and places substantial responsibility for coordination at the local level. Tsutsui (2014) similarly describes the Community-Based Integrated Care System as an attempt to organise comprehensive care within geographically defined local communities, with municipalities playing an important role in implementation. This territorial dimension distinguishes the Japanese configuration from more centralised models of long-term care governance. National legislation and financing establish the overall institutional framework, while municipalities retain substantial responsibility for organising local service networks and adapting implementation to local demographic and social conditions.

The Community-based integrated care system can therefore be interpreted as the institutional expression of a community-based care paradigm. Care needs are approached not only as individual functional deficits but as situations requiring coordinated responses across medical, social, family and community spheres. At the same time, the system should not be idealised as a complete alternative to family caregiving. Its reliance on community and informal resources may complement formal provision but may also reproduce existing inequalities in the distribution of unpaid care. The Japanese case thus illustrates a dual process: The formal socialisation of long-term care through universal public insurance and the continuing mobilisation of family and community resources within a territorially integrated model of care.

3.3 Comparative Synthesis: Two Care Representational Regimes

Table 2 synthesises the main findings of the France-Japan comparison using the integrated analytical framework presented in Section 2.1. The comparison indicates that differences between the two systems concern not only institutional arrangements but also the ways in which dependency, autonomy and responsibility for care are defined and translated into policy instruments.

Table 2 - Comparative analysis of long-term care systems in France and Japan

(de Condappa, 2026)

Dimension	France	Japan
Welfare-state regime	Conservative-corporatist configuration characterised by a strong public guarantee of social rights and social insurance arrangements (Esping-Andersen, 1990 ; Palier, 2006).	Hybrid configuration combining institutional social protection with substantial family and community responsibilities (Okamoto & Komamura, 2022).
Dominant representation of ageing and dependency	Dependency is predominantly represented as an objectifiable functional and cognitive deficit that can be assessed, classified and compensated through public intervention.	Care need is more strongly represented as a relational situation requiring coordination among the individual, family, community, service providers and public institutions.
Dominant paradigm	Medico-functional paradigm in which dependency constitutes a measurable loss of autonomy giving access to compensatory rights and services.	Community-based care paradigm in which long-term care is organised through shared responsibility, territorial coordination and subsidiarity.
Principal evaluation instrument	AGGIR grid, classifying beneficiaries from GIR 1 to GIR 6 according to standardised functional assessment.	National care-needs certification system, classifying beneficiaries according to support and care levels and linking assessment to an individualised care plan.

Dimension	France	Japan
Principal benefit instrument	Allocation Personnalisée d'Autonomie (APA), an individual social entitlement calibrated according to assessed dependency and used to finance a care plan.	Kaigo Hoken, providing predominantly in-kind long-term care services organised according to assessed needs.
Conception of autonomy	Autonomy is primarily conceived as an individual right whose loss gives rise to public compensation and professional intervention.	Autonomy is more strongly associated with the capacity to continue living within one's usual social and community environment with coordinated support.
Role of the State	The State and public institutions act as principal guarantors of social rights within a comparatively centralised regulatory framework, although implementation also involves departmental and local authorities.	The central State establishes the legislative and financial framework, while municipalities play a major operational role in organising and coordinating long-term care services.
Social care configuration	Public and professional provision occupies a highly visible position within the formal policy architecture, alongside continuing family involvement.	Care responsibilities are distributed across individual, family, community, social insurance and governmental levels, notably through the Ji-jo, Go-jo, Kyo-jo and Ko-jo framework (Sudo et al., 2018).
Dominant care model	Home-based support coexists with substantial specialised institutional provision through EHPADs.	The Community-based integrated care system aims to coordinate medical care, long-term care, prevention, housing and everyday support within local communities.
Role of the family	Family caregivers remain important, although formal policy instruments foreground publicly financed and professional care.	Family caregiving remains an important component of long-term care despite the formal socialisation of care through the Kaigo Hoken.
Gender dimension of care	Informal caregiving remains strongly gendered. Women account for approximately 60% of caregivers supporting older people living at home (Laborde et al., 2021). This indicates that unpaid female care remains substantial alongside professional and publicly financed services.	In a representative repeated cross-sectional study of 12,764 co-resident family caregivers, 73.5% of caregivers were women (Miyawaki et al., 2020). The expansion of formal long-term care services has therefore not eliminated the gendered distribution of unpaid family care.
Financial sustainability and reform tensions	The creation of the fifth branch of Social Security in 2020 strengthened the institutional recognition of autonomy as a social risk, while questions concerning sustainable financing and increasing demand remain central to reform trajectories (Libault, 2019).	Growth in long-term care expenditure has led to successive reforms aimed at maintaining universal access while controlling costs and strengthening preventive and community-based provision (Iwagami & Tamiya, 2019 ; Tamiya et al., 2011).
Recent trajectory	Institutional strengthening of autonomy policy through the creation of the fifth branch in 2020 without complete replacement of the medico-functional assessment paradigm.	Progressive development of the Community-Based Integrated Care System, deepening territorial integration and coordination within the existing long-term care insurance framework.
Care representational regime (exploratory)	Medico-functional care representational regime in which dependency is predominantly institutionalised as an	Community-based care representational regime in which care need is more strongly institutionalised as a relational

Dimension	France	Japan
theoretical proposition)	assessable deficit, autonomy as an individual right and professional or public intervention as a privileged legitimate response.	situation, autonomy as an outcome supported within the community and responsibility as distributed across individual, family, community and public actors.

Note. APA = Allocation Personnalisée d'Autonomie ; AGGIR = Grille Autonomie Gériatrie Groupes Iso-Ressources ; CBICS = community-based integrated care system ; CNSA = Caisse Nationale de Solidarité pour l'Autonomie ; EHPAD = Établissement d'Hébergement pour Personnes Âgées Dépendantes ; Kaigo Hoken = Japanese long-term care insurance.

The comparison highlights an important distinction between common policy objectives and the institutional pathways through which these objectives are pursued. Both countries recognise dependency in old age as a social risk that cannot be addressed exclusively within the family sphere, and both increasingly prioritise ageing in place. However, comparable objectives are translated into different configurations of assessment, benefits, governance and responsibility.

In France, the combination of standardised functional assessment, individual entitlement and professional intervention produces a comparatively strong medico-functional structuring of dependency. In Japan, standardised needs assessment is embedded within a broader system of service coordination, municipal governance and community-based integration. The gender dimension also reveals a significant convergence. In both systems, the development of formal long-term care has not eliminated unpaid family care, which continues to be disproportionately performed by women. The quantitative indicators reported here derive from different populations, survey designs and reference periods and should therefore not be interpreted as directly comparable prevalence estimates. Their analytical significance lies in demonstrating the persistence of gendered informal care within both institutional configurations.



Note. Dates are drawn from the documentary sources analysed in sections 3.1 and 3.2 of the article.

Figure 5. Comparative timeline of long-term care reforms in France and Japan
(de Condappa, 2026)

The central convergence between the two national configurations therefore lies in the recognition that long-term care constitutes a collective social issue requiring institutional mechanisms of solidarity (Daly & Lewis, 2000 ; Okamoto & Komamura, 2022). Both countries also prioritise ageing in place as an important orientation of contemporary long-term care policy (Picard, 2023). The principal divergences concern the definition and administrative treatment of dependency, the allocation of responsibilities among care actors and the instruments through which support is organised. France relies more strongly on a medico-functional approach structured around standardised assessment and social entitlement, whereas Japan combines needs assessment with municipal coordination and community-based integration (Morikawa, 2014 ; Sudo et al., 2018). The comparison therefore demonstrates that similar demographic pressures and policy objectives can produce different institutional responses when policy paradigms, instruments and configurations of responsibility differ.

3.4 From institutional Configurations to Care Representational Regimes

The comparative analysis reveals two internally coherent configurations linking representations of dependency, policy paradigms, instruments and modes of care organisation.

In France, dependency is predominantly institutionalised as an assessable loss of functional autonomy addressed through standardised evaluation, social entitlement and professional or public intervention. The recurrent association between the AGGIR grid, eligibility categories, the APA and specialised institutional provision provides the empirical basis for identifying a medico-functional configuration.

In Japan, long-term care needs are embedded in a configuration combining standardised needs assessment with predominantly in-kind services, personalised care planning, municipal coordination and the formal articulation of individual, family, community and governmental responsibilities. These elements provide the empirical basis for identifying a community-based configuration.

These configurations constitute the empirical foundation of the exploratory concept of a care representational regime. The concept refers to the relatively stable articulation of institutionalised meanings, normative paradigms, policy instruments and care arrangements within a given context. The two configurations identified here should be understood as empirically derived analytical propositions specific to the cases examined rather than as exhaustive or universally applicable types of long-term care systems.

3.5 Analytical Scope of the Comparison

The results invite analysis of long-term care policies beyond their formal institutional arrangements. The French and Japanese cases suggest that assessment mechanisms, benefits and organisational structures acquire meaning through broader cognitive and normative configurations concerning dependency, autonomy and legitimate responsibility for care. The transferability of the analytical framework should, however, be distinguished from the transferability of the substantive configurations identified in France and Japan. The four analytical dimensions - social representations, policy paradigms, policy instruments and social care configurations - may be applied to other long-term care systems, provided that sufficient institutional and documentary material is available to reconstruct relationships among problem definitions, normative assumptions, policy instruments and the allocation of care responsibilities.

By contrast, the medico-functional and community-based care representational regimes identified in this study should not be treated as universal categories into which other countries can automatically be classified. Their relevance beyond the France-Japan comparison must be established empirically. Application of the framework to other national or subnational contexts would therefore require the analytical indicators to be re-operationalised according to local terminology, welfare-state structures, institutional arrangements and historical trajectories. Particular caution would be required in federal or highly decentralised systems, in settings where formal long-term care institutions remain weakly developed, and in contexts characterised by substantial discrepancies between national policy frameworks and local implementation.

The comparison also highlights the importance of distinguishing formally institutionalised representations from the social representations actually held by citizens, caregivers, professionals and policy-makers. The framework developed here enables the former to be analysed through documentary and institutional evidence ; it does not establish the latter without primary empirical research. Multi-country research including liberal, social-democratic and other East Asian welfare systems would provide an important test of both the comparative usefulness and the boundary conditions of the framework. The France-Japan comparison should consequently be understood as an analytical starting point. Its contribution lies less in proposing two universal models than in demonstrating how the relationship among meanings, paradigms, instruments and institutional arrangements can be reconstructed systematically within comparative long-term care research.

4 Discussion

4.1 Summary of Findings

The principal contribution of this article does not lie in identifying institutional differences between France and Japan, which have already been documented in the comparative literature, but in showing that these differences form coherent configurations linking institutionalised representations, policy paradigms, policy instruments and forms of care organisation. The French case is characterised by a predominantly medico-functional configuration in which dependency is rendered administratively observable through standardised functional assessment, translated into eligibility categories and addressed through public entitlements and professional intervention. The Japanese case combines standardised needs assessment with in-kind service provision, municipal coordination and a broader distribution of responsibility among individuals, families, communities and public institutions. The comparison therefore suggests that long-term care systems cannot be understood solely through their organisational or financial arrangements. Their instruments and institutions are embedded within broader cognitive and normative configurations that contribute to defining what constitutes dependency, how autonomy is understood and which actors are considered legitimately responsible for care.

The analysis also identifies an important convergence. In both countries, the expansion of formal long-term care provision has not eliminated unpaid family caregiving, which remains disproportionately performed by women. This persistence highlights a gap between the formal institutionalisation of care and the actual distribution of care responsibilities within families.

4.2 Limitations of the Study

Four main limitations should be acknowledged.

First, the absence of primary empirical data constitutes the principal limitation of this research. The representations identified in this study are not measured directly among citizens, caregivers, professionals or policymakers. They are reconstructed from their institutional, discursive and instrumental expressions. The findings must therefore be interpreted as an analysis of institutionalised representations rather than as a direct empirical account of the social representations actually held by particular social groups. This distinction is fundamental. Institutional documents, policy instruments and administrative categories provide evidence of meanings that have acquired sufficient legitimacy to become embedded in public action, but they do not establish the extent to which these meanings are shared, contested or reinterpreted by individuals and groups.

Second, the binary France-Japan comparison cannot capture the full diversity of long-term care configurations. The analytical framework would benefit from being applied to a broader range of welfare-state contexts to assess whether the relationships identified among representations, paradigms, instruments and care configurations are reproduced elsewhere.

Third, both countries exhibit substantial internal heterogeneity. In France, the implementation of the APA varies across departments, while in Japan municipalities differ in demographic composition, service availability and implementation capacities. A national-level comparison necessarily simplifies these territorial variations.

Fourth, financial sustainability is addressed only as a complementary dimension in the present article. Budgetary pressures, financing mechanisms and expenditure trajectories may significantly influence reform choices and policy instruments. A more systematic economic analysis would therefore be required to determine how financial constraints interact with the cognitive and normative dimensions examined here.

These limitations do not invalidate the comparative framework but define the level at which its conclusions should be interpreted.

4.3 Theoretical and Practical Implications

4.3.1 Theoretical Contributions of the Integrated Analytical Framework

This research contributes to comparative social gerontology by articulating four theoretical traditions that are often mobilised separately: social representations theory, the cognitive approach to public policy, the sociology of policy instrumentation and the comparative analysis of social care. The value of this articulation lies in its capacity to connect meanings, norms, instruments and institutional arrangements within a single analytical framework.

Social representations provide a way of examining the collective meanings through which dependency, autonomy and care become socially intelligible. Policy paradigms provide an intermediate level through which particular definitions of problems and legitimate responses become institutionally stabilised. Policy instruments translate these paradigms into operational categories, eligibility rules and organisational mechanisms. Social care configurations, finally, show how responsibilities are distributed among the State, market, family and community.

The framework therefore moves beyond an analysis centred exclusively on institutional structures. It makes it possible to examine how particular conceptions of ageing and dependency become embedded in instruments and how those instruments may in turn contribute to reproducing the meanings on which they are based. This perspective is

consistent with work emphasising the role of ideas and discourse in institutional development. Schmidt (2008), for example, shows that institutions are sustained not only by formal rules but also by interpretive frameworks that shape the perception of public problems and legitimate possible solutions.

The present article extends this perspective by explicitly connecting such institutionalised ideas with the analytical vocabulary of social representations.

4.3.2 Alternative Interpretations of the Observed Differences

The results presented in this article may naturally be subject to alternative interpretations.

A first reading, of institutionalist inspiration, would lead to explaining the observed differences primarily through the historical trajectories specific to the French and Japanese social protection systems. In this perspective, instruments and representations would appear as consequences of institutional arrangements rather than as factors participating in their stabilisation.

A second interpretation would place greater emphasis on demographic and economic constraints. The observed differences could then be analysed as pragmatic responses to distinct contexts of ageing, population density or financial sustainability of social protection systems.

A third reading would underline the role of cultural traditions and family norms, particularly in the Japanese case. Such an interpretation would risk, however, reducing public policies to simple institutional expressions of cultural values assumed to be homogeneous and stable, without sufficiently taking into account the processes of transformation and reinterpretation that accompany their institutionalisation.

The approach proposed in this article does not deny the relevance of these various factors. It suggests, however, that they are insufficient to explain the coherence observed between representations of ageing, normative paradigms, policy instruments and forms of care organisation. The analytical framework mobilised aims precisely to analyse the way in which these different dimensions articulate in the production, stabilisation and evolution of public policies.

4.3.3 Interpretive Limitations of the Proposed Framework

The proposed framework raises three principal interpretive challenges.

The first concerns the risk of cultural determinism. By identifying relatively stable configurations of meaning, the analysis could appear to treat national representations as fixed or culturally given. This interpretation would be inconsistent with the framework adopted here. The concept of a care representational regime refers to historically constructed and institutionally stabilised configurations, not to immutable cultural characteristics. These configurations may evolve through political conflict, institutional reform and changes in dominant representations.

The second challenge concerns the risk of cultural essentialisation in the France-Japan comparison. The Japanese case, in particular, should not be reduced to supposedly permanent values of family obligation or community solidarity. The development of the Kaigo Hoken itself demonstrates that the institutional distribution of responsibility for care has undergone substantial change.

The third challenge concerns the epistemological legitimacy of inferring representations from documentary and institutional evidence.

Social representations theory has traditionally relied on empirical methods designed to identify the content and organisation of representations held by social groups, including interviews, free associations, questionnaires and similarity analysis (Abric, 1994 ; Moliner & Guimelli, 2015).

The present study does not employ these methods and therefore does not claim to identify social representations in this strict psychosocial sense. Instead, it analyses institutionalised representations: conceptions of dependency, autonomy and care that have acquired sufficient political and administrative legitimacy to become embedded in policy instruments, institutional categories and legislative arrangements.

This analytical object is distinct from the lived representations of citizens, caregivers or professionals. The distinction is supported by several complementary traditions. Lascoumes and Le Galès (2004) show that policy instruments embody particular representations of the social world. Jobert and Muller (1987) similarly emphasise that public policy paradigms formalise particular understandings of problems and legitimate responses. Within the field of social representations, the distinction between representations held by social groups and representations institutionally produced or disseminated also supports the need to differentiate levels of analysis. The results of this article should consequently not be read as statements about what French or Japanese citizens collectively think about dependency. They describe the meanings that have become stabilised within the architecture of public policy. The gap between institutionalised representations and lived representations constitutes an important empirical question for subsequent research.

4.3.4 Implications for Public Policy

At the practical level, the comparison calls for caution regarding strategies of institutional transfer. A policy instrument that functions within one institutional and representational configuration may not produce equivalent effects when transferred to another context. Institutional arrangements are embedded within particular understandings of autonomy, responsibility and legitimate intervention. The French and Japanese cases illustrate this problem clearly. The Japanese emphasis on municipal coordination and community-based integration cannot simply be transplanted into a system organised around different administrative traditions and relationships among the State, local authorities and families. Likewise, the French emphasis on individual entitlement and standardised compensation reflects a particular institutional history and cannot be assumed to generate identical effects elsewhere. The gender dimension constitutes a further practical implication. In both countries, unpaid care remains disproportionately performed by women despite the development of formal long-term care arrangements. This suggests that reforms aimed solely at expanding services or modifying financing arrangements may leave underlying inequalities in the distribution of unpaid care largely unchanged. More explicit recognition of informal care within policy design is therefore necessary if long-term care reforms are to address not only access to services but also the social distribution of care responsibilities. More broadly, the comparison suggests that the effectiveness and social acceptability of long-term care reforms depend partly on the relationship between new instruments and the representations through which dependency, autonomy and responsibility are already understood.

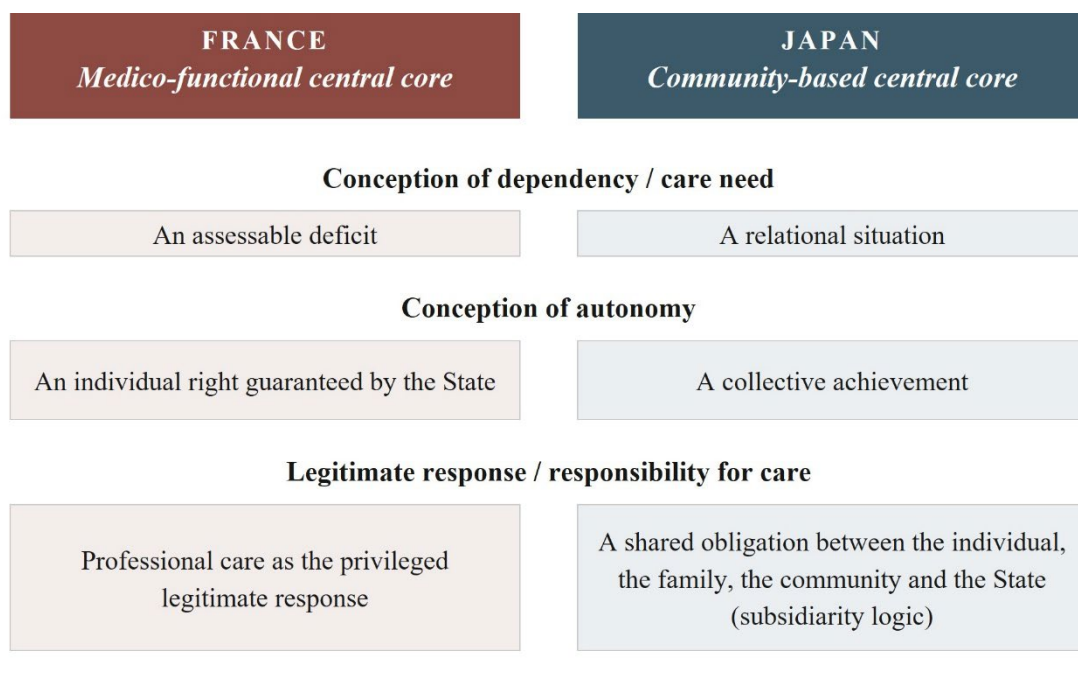
4.4 Towards the Concept of Care Representational Regime

The comparative findings support the exploratory use of the concept of a care representational regime. The concept refers to a relatively stable configuration of institutionalised meanings concerning dependency, autonomy and responsibility for care that becomes articulated with policy paradigms, policy instruments and care arrangements. Its

purpose is not to replace existing welfare-state typologies. Welfare-state regimes primarily describe institutional configurations and relationships among State, market and family. The concept of a care representational regime instead focuses on the configurations of meaning that contribute to making particular institutional arrangements intelligible and legitimate. In the French case, the evidence points towards a medico-functional care representational regime in which dependency is predominantly institutionalised as an assessable loss of functional autonomy, autonomy is framed as an individual social right and professional or public intervention constitutes a privileged legitimate response.

In the Japanese case, the evidence points towards a community-based care representational regime in which care needs are more strongly framed as relational situations requiring coordination across individual, family, community and public levels.

These two configurations should not be interpreted as fixed national essences or exhaustive categories. They are analytical propositions derived from the cases examined in this study.



Note. This figure presents the care representational regimes as an exploratory theoretical proposition (section 4.4) ; their validity would require comparative empirical research mobilising the methods proper to social representations theory.

*Figure 6. Two care representational regimes : France and Japan compared
(de Condappa, 2026)*

The empirical validation of the concept requires further research.

A first avenue would involve direct investigation of the representations held by citizens, informal caregivers, professionals and policy-makers using methods conventionally employed in social representations research, including free associations, semi-structured interviews, central-core questionnaires and similarity analysis.

A second avenue would involve comparative analysis of professional and institutional discourse in a larger number of national contexts.

A third avenue would examine the relationship between institutionalised representations and lived representations in order to determine where they converge, diverge or come into conflict.

Such research would make it possible to evaluate whether the concept of a care representational regime provides a useful comparative analytical tool beyond the two cases examined here.

At this stage, the concept should therefore be understood as an exploratory theoretical proposition and as a research programme rather than as an established typology. The concept of care representational regime presents affinities with institutionalist approaches centred on the role of ideas, but distinguishes itself from them by according a central place to social representations and the collective meanings associated with ageing, dependency and care. Unlike welfare-state regimes, which primarily describe institutional arrangements, it aims to account for the structures of meaning that contribute to their stability and legitimation. It thus constitutes an intermediate analytical level enabling the cognitive mechanisms studied by social psychology to be connected to the institutionalisation processes analysed by political science and the sociology of public action.

5 Conclusion

This article has proposed a comparative analysis of long-term care policies in France and Japan through an integrated analytical framework combining social representations, policy paradigms, policy instruments and social care configurations. The comparison shows that long-term care systems cannot be understood solely as institutional, organisational or financial arrangements. They also reflect broader cognitive and normative configurations that shape how dependency, autonomy and responsibility for care are defined and translated into public action.

In France, the analysis identifies a predominantly medico-functional configuration in which dependency is institutionalised as an assessable loss of functional autonomy. This representation is translated into standardised assessment through the AGGIR grid, eligibility categories and public compensation through the APA. The creation of the fifth branch of Social Security in 2020 strengthened the institutional recognition of autonomy as a distinct social risk but did not fundamentally replace the assessment paradigm on which the system continues to rely. In Japan, long-term care is organised through a different configuration. The Kaigo Hoken socialised part of the responsibility for care through universal public long-term care insurance, while the Community-Based Integrated Care System progressively strengthened municipal coordination, territorial integration and the articulation of individual, family, community and public responsibilities. The Japanese configuration therefore combines formal long-term care provision with continuing reliance on family and community resources. Despite these differences, the comparison also reveals important convergences. Both countries increasingly prioritise ageing in place and recognise long-term care as a collective social issue that cannot be addressed exclusively through family responsibility. At the same time, formal long-term care arrangements in both countries coexist with substantial unpaid family caregiving, which remains disproportionately performed by women.

References

- Abric, J.-C. (1994). *Pratiques sociales et représentations*. Presses Universitaires de France.
- Assemblée nationale. (2018). *Rapport d'information sur la prise en charge des personnes âgées en perte d'autonomie*. Commission des affaires sociales.
- Caradec, V. (2012). *Sociologie de la vieillesse et du vieillissement*. Armand Colin.
- Caisse nationale de solidarité pour l'autonomie [CNSA]. (2024). *Les chiffres clés de l'aide à l'autonomie 2023*.
- Daly, M., & Lewis, J. (2000). The concept of social care and the analysis of contemporary welfare states. *The British Journal of Sociology*, 51(2), 281-298. <https://doi.org/10.1111/j.1468-4446.2000.00281.x>
- Direction de la recherche, des études, de l'évaluation et des statistiques [DREES]. (2024). *L'allocation personnalisée d'autonomie (APA)*. In *L'aide et l'action sociales en France, édition 2024* (Fiche 15).
- Ennuyer, B. (2013). Enjeux de sens et enjeux politiques de la notion de dépendance. *Gérontologie et société*, 36(145), 25-35. <https://doi.org/10.3917/gs.145.0025>
- Esping-Andersen, G. (1990). *The three worlds of welfare capitalism*. Princeton University Press. <https://doi.org/10.1177/095892879100100108>
- Guillemard, A.-M. (1986). *Le déclin du social: Formation et crise des politiques de la vieillesse*. Presses Universitaires de France. <https://doi.org/10.3917/puf.guill.1986.01>
- Hall, P. A. (1993). Policy paradigms, social learning, and the state: The case of economic policymaking in Britain. *Comparative Politics*, 25(3), 275-296. <https://doi.org/10.2307/422246>
- Halpern, C., Lascoumes, P., & Le Galès, P. (Eds.). (2014). *L'instrumentation de l'action publique: Controverses, résistance, effets*. Presses de Sciences Po. <https://doi.org/10.3917/scpo.halpe.2014.01.0015>
- Institut national de la statistique et des études économiques [INSEE]. (2024a). *Perte d'autonomie*. In *France, portrait social, édition 2024*.
- Institut national de la statistique et des études économiques [INSEE]. (2024b). *Population par âge*. Tableaux de l'économie française.
- Iwagami, M., & Tamiya, N. (2019). The long-term care insurance system in Japan: Past, present, and future. *JMA Journal*, 2(1), 67-69. <https://doi.org/10.31662/jmaj.2018-0015>
- Jodelet, D. (1984). Représentation sociale: Phénomènes, concept et théorie. In S. Moscovici (Ed.), *Psychologie sociale* (pp. 361-382). Presses Universitaires de France.
- Jodelet, D. (2015). *Représentations sociales et mondes de vie*. Éditions des Archives contemporaines.
- Jobert, B., & Muller, P. (1987). *L'État en action: Politiques publiques et corporatismes*. Presses Universitaires de France.
- Laborde, C., Bigossi, F., & Grémy, I. (2021). Proches aidants: Qui sont-ils et que font-ils? *ADSP*, 116(4), 6-9. <https://doi.org/10.3917/aedesp.116.0006>
- Lascoumes, P., & Le Galès, P. (Eds.). (2004). *Gouverner par les instruments*. Presses de Sciences Po. <https://doi.org/10.3917/scpo.lasco.2005.01.0011>

- Libault, D. (2019). *Grand âge, le temps d'agir: Rapport de la concertation Grand âge et autonomie*. Ministère des Solidarités et de la Santé.
- Loi n° 2001-647 du 20 juillet 2001 relative à la prise en charge de la perte d'autonomie des personnes âgées et à l'allocation personnalisée d'autonomie. (2001). *Journal officiel de la République française*.
- Loi n° 2004-626 du 30 juin 2004 relative à la solidarité pour l'autonomie des personnes âgées et des personnes handicapées. (2004). *Journal officiel de la République française*.
- Loi n° 2015-1776 du 28 décembre 2015 relative à l'adaptation de la société au vieillissement. (2015). *Journal officiel de la République française*.
- Loi n° 2020-992 du 7 août 2020 relative à la dette sociale et à l'autonomie. (2020). *Journal officiel de la République française*.
- Ministry of Justice, Japan. (1997). *Long-Term Care Insurance Act (Kaigo hoken ho)*. Japanese Law Translation Database System.
- Miyawaki, A., Kobayashi, Y., Noguchi, H., Watanabe, T., Takahashi, H., & Tamiya, N. (2020). Effect of reduced formal care availability on formal/informal care patterns and caregiver health: A quasi-experimental study using the Japanese long-term care insurance reform. *BMC Geriatrics*, 20, 207. <https://doi.org/10.1186/s12877-020-01588-7>
- Moliner, P., & Guimelli, C. (2015). *Les représentations sociales: Fondements théoriques et développements récents*. Presses Universitaires de Grenoble. <https://doi.org/10.3917/pug.guime.2015.01>
- Morikawa, M. (2014). Towards community-based integrated care: Trends and issues in Japan's long-term care policy. *International Journal of Integrated Care*, 14, e005.
- Moscovici, S. (2015). *La psychanalyse, son image et son public* (3rd ed.). Presses Universitaires de France. (Original work published 1961)
- Okamoto, S., & Komamura, K. (2022). Towards universal health coverage in the context of population ageing: A narrative review on the implications from the long-term care system in Japan. *Archives of Public Health*, 80, 210. <https://doi.org/10.1186/s13690-022-00970-8>
- Palier, B. (2006). *La réforme des systèmes de santé* (3rd ed.). Presses Universitaires de France. <https://doi.org/10.1002/9781444306798>
- Palier, B., & Martin, C. (Eds.). (2008). *Reforming the Bismarckian welfare systems*. Blackwell Publishing.
- Picard, C. (2023). *Le Japon face aux enjeux démographiques: Politiques publiques et innovations sociales en faveur du maintien à domicile des personnes âgées* [Doctoral dissertation, Université Paris-Est and Kyoto Prefectural University].
- Schmidt, V. A. (2008). Discursive institutionalism: The explanatory power of ideas and discourse. *Annual Review of Political Science*, 11, 303-326. <https://doi.org/10.1146/annurev.polisci.11.060606.135342>
- Statistics Bureau of Japan. (2024). *Population estimates: Current population estimates as of October 1, 2024*. Ministry of Internal Affairs and Communications.
- Sudo, K., Kobayashi, J., Noda, S., Fukuda, Y., & Takahashi, K. (2018). Japan's healthcare policy for the elderly through the concepts of self-help (Ji-jo), mutual aid (Go-jo), social solidarity care (Kyo-jo), and governmental care (Ko-jo). *Bioscience Trends*, 12(1), 7-11. <https://doi.org/10.5582/bst.2017.01271>

- Tamiya, N., Noguchi, H., Nishi, A., Reich, M. R., Ikegami, N., Hashimoto, H., Shibuya, K., Kawachi, I., & Campbell, J. C. (2011). Population ageing and wellbeing: Lessons from Japan's long-term care insurance policy. *The Lancet*, 378(9797), 1183-1192. [https://doi.org/10.1016/S0140-6736\(11\)61176-8](https://doi.org/10.1016/S0140-6736(11)61176-8)
- Tsutsui, T. (2014). Implementation process and challenges for the community-based integrated care system in Japan. *International Journal of Integrated Care*, 14, e002. <https://doi.org/10.5334/ijic.988>
- World Health Organization. (2025). *Ageing and health*.