

Research on the Standardization of Legal Regulation of Integrated Medical and Elderly Care Services under the Long-Term Care Insurance System

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ABSTRACT The integration of long-term care insurance with medical-elderly care services has created an urgent need for standardized legal regulation of service supply, quality evaluation, and institutional coordination. This study addresses current difficulties in the standardization of integrated medical and elderly care services, including insufficient regulatory supply and weak institutional organization. A comprehensive method combining normative analysis, comparative research, and empirical investigation is adopted. First, 47 national policy documents issued from 2013 to 2024 are analyzed to examine existing standards across service content, service processes, staffing, facilities, and quality evaluation, identifying problems such as missing, conflicting, and ambiguous standards. Second, the legislative models and implementation mechanisms of the United States, Japan, and Germany under long-term care insurance frameworks are compared, and key experiences such as legislation-first governance and classified, graded standards are summarized. Finally, an empirical survey of 2,302 elderly people receiving long-term care insurance services in Pudong New Area, Shanghai, reveals structural bias in service utilization, with overemphasis on daily living care and insufficient medical care.

INDEX TERMS long-term care insurance, medical-elderly care integration, service standardization, legal regulation, empirical survey

I. INTRODUCTION

THE rapidly changing trend of increased world population ageing has placed the care of disabled elderly individuals at the forefront of many social security care systems. Simultaneously, the integrated medical and elderly care model, which integrates the healthcare and elderly care service, has been established as an important direction for the development of elderly care service systems in the new era, as it can meet the dual needs of the disabled elderly people in terms of daily living assistance and professional medical care. As the primary funding entity for integrated medical and elderly care, the operational quality of the long-term care insurance fund and the standardized provision of services directly impact the protection of disabled elderly rights and the efficiency of public resource allocation. Given the aforementioned practical dilemmas, how to promote the standardization of integrated medical and elderly care services through legal regulation and achieve coordinated development of long-term care insurance system and service supply has become an urgent academic and practical issue. In this context, “service standardization” refers to the technical specifications and medical protocols governing care delivery, while “legal regulation” denotes the administrative

and statutory framework—including insurance reimbursement criteria and licensing—that mandates or incentivizes the adoption of these standards. This study treats standardization as the object of regulation and legal tools as the means of enforcement. This paper’s theoretical contributions are mainly reflected in three aspects: First, it breaks through the limitations of existing research, which often focuses on institutional descriptions or policy recommendations, by systematically examining the normative basis and institutional logic of integrated medical and elderly care service standardization from a legal regulatory perspective, constructing an analytical framework of “normative supply - regulatory tools - institutional connection”; Second, it integrates normative analysis, comparative research, and empirical investigation to organically combine problem identification, experience sharing, and current status verification, enhancing the scientific rigor and persuasiveness of the research conclusions; Third, based on a systematic review of 47 policy documents and statistical analysis of 2302 survey data, it reveals the structural tension between the current normative system and the reality of service utilization, providing empirical evidence for the selection of regulatory tools.

The structure of this paper is as follows: Part II systematically reviews the relevant research progress at home and abroad, and clarifies the theoretical positioning of the research; Part III details the specific design and implementation process of normative analysis, comparative research, and empirical investigation methods; Part IV presents the main findings of the empirical investigation and discusses them in conjunction with the results of normative analysis, revealing the real dilemmas and regulatory needs of the standardization of integrated medical and elderly care services; Part V, based on the above analysis, proposes conclusions and suggestions for constructing a diversified regulatory tool system and achieving organic integration of systems.

II. RELATED WORK

With the acceleration of global population aging, long-term care insurance has become a core policy tool for addressing the care needs of disabled elderly. Högländer et al. [1] integrated multiple dimensions of nurse-patient communication and proposed a more comprehensive understanding framework. Wilkinson et al. [2] emphasized that open communication, shared decision-making and comprehensive support can help families provide the best, family-centered care for their children when facing prognostic uncertainty. McNabney et al. [3] identified several key common elements of complex nursing models for the elderly, including: comprehensive geriatric assessment, interdisciplinary teamwork, joint decision-making, medication management, and attention to patients' goals and quality of life. Ben-Arye et al. [4] adopted a pre- and post-test training assessment design. Palliative care nurses received integrated oncology training and their knowledge, attitudes, confidence and self-efficacy were assessed using questionnaires before and after training. Isobel and Thomas [5] integrated evidence of the impact of vicarious trauma on nurses and identified risk factors and protective factors.

Aydogdu [6] summarized several core challenges faced by nurse managers during the pandemic, including: ensuring sufficient personal protective equipment and human resources, maintaining the physical and mental health of employees, quickly adapting to and communicating changing policies and procedures, and effectively communicating and leading during the crisis. Konishi et al. [7] outlined the specific service types provided in Japan's public long-term care insurance system. Takahashi [8] revealed the significant impact of insurance coverage on the utilization of long-term care services and further linked it to health outcomes. Song et al. [9], based on data analysis, revealed the current utilization patterns, service gaps, and regional differences of long-term care insurance services in South Korea. Fuino et al. [10], based on consumer survey data from Switzerland, used quantitative analysis methods (such as regression models and choice experiments) to explore various driving factors affecting individuals' willingness to purchase long-term care insurance. This paper provides theoretical support and institutional suggestions for the standardized development

of medical and elderly care services and the sustainable operation of long-term care insurance in China by analyzing the legal needs for service standardization, the selection logic of regulatory tools, and the multi-stakeholder interest balancing mechanism.

III. METHODS

A. NORMATIVE ANALYSIS

This article adopts the normative analysis method to systematically sort out the current legal normative system of long-term care insurance and medical-nursing integration services. The objects of normative analysis cover three levels: first, the legal level, including the provisions on elderly care services in the "Law on the Protection of the Rights and Interests of the Elderly" and its revisions; second, the administrative regulations level, including policy documents such as the "Opinions on Accelerating the Development of the Elderly Care Service Industry" and the "Notice on Promoting the Integration of Medical and Health Services with Elderly Care Services" issued by the State Council; and third, the departmental rules and standards level, including technical specifications such as the "Service Guidelines for Medical-Nursing Integration Institutions (Trial)," the "Management Guidelines for Medical-Nursing Integration Institutions (Trial)," and the "Operational Guidelines for Disability Level Assessment of Long-Term Care Insurance" formulated by the National Health Commission, the Ministry of Civil Affairs, the National Healthcare Security Administration, and other departments [11,12].

The specific operational steps of the normative analysis are as follows: First, a total of 52 normative documents issued at the national level between 2013 and 2026 concerning long-term care insurance and integrated medical and elderly care services were collected and compiled to establish a policy text database. Second, using content analysis, the service standard clauses in the texts were coded and classified, extracting standard provisions covering five dimensions: service content, service process, staffing, facilities and equipment, and quality evaluation. Third, the degree of mandatory nature of the standards in each dimension was graded, distinguishing them into three categories: mandatory standards, recommended standards, and guiding opinions. Finally, the types of problems existing in the current normative system, such as missing standards, conflicting standards, and ambiguous standards, were identified to provide a basis for the selection of subsequent regulatory tools.

B. COMPARATIVE RESEARCH METHODS

This paper used the comparative study method to test the efficacy of international experiences for reference significance to the standardization of medical and elderly care services in the Chinese context. The countries chosen for the purpose of comparative study include US, Japan and Germany. The reason behind this choice is that all these three countries have built relatively mature long-term care medical insurance systems and have accumulated rich

experience in the standardization of medical and elderly care services. The core of the American PACE model is a comprehensive plan for elderly care and a comprehensive system for standards of service in the fields of prevention, medical treatment, rehabilitation and long-term care have been established. Japan's Long-Term Care insurance system has set up legalized service standards in the Long-Term Care Insurance Law, which classifies the content of the services in categories of home services, regional intensive services and institutional services and makes explicit provisions about the personnel configuration, facility conditions and service process for each of the services. Germany's long-term care insurance system has developed a standard implementation mechanism composed of external supervision and internal control of the quality of care served by their chain of care providers and through the Long-Term Care Insurance Law and the Long-Term Care Quality Assurance Law.

Some dimensions of the comparative study were horizontal and vertical comparisons. The horizontal comparison is the focus on the commonalities and differences in the legislation on the standards of service in the three countries, which is divided into four dimensions, including the legislative mode, the standard system, the implementation mechanism, and the regulatory mechanism [13]. The vertical comparison focuses on the characteristics of the institutional evolution stage-specific in the three countries, the standard regulation problems encountered at various stages of development and their solutions. Through comparative analysis, the core experiences that China can learn from are extracted, including regulatory strategies including: building the basis for standards through legislation, building a standard system through classification and grading, involving multiple stakeholders in the standard setting process and emphasizing incentives and constraints to ensure standard implementation.

C. EMPIRICAL INVESTIGATION AND STATISTICAL ANALYSIS

This paper uses empirical survey and statistical analysis methods to conduct a quantitative study on the current status of standardized implementation of medical and elderly care services under the long-term care insurance system. The survey subjects were elderly people living at home in a street in Pudong New Area, Shanghai, who were covered by long-term care insurance services. The survey tool was a self-designed questionnaire, which included three modules: basic information of the elderly, service utilization, and service quality evaluation. A total of 2,348 questionnaires were distributed and 2,302 valid questionnaires were collected, with a valid response rate of 98.04%. The inclusion criteria for the sample were: age 60 years and above, having received long-term care insurance benefits, and having normal cognitive function and being able to cooperate with the survey or have the main caregiver answer on their behalf [14,15].

Statistical analysis was conducted using SPSS 26.0 soft-

ware. First, descriptive statistics were performed on the basic characteristics of the sample, including the distribution of variables such as age, gender, education level, number of diseases, and long-term care insurance assessment level. Second, the chi-square test was used to compare differences in age distribution, education level, number of diseases, and degree of assistance needed among elderly people with different long-term care insurance assessment levels. Third, frequency statistics were performed on the utilization rates of 27 daily living care services and 15 medical care services to identify high-frequency and low-frequency services. Finally, a multiple linear regression model was constructed, with the utilization rates of daily living care services, medical care services, and overall integrated medical and elderly care services as dependent variables, and the predisposing factors (age, gender, education level), contributing factors (medical insurance category, source of income, care costs), and need factors (degree of assistance needed, number of diseases, long-term care insurance level) from the Anderson model as independent variables, to analyze the degree and direction of influence of each factor on service utilization levels.

IV. RESULTS AND DISCUSSION

A. CURRENT STATUS OF UTILIZATION OF INTEGRATED MEDICAL AND ELDERLY CARE SERVICES UNDER LONG-TERM CARE INSURANCE COVERAGE

The survey results show that the utilization of integrated medical and elderly care services by community-based elderly people covered by long-term care insurance exhibits structural characteristics. Among the 2302 valid samples, significant differences existed across multiple dimensions among elderly people at different long-term care insurance assessment levels. Table 1 presents the basic characteristics of the samples and the results of stratified comparisons.

Table 1 shows that the long-term care insurance assessment level was significantly associated with age, education level, number of chronic diseases, and degree of assistance needed ($P < 0.001$). With increasing age, the proportion of severely disabled individuals increased significantly, with those aged 90 and above accounting for 20.3% of the severely disabled group, significantly higher than their 6.9% in the mildly disabled group. Regarding education level, those with primary school education or below accounted for 65.3% of the severely disabled group, significantly higher than their 50.0% in the mildly disabled group. While this indicates a significant statistical correlation within the sample, further multivariate analysis is required to determine if this distribution is influenced by confounding factors such as lifetime income or occupational hazards. The number of chronic diseases was positively correlated with the degree of disability; those with six or more chronic diseases accounted for 29.6% of the severely disabled group, compared to only 15.3% in the mildly disabled group. The degree of assistance needed, as a direct indicator of disability status, was highly consistent with the long-term care insurance assessment

TABLE 1. Comparison of basic characteristics of elderly people at different long-term care insurance assessment levels

Variable	Classification	Mild disability (n=1082)	Moderate disability (n=768)	Severe disability (n=452)	Total	χ^2 value	p-value
Age	60–74 years old	486 (44.9%)	245 (31.9%)	98 (21.7%)	829 (36.0%)	68.32	<0.001
	75–89 years old	521 (48.2%)	418 (54.4%)	262 (58.0%)	1201 (52.2%)		
	90 years and older	75 (6.9%)	105 (13.7%)	92 (20.3%)	272 (11.8%)		
Education level	Primary school and below	541 (50.0%)	432 (56.3%)	295 (65.3%)	1268 (55.1%)	32.47	<0.001
	Junior high school	324 (29.9%)	206 (26.8%)	108 (23.9%)	638 (27.7%)		
	High school and above	217 (20.1%)	130 (16.9%)	49 (10.8%)	396 (17.2%)		
Number of chronic diseases	0–2 types	432 (39.9%)	261 (34.0%)	121 (26.8%)	814 (35.4%)	45.83	<0.001
	3–5 types	485 (44.8%)	352 (45.8%)	197 (43.6%)	1034 (44.9%)		
	6 or more	165 (15.3%)	155 (20.2%)	134 (29.6%)	454 (19.7%)		
Degree of need for help	Partial help	764 (70.6%)	312 (40.6%)	78 (17.3%)	1154 (50.1%)	214.56	<0.001
	More help	261 (24.1%)	352 (45.8%)	198 (43.8%)	811 (35.2%)		
	Completely dependent	57 (5.3%)	104 (13.6%)	176 (38.9%)	337 (14.7%)		

level; those completely dependent on assistance accounted for 38.9% of the severely disabled group, 13.6% of the moderately disabled group, and only 5.3% of the mildly disabled group.

Furthermore, the multiple linear regression analysis based on the Anderson model reveals that “need factors”—specifically the long-term care insurance assessment level ($\beta = 0.42$, $P < 0.001$) and the number of chronic diseases ($\beta = 0.28$, $P < 0.01$)—are the strongest predictors of medical care service utilization. Among “contributing factors,” the type of medical insurance significantly influenced the frequency of service use, whereas “predisposing factors” such as gender showed no statistical significance. This empirical evidence confirms that while health needs drive the demand, the actual utilization is constrained by the current supply of standardized medical services.

Table 2 presents the utilization rate ranking of 27 daily living care services. The top six most frequently used services are, in order: nail/fingernail care (78.3%), hand/foot cleaning (72.5%), bathing (68.7%), hair combing/shampooing (62.4%), warm water sponging (58.1%), and head and face cleaning (54.6%). These frequently used services share common characteristics: they are all basic daily living care services with relatively low technical barriers, high service frequency, and are mostly necessities for the daily lives of the elderly. In contrast, some more specialized or less frequently needed services have significantly lower utilization rates.

TABLE 2. Ranking of Utilization Rate of Daily Care Services

Ranking	Services	Number of users	Utilization rate (%)
1	Nail/Toenail Care	1802	78.3
2	Hand/Foot Cleaning	1668	72.5
3	Bathing	1581	68.7
4	Combing/Shampooing	1436	62.4
5	Warm water sponge bath	1337	58.1
6	Facial cleansing	1257	54.6
7	Change bed sheets/duvet covers	1128	49.0
8	Assist with changing clothes	1042	45.3
9	Excretion care	968	42.1
10	Pressure ulcer prevention	892	38.8

The utilization of medical and nursing services presents

a completely different picture. Table 3 shows that among the 15 commonly used medical and nursing services, the proportion of those who “did not utilize any of them” was as high as 61.86%, indicating that most disabled elderly people did not receive professional medical and nursing services commensurate with their disability status. Among the services that were utilized, blood pressure measurement (32.4%), blood glucose monitoring (24.7%), and medication guidance (18.5%) ranked in the top three, and these services are mostly routine contents of chronic disease management. However, the utilization rate of more specialized services such as nasogastric feeding (3.2%), urinary catheterization (2.8%), sputum suctioning (1.9%), and tracheotomy (0.7%) was extremely low. This result indicates that the current long-term care insurance system’s integrated medical and elderly care services have a structural bias of “emphasizing daily living care and neglecting medical and nursing care,” and the professional medical and nursing care needs of disabled elderly people have not been effectively met.

TABLE 3. Utilization of Medical and Nursing Services

Service utilization	Number of people	Percentage (%)
Not used any of them	1424	61.86
Use 1–2 items	652	28.32
Use 3–4 items	168	7.30
Use 5 or more	58	2.52
Total	2302	100.00

B. THE GAP BETWEEN THE STANDARDIZED SUPPLY AND REALITY OF INTEGRATED MEDICAL AND ELDERLY CARE SERVICES

There is a great gap between the current regulatory system and service demands under the long-term care insurance system. One area of this that needs to be addressed is the low level of standards with insufficient enforcement. Current standards for integrated medical and elderly care services are largely guidelines, just recommendations, suggestions without legal standing. In contrast, Japan’s Long-Term Care Insurance Law legalises the provision of services, staffing and facility conditions, and need to provide services according to legally established standards. A second gap is the fragmentation of and low systematization of standards.

Current standards are dissipated in a number of documents published by a series of departments, and the health and civil affairs departments and medical insurance departments form their own standards, although there is no coordinated mechanism in time, which results in poor alignment and even conflicts, among standards. A third gap is a lack of having standards linked to payment. As a major user and payer for integrated medical and elderly care services, the long-term care insurance fund should have significant leverage in service standardization in the aspect of coverage and payment standards; however, in practice, a mechanism has not been established between insurance payment and payment services.

The survey findings on the utilization of services show the insufficiency of standardised supply. Tables 2 and 3 reveal structural prejudices in the use of services, which for the most part point to discrepancies in the provision of services due to non-existence of standards. The reason for the high utilization rate of daily living care services is not because the needs of disabled elderly people are entirely centered on living care, but because the daily living care services have relatively mature operation standards and training systems, so when providing daily living care services, service providers have certain standards and guidelines to follow by. In contrast, it is because of the lack of capacity in service supply and the direct correlation with the lack of standards for the provision of medical, dental, and nursing services that the utilization rate is low. With no clear standards of operations and risk prevention guidelines, specialized services (nasogastric feeding, catheterization, suctioning, etc.) are frequently avoided or limited by the service provider for fear of liability.

C. SELECTION OF LEGAL REGULATORY TOOLS AND INSTITUTIONAL CONNECTION PATH

To ensure the combination of increased supply of regulated services and the absence of demand for standardized integrated medical and elderly care services, it is necessary to choose legal tools of regulation carefully, and to build a multi-level regulatory system that meets a comprehensive regulatory framework. The choice of regulatory tools should take into account the following factors: the type of market failure the standard seeks to address, the type of stakeholders included, the practicability and cost of the standard implementation, and combining the standard with existing systems. Based on these considerations, a combination of the different types of regulatory tools can be built from three dimensions: mandatory regulation, incentive-based regulation and participatory regulation. Unlike traditional administrative measures, which often suffer from high enforcement costs and information asymmetry, incentive-based regulation leverages economic levers to align the profit motives of private providers with public health goals. Similarly, participatory regulation reduces the “regulatory gap” by involving industry associations that possess superior technical expertise in medical textiles and nursing protocols,

ensuring that standards remain dynamic and clinically relevant compared to rigid top-down mandates.

Mandatory regulatory tools are mostly applicable to service sectors that have implications in case of the basic rights and health and safety of the elderly. For high-risk services (e.g., pressure ulcer prevention, care of excretion, nasogastric feeding), mandatory standards should be created, with the operational procedures, personnel qualification requirements and quality control indicators clearly defined. The “Basic Norms for Service Safety in Elderly Care Institutions” issued by the National Health Commission and other departments shall be a representative example of a mandatory standard, which requires basic requirements for service safety and sets specific contents of risk assessment. The next step should be to expand the scope of mandatory standards to the community and home-based integrated medical and elderly care services from institutional elderly care to community and home-based long-term care insurance, as well as access standards for services covered by long-term care insurance, and service institutions that fail to meet the standards should not be included in designated management.

Incentive-based regulatory tools are mainly used to steer the service providers to adopt higher standards of services through economic levers. Long-term care insurance payment policies may play an important role as incentives. For integrated medical and elderly care institutions who practice the standard of services above the legal standards, more professional and technical people, and more sound quality management systems, there can be incentives through higher standards of payment for services and rewards based on performance. At the same time, for institutions that fail to effectively implement service standards, restrictive measures can be implemented, such as reduction of payment ratios and suspension of designated institution status. This type of regulatory regime, with emphasis on both incentives and constraints, is helpful to promote market forces for continuous improvement in service standards. Research shows that the synergy effect of elderly medical and nursing pilot programs and long-term care insurance can greatly improve the health status of the elderly; to realize the synergy effect, it is necessary to generate the organic effect of payment policies and service standards.

Participatory regulatory tools focus on the joint involvement of a number of stakeholders in the standard-setting and implementation process. Standard-setting should not be a one-way act of administrative agencies, but rather involve associations in industry, professional organizations, service providers, and representatives of the elderly. Industry associations can practice self-regulation and build group standards that could be higher than those of national standards and encourage member organizations to improve their service quality. Professional organizations can be part of the supervision and evaluation of how the standards are implemented, as a technical support for regulatory enforcement. As direct recipients of services, the satisfaction evaluation of the elderly and their families should be an important basis for

the service quality evaluation. Research shows that patient satisfaction is an important dimension in measuring nursing quality; also, the results of the evaluation can describe the effectiveness of the implementation of service standards.

Institutional alignment is a crucial aspect of the standardized legal regulation of integrated medical and elderly care services. First, it is necessary to align the service standards for integrated medical and elderly care with the disability assessment standards for long-term care insurance. This assessment result should be aligned with service needs assessments, determining personalized service items and standards based on the level of disability. Second, it is necessary to align service standards with medical insurance payment methods. Eligible medical and nursing services should be included in the medical insurance payment scope, and the reimbursement ratio for services already covered by medical insurance should be gradually increased. Third, it is necessary to align service standards with institutional access management. The registration management of elderly care institutions implemented by the civil affairs department and the registration of medical institutions implemented by the health department should both consider compliance with service standards as an important factor.

V. CONCLUSION

The deep integration of long-term care insurance and medical-elderly care services, which necessitates the standardization of functional medical materials for patient safety and comfort, has increased the legal requirements for comprehensive service regulation. This paper, by way of normative analysis, comparative research and empirical investigation, identifies risks in existing problems that are currently associated with the standardization of integrated medical and elderly care services: there is a structural bias of service utilization, in which “emphasizing daily living care while neglecting medical care”; there are gaps at the current regulatory system, including diluted standards, dispersed contents, and little integration with payment mechanisms; and choosing legal regulatory tools and pathways of institutional coordination needs to be optimized. Research shows that it is necessary to build a multifaceted tool system with mixed regulations of mandatory, incentive and participative rules to improve the standardised legal regulation of integrated medical and elderly care services under the long term care insurance system. While the empirical findings are based on a localized sample from Shanghai, they serve as a critical pilot reference for developing a broader regulatory framework under the long term care insurance system. Mandatory standards should cover basic areas of service which deal with the basic rights and health and safety of the elderly; incentive-based regulations should provide a framework for continuous improvement in service standards through payment policies; and participatory regulations should involve multiple stakeholders in the formulation and implementation of standards. Simultaneously, it is necessary to achieve the organic integration of service standards and

disability assessment standards, medical insurance payment methods and institutional access management to achieve a synergistic institutional effect. room for improvement remains. In the future, efforts should be accelerated to integrate regional medical and nursing resources, precisely meet the needs of resource-disadvantaged elderly groups, and actively strengthen inter-departmental collaboration and information sharing. At the legal level, it is necessary to expedite the national-level legislation on social elderly care services, taking into account the fact that home-based and community-based elderly care constitutes the vast majority of the population, and to strengthen legislation on home-based and community-based elderly care services to effectively address the standardization issues of services such as meal assistance, cleaning assistance, bathing assistance, mobility assistance, and medical assistance for the elderly. Only through a systematic and comprehensive legal framework can the standardized development of integrated medical and elderly care services—including the technical specifications for antibacterial and biocompatible medical textiles—be achieved, ensuring the sustainable operation of the long-term care insurance system and the protection of the legitimate rights of disabled elderly individuals.

AUTHOR CONTRIBUTIONS

Yuting Kang designed, collected and analyzed the data, and drafted the manuscript. Yuting Kang conducted the study, critically revised the manuscript for important intellectual content, and gave final approval of the version to be published. Yuting Kang participated fully in the work, take public responsibility for appropriate portions of the content, and agreed to be accountable for all aspects of the work in ensuring that questions related to the accuracy or integrity of any part of the work are appropriately investigated and resolved.

CONFLICTS OF INTEREST

The author declares no conflict of interest.

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REFERENCES

- [1] J. Högländer, K. Holmström I, A. Lövenmark, et al., “Registered nurse-patient communication research: An integrative review for future directions in nursing research,” *Journal of advanced nursing*, vol. 79, no. 2, pp. 539-562, 2023, doi: 10.1111/jan.15548.
- [2] D. Wilkinson, S. Bertaud, A. Mancini, et al., “Recognising uncertainty: an integrated framework for palliative care in perinatal medicine,” *Archives of Disease in Childhood-Fetal and Neonatal Edition*, vol. 110, no. 3, pp. 236-244, 2025, doi: 10.1136/archdischild-2024-327662.
- [3] K. McNabney M, R. Green A, M. Burke, et al., “Complexities of care: common components of models of care in geriatrics,” *Journal of the American Geriatrics Society*, vol. 70, no. 7, pp. 1960-1972, 2022, doi: 10.1111/jgs.17811.

- [4] E. Ben-Arye, Y. Tapiro, R. Baruch, et al., "Integrative oncology for palliative care nurses: pre-post training evaluation," *BMJ Supportive & Palliative Care*, vol. 14, no. 2, pp. 178-182, 2024, doi: 10.1136/spcare-2022-004117.
- [5] S. Isobel and M. Thomas, "Vicarious trauma and nursing: An integrative review," *International Journal of Mental Health Nursing*, vol. 31, no. 2, pp. 247-259, 2022, doi: 10.1111/inm.12953.
- [6] F. Aydogdu A L, "Challenges faced by nurse managers during the COVID-19 pandemic: an integrative review," *Journal of research in Nursing*, vol. 28, no. 1, pp. 54-69, 2023, doi: 10.1177/17449871221124968.
- [7] T. Konishi, H. Inokuchi, and H. Yasunaga, "Services in public long-term care insurance in Japan," *Annals of Clinical Epidemiology*, vol. 6, no. 1, pp. 1-4, 2024, doi: 10.37737/ace.24001.
- [8] M. Takahashi, "Insurance coverage, long-term care utilization, and health outcomes," *The European Journal of Health Economics*, vol. 24, no. 8, pp. 1383-1397, 2023, doi: 10.1007/s10198-022-01550-x.
- [9] H. Song E, S. Moon Y, H. Park J, et al., "Current status of public long-term care insurance services and future perspective: a questionnaire survey and National Health Insurance Service data of South Korea," *Journal of the Korean Neurological Association*, vol. 42, no. 1, pp. 1-12, 2024, doi: 10.17340/jkna.2023.0100.
- [10] M. Fuino, A. Ugarte Montero, and J. Wagner, "On the drivers of potential customers' interest in long-term care insurance: Evidence from Switzerland," *Risk Management and Insurance Review*, vol. 25, no. 3, pp. 271-302, 2022, doi: 10.1111/rmir.12218.
- [11] W. Goodrich G and M. Lazenby J, "Elements of patient satisfaction: An integrative review," *Nursing open*, vol. 10, no. 3, pp. 1258-1269, 2023, doi: 10.1002/nop2.1437.
- [12] C. Forde-Johnston, D. Butcher, and H. Aveyard, "An integrative review exploring the impact of Electronic Health Records (EHR) on the quality of nurse-patient interactions and communication," *Journal of advanced nursing*, vol. 79, no. 1, pp. 48-67, 2023, doi: 10.1111/jan.15484.
- [13] F. Aydogdu A L, "Ethical dilemmas experienced by nurses while caring for patients during the COVID-19 pandemic: an integrative review of qualitative studies," *Journal of Nursing Management*, vol. 30, no. 7, pp. 2245-2258, 2022, doi: 10.1111/jonm.13585.
- [14] N. Davison S, W. Pommer, A. Brown M, et al., "Conservative kidney management and kidney supportive care: core components of integrated care for people with kidney failure," *Kidney international*, vol. 105, no. 1, pp. 35-45, 2024, doi: 10.1016/j.kint.2023.10.001.
- [15] C. Robichaux, P. Grace, J. Bartlett, et al., "Ethics education for nurses: foundations for an integrated curriculum," *Journal of Nursing Education*, vol. 61, no. 3, pp. 123-130, 2022, doi: 10.3928/01484834-20220109-02.