HGPI Health and Global Policy Institute

AMR Alliance Japan

Health and Global Policy Institute (HGPI) and AMR Alliance Japan

Discussion Paper



Addressing AMR Measures for an Era of Healthy Longevity:

Ensuring Safety and Security for Older Adults in a Super-Aged Society



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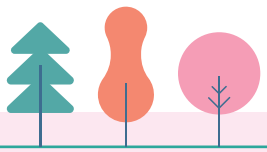
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Introduction

Projections show that population aging in Japan may reach 35% by 2040, making it one of the first countries in the world that will have a super-aged society. As immune function declines with age, older people are generally more susceptible to infectious diseases. Additionally, many older adults live with multiple health conditions. As the population ages, society as a whole is becoming more vulnerable to infectious diseases.

Among the various threats posed by infectious diseases, antimicrobial resistance (AMR) is recognized as a key issue that presents major risks to public health in Japan and overseas. While people are often prescribed antimicrobials for infectious diseases, the more antimicrobials being used, the greater the chances that AMR will develop and spread. Older adults are no exception to this threat; people age 70 or older account for approximately 70% of new AMR bacterial infection cases in Japan.

In this context, measures for AMR control in senior living facilities warrant special attention. The need for such measures has already been highlighted in Japan's National Action Plan on AMR (NAP), and gradual progress has been made in initiatives for senior living facilities since the NAP was formulated in 2016. For example, periodic point prevalence surveys (PPS) on antimicrobial use among older residents in long-term care health facilities have been conducted since 2019, and in 2020, the AMR Clinical Reference Center presented a Japanese translation of the "Core Elements of Antibiotic Stewardship for Nursing Homes" published by the U.S. Centers for Disease Control and Prevention (CDC). Later, a new additional fee for enhanced infection control measures for senior living facilities and other institutions was included in the 2024 revision of the long-term care service fee schedule, and a research team from the Ministry of Health, Labour and Welfare (MHLW) published guidelines on AMR control in senior living facilities in 2025. In sync with these developments, adjustments to the additional fee for enhanced infection control measures and other medical service fee schedule revisions have been implemented in 2026, helping to establish an environment in which healthcare institutions can exercise more flexibility when providing advice in response to requests from insured long-term care facilities and other such facilities for older adults.

Improving the effectiveness of AMR measures in senior living facilities will require giving ample consideration to the respective societal roles and characteristics of each facility. While efforts to establish systems that enable people to live in familiar communities until end of life are currently advancing based on Regional Medical Care Visions and the Integrated Community Care System, population aging and progress in medical technology have transformed the national disease profile and healthcare needs. Driven by these changes, the scope of healthcare has expanded from hospitals to senior living facilities and homes, and senior living facilities have become vital providers of healthcare and long-term care within communities. There are also various types of senior living facilities,[1] many of which are not staffed by full-time physicians. The scope of medical care that can be provided on-site at such facilities is limited. Even in these environments, nurses, care workers, and other staff who support the health of residents are making substantial contributions to AMR control through proactive infection prevention and the care they provide on a daily basis.

1. Specific types of senior living facilities in Japan include: special nursing homes for the elderly, long-term care health facilities, and long-term care medical facilities, which are covered by long-term care insurance; nursing homes for the elderly and low-cost homes for the elderly, which are welfare facilities for the elderly; fee-based homes for the elderly; and serviced housing for the elderly. (Please note that this document uses the term "elderly" only to reflect its usage in the laws and other publications of the Government of Japan or similar entities.)



In this context, aiming to raise public awareness of AMR control in an aging society as well as to promote more effective and integrated countermeasures for a society of healthy longevity, Health and Global Policy Institute (HGPI) has synthesized discussion points on AMR control in senior living facilities for consideration over the medium to long term. Reducing the incidence of and preventing infectious diseases are crucial for AMR control, and both require consistently providing appropriate care to each older person on a daily basis. This discussion paper aims to go beyond individual care practices, procedures, specific clinical activities, and other AMR measures that rely solely on the efforts of facilities and staff, and shifts towards institutional frameworks and systems that underpin care, as a first step in establishing and further expanding sustainable mechanisms at the societal level.

In preparing this discussion paper, we conducted desk research and held interviews with people involved in senior living facilities as well as a wide range of representatives of industry, government, academia, and civil society. For our interviews, we selected facilities that encompassed various operational models and regional conditions, focusing primarily on long-term care health facilities and special nursing homes for the elderly. We also gathered opinions from stakeholders, including staff members working at facilities and local governments, research institutions, and other such bodies.

Chapter 1 provides an overview of the current status and positioning of AMR measures in senior living facilities. It is primarily based on our interviews and was compiled independently by HGPI. Chapter 2 sets out seven key discussion points to consider for the promotion of AMR measures in senior living facilities. Although these items center on core AMR control themes, recognizing that effective infection prevention underpins all AMR control efforts, some items overlap with broader infection prevention and control (IPC) efforts. In particular, themes that are closely related to overall IPC efforts include developing human resources and multidisciplinary collaboration (see Chapter 2-4) and administrative infrastructure (see Chapter 2-7). Finally, Chapter 3 offers perspectives that should be shared across all types of facilities, professions, and positions when considering the discussion points presented in Chapter 2.



1: The Current State of AMR Measures in Senior Living Facilities

To gain insight into the current state of AMR control in senior living facilities, we held individual interviews primarily with staff working at such facilities. Their voices are compiled in this chapter. The interviews revealed that they have a high level of interest in IPC measures for various reasons. We were also able to identify their criteria for prioritizing such measures. At the same time, our findings suggested that AMR prevention does not fit those criteria well and is prone to being assigned a lower priority within facilities as a result.

1-1: The Positioning of Infection Prevention and Control (IPC) in Senior Living Facilities

In senior living facilities, IPC is a topic of great interest and a vital measure for ensuring safety for both residents and staff. In particular, there has been a significant increase in recognition among staff members in the wake of the COVID-19 pandemic, and in many facilities, it has become a high-priority issue in daily operations as well as for general management.

However, many senior living facilities do not have full-time physicians on staff and limited numbers of long-term care staff, leading to practical difficulties in implementing stringent criteria such as those used in medical facilities. Our interviews revealed that while senior living facilities rigorously implement standard precautions, they prioritize IPC measures based on the three main perspectives described below, and focus their efforts accordingly.

- **The risk of severe illness or death following infection onset**
  - Facilities determine each resident's risk of severe complications or death from infection based on comprehensive assessments that account for immune function, as well as the disease in question, its available treatments, and the ease with which it spreads in communal living environments. Because residents often live with multiple chronic conditions and have weakened immune systems due to aging, facility-acquired infections can easily lead to severe illness or death.

- **The risk of infections among staff and potential impact on facility operations**
  - When staff members acquire an infection, their own health is affected which can lead to absences. As absences accumulate, the resulting staff shortages can disrupt daily facility operations.

- **The availability of methods for prevention, testing, treatment, and infection control**
  - It is easier to incorporate IPC into routine care practices when pathogens can be detected with on-site testing and when diseases have clearly established protocol for treatment or contact prevention. Clear protocols for specific procedures (such as handling vomit or donning and doffing personal protective equipment (PPE)) also help ensure that these measures become firmly established.
  - Even when prevention and treatment methods for a disease have not been established, facilities tend to prioritize IPC when that disease carries a high risk of severe illness or death. For instance, norovirus can be fatal if vomiting leads to airway obstruction or aspiration pneumonia, but it currently has no approved vaccines or antivirals. This makes norovirus a priority target for facility prevention because of its potential for outbreaks in communal living environments.

1-2: The Positioning of AMR Measures in Senior Living Facilities

The scope of medical care that can be provided on-site at senior living facilities is limited. This means that if a resident's health significantly deteriorates (e.g. after developing a new disease) and adequate treatment cannot be provided within the facility, the resident may be referred to a healthcare institution or even hospitalized. Since residents return to the senior living facility once their condition stabilizes, there are many cases in which residents move back and forth between facilities. When this occurs, residents can bring newly-acquired AMR pathogens back to the senior living facility following hospitalization, or introduce AMR pathogens into medical facilities upon admission. In addition, an increasing number of older adults require specialized medical care, such as tube feeding, airway suctioning, and urinary catheterization. This further heightens the risk that AMR pathogens will become established and spread.

Furthermore, senior living facilities provide many opportunities for contact between residents and staff, including during group activities, meal assistance, rehabilitation, and physical assistance. These interactions create an environment in which AMR pathogens can easily spread.

Despite these factors, the three criteria used to set IPC priorities are difficult to apply to AMR pathogens. In cases where residents are carriers of an AMR pathogen but have no active disease, implementing AMR control measures becomes hard to justify. As a result, AMR control tends to be assigned a lower priority within facilities.

The risk of severe illness or death following infection onset

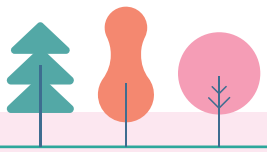
- Many residents who carry an AMR pathogen do not develop infections and remain asymptomatic. Even when an AMR pathogen has spread within a facility, it is not often recognized as an imminent risk. However, when AMR pathogens cause aspiration pneumonia, urinary tract infections, or other infections that occur frequently in senior living facilities, the range of effective antimicrobials is limited. This hinders treatment and can lead to severe infections.

The risk of infections among staff and potential impact on facility operations

- Healthy staff members who carry AMR pathogens are unlikely to develop infections or severe illnesses. This makes it less likely that the facility and its staff will recognize AMR pathogens as an immediate threat requiring urgent action. Additionally, many of the major AMR pathogens are spread through contact transmission. Unlike influenza, COVID-19, or other diseases that spread through droplet or airborne transmission, it takes time for AMR pathogens to spread from staff members to residents. Because staff members are less likely to develop infections due to AMR pathogens than residents, staff members are less likely to anticipate staff shortages in situations where an outbreak occurs, complicating facility operations.

The availability of methods for prevention, testing, treatment, and infection control

- Senior living facilities generally lack microbiological testing equipment and must outsource testing for AMR pathogens. Results take several days to obtain, which makes it difficult to determine in real time whether a resident is carrying an AMR pathogen.
- Consistent adherence to standard precautions and antimicrobial stewardship are vital for combatting AMR pathogens. However, people rarely feel the true impact of these measures because it can be difficult to see how they lead to clear results, such as a major drop in infections. Therefore, despite the potential implications on society and the future risks, AMR control tends to be deprioritized due to staffing constraints.



2: Discussion Points on AMR Measures in Senior Living Facilities

Although senior living facilities prioritize IPC measures based on the three perspectives described above, AMR control is often assigned a lower priority because the necessity and effectiveness of AMR countermeasures can be difficult to determine. Recognizing these circumstances, this chapter compiles seven discussion points related to systems and institutional frameworks that require further consideration for AMR control in senior living facilities.

2-1: Standards for AMR Measures in Senior Living Facilities

Key points

Before best practices for AMR control in senior living facilities can be determined, effective measures first need to be identified. However, evidence on AMR countermeasures specific to the context of senior living facilities remains limited. There are also various kinds of senior living facilities that fulfill different roles according to their characteristics. Even facilities of the same type may vary in purpose because they have different intended roles in their respective local healthcare delivery systems, making uniform standards difficult to establish. In light of this, AMR measures that apply to all types of senior living facilities need to be distinguished from the elements that should be adapted to circumstances in each facility and region.

Details

Generating evidence on AMR measures in senior living facilities

- In healthcare institutions, after the effectiveness of control measures for AMR and infectious diseases has been verified, those findings are reflected in hospital performance evaluations. However, sufficient evidence on which measures are effective in preventing the emergence and spread of AMR pathogens in senior living facilities has yet to be accumulated. Identifying best practices for IPC in senior living facilities will require conducting surveys and research that reflect their unique characteristics as living environments.
- However, senior living facilities often operate with limited staffing, and participation in research and surveys can impose additional burdens on personnel. In addition, obtaining consent directly from residents can be difficult, so it is often necessary to seek consent from their families instead. While keeping the burden for facilities in mind, we must examine methods of continuously monitoring and evaluating the effects of AMR control, including through the use of existing data and surveys.

Defining how duties are divided based on local healthcare delivery systems

- The scope of AMR control at senior living facilities not only varies based on internal staffing, but also differs according to local healthcare delivery systems or arrangements for collaboration with healthcare institutions. For example, physicians in communities with extensive in-home care services are able to keep in regular contact with residents through home visits and similar means. In some cases, this makes it possible to conduct testing and even administer antimicrobials on-site at facilities. In regions where it is easier to arrange medical visits or hospitalizations for residents (such as those where healthcare institutions readily accept emergency transfers), facilities are responsible for noticing changes in residents' conditions and determining when medical examinations are necessary.
- Senior living facilities and healthcare institutions therefore have roles that vary according to region. After taking their unique characteristics into account, the next step is to establish shared principles for AMR control that apply to all senior living facilities, while identifying the areas where measures need to be adapted to the circumstances of each facility and region.

2-2: Diagnostic Testing in Senior Living Facilities

Key points

Senior living facilities are not conducting adequate testing to identify causative bacteria or assess antimicrobial susceptibility. This lack of testing prevents facilities from knowing the prevalence of AMR pathogens on-site and hinders efforts to select or adjust antimicrobials according to test results. However, these issues cannot be resolved simply by conducting more testing. Testing must be performed in appropriate situations while bearing in mind the purpose of each test and the conditions of residents. It will be necessary to develop basic principles that reflect the characteristics of each facility that specify when, for what purpose, and to what extent testing should be performed. Then, we must consider mechanisms that support appropriate testing that cover factors like cost sharing, staffing, testing systems, and collaboration with healthcare institutions.

Details

Defining basic principles for testing in senior living facilities

- The Japan Association of Geriatric Health Services Facilities conducted a survey that found testing was not performed in 93.5% of cases of antimicrobial use.[2] This finding suggests that antimicrobials are prescribed empirically and without testing in response to symptoms like fever.
- Identifying causative bacteria and identifying which antimicrobials treat them effectively are vital practices for the appropriate prescription of antimicrobials. In addition to proper specimen collection, these practices require culture testing and antimicrobial susceptibility testing. However, many senior living facilities lack on-site capacity for microbiological testing, so they outsource testing to external institutions. The need to outsource complicates efforts to identify causative bacteria and which antimicrobials are effective in a timely manner. Results can take several days, and in facilities without a full-time physician, it is not easy to revise the treatment plan or antimicrobial prescription promptly once the results arrive.
- Conducting more tests does not automatically guarantee antimicrobial stewardship. For example, sputum cultures are easily contaminated by oral flora, so the organisms that are detected are not always causative pathogens. Testing may also detect bacteria from pressure injuries and other wound sites, even when there is not an infection. Furthermore, tests in older adults frequently detect bacteria in urine even in the absence of symptoms, particularly among residents who are long-term catheter users. As these examples show, testing without careful judgment about its purpose and the context in which it is carried out may lead to the misinterpretation of causative bacteria, and potentially lead to the administration of unnecessary antimicrobial treatment.

Restructuring testing fees in manner that reflects the characteristics of senior living facilities

- Among services provided in long-term health care facilities, service fees in the long-term care reimbursement system provide coverage for routine testing, medication administration, and procedures, but there is limited medical service fee eligibility for medical procedures. Except when billed under the fee for in-facility care for specific diseases in the long-term care service fee schedule, facilities must cover the costs of culture tests and antimicrobial susceptibility tests when performed prior to infectious disease treatment. In other words, even when testing capacity is present, financial constraints may limit implementation.
- In special nursing homes for the elderly, tests and medicines administered as part of infectious disease treatments for symptoms like fever can be billed under the medical service fee schedule. However, tests performed on asymptomatic residents as part of outbreak control are not eligible for health insurance coverage and must be covered by facilities or residents. Such tests include screening tests used to determine carrier status for AMR pathogens.
- As discussed above, cost-sharing mechanisms for testing vary according to facility type. After defining basic principles for on-site testing at senior living facilities, ensuring appropriate AMR control in senior living facilities will require clarifying and redesigning cost-sharing arrangements for necessary testing, as well as determining how to best provide institutional support while taking differences in facility roles and healthcare delivery systems into account.

2. Japan Association of Geriatric Health Services Facilities. (2017). *Research Project on Appropriate Infectious Disease Response, Including Multidrug-Resistant Bacteria, in Senior Living Facilities: Project Report.* https://www.roken.or.jp/wp/wp-content/uploads/2012/07/H28_kansensyo_report.pdf

Developing human resources and collaboration systems to support diagnostic testing

- The limited number of physicians and nurses hinders senior living facilities from conducting full on-site testing, including collecting samples, evaluating findings, and adjusting treatment plans. Certain facilities are visited by professionals like physicians, nurse practitioners (NPs), and nurses with certification in specific medical procedures who perform testing during their on-duty hours, which are limited. It will be important to establish systems that foster collaboration with external professionals (such as those working at healthcare or testing institutions), that enable necessary tests to be performed in appropriate settings, and that ensure test results are reflected in care.
- While proper specimen collection is crucial for accurate testing, senior living facilities tend to have few personnel who are well-versed in specimen collection. As a result, even when it has been determined that testing will be required, it is not always possible to collect the necessary specimens on-site. With poor-quality specimens, tests may not accurately reflect causative bacteria. This can lead to the administration of antimicrobials that are not medically necessary.
- Interpreting test results can also present challenges. Determining whether a detected bacterium is causing an infection or is simply normal flora requires clinical expertise that takes into account the resident's clinical course and symptoms, not test results alone. Other factors that can also inform this judgment includes the history of past infectious diseases, history of antimicrobial use, and information on previously-detected bacteria. However, senior living facilities have few staff who can make these decisions and they are not always provided with information obtained at healthcare institutions in a timely manner. One option for senior living facilities may be to partner with healthcare institutions for the specialized knowledge needed to interpret test results, using the framework for collaboration between these institutions as a foundation.
- Rapid tests, which are already widely used for influenza and COVID-19, is one potential option to compensate for structural constraints in senior living facilities. Although there are rapid tests and advanced diagnostics, such as genetic testing, for AMR pathogens, issues such as equipment costs, required technical expertise, and staffing requirements have prevented their routine use in senior living facilities. The development and widespread adoption of rapid testing methods that can be readily implemented in senior living facilities are highly anticipated.

2-3: Antimicrobial Therapy in Senior Living Facilities

Key points

When administering antimicrobial therapy in senior living facilities, the nature of these facilities as living environments as well as the limitations on medical treatments that they can provide must be taken into account. While the long-term care service fee schedule covers treatments provided in long-term health care facilities for various conditions like pneumonia, urinary tract infections, and cellulitis, these facilities handle a diverse range of infectious diseases. Furthermore, factors such as access to healthcare institutions, the resident's wishes, and physical strain can complicate medical examinations and hospitalizations, even when treatment at a healthcare institution is necessary. While taking actual conditions in senior living facilities into consideration, we must identify basic principles for antimicrobial therapy and define clear criteria for determining when to treat a resident on-site and when to refer them to a healthcare institution.

Details

Clarifying basic principles for antimicrobial therapy in senior living facilities

- Antimicrobial therapy in senior living facilities is provided while referring to clinical practice guidelines used in healthcare institutions. While many of the guidelines used in healthcare institutions provide standard treatment methods for each specific disease, they do not provide ample coverage of how to proceed with treatment in consideration of residents' daily lives or personal preferences. In addition, because treatments that require injections are difficult to administer in environments without physicians, facilities and physicians are working to maintain flexibility to accommodate individual circumstances and preferences. For example, in cases where a resident wants to avoid injections or in which ongoing medical management will be difficult due to dementia or other such conditions, physicians may opt to prescribe oral medications instead.
- Routine examinations, administration of medications, and procedures provided in long-term health care facilities are covered by facility service fees in the long-term care service schedule, and facilities must cover the costs of antimicrobials within the scope of existing reimbursements. In practice, this leads to certain restrictions on which antimicrobials can be used at these facilities. In fact, due to cost, administration frequency, and burden for residents and staff, some facilities limit the use of intravenous antimicrobials to single types that only need to be administered once daily.

- The long-term care service fee schedule includes a “fee for in-facility care for specific diseases” which provides separate reimbursements for on-site treatments for pneumonia, urinary tract infections, shingles, and cellulitis. As these are not the only diseases that can affect older adults, it is difficult to establish uniform standards for the scope of antimicrobial therapies provided within facilities.
- Depending on the region, long transit times can be a factor when infectious diseases require treatment at a healthcare facility. Additionally, residents may prefer to avoid hospitalization, and transport itself may impose physical burdens. After defining basic principles for antimicrobial therapy in senior living facilities, environments must be developed in which treatments can be provided while taking resident preferences and facility circumstances into account.

2-4: Human Resource Development and Multidisciplinary Collaboration at Senior Living Facilities

Key points

Infectious disease control in senior living facilities depends on a diverse range of professionals each fulfilling their respective roles. In addition to doctors and nurses, these professionals include the long-term care staff who provide care on a daily basis and the administrators who manage facilities. However, different professionals may have different educational backgrounds or expertise in the area of infectious disease, and there are times when providing specialized care entirely on-site is a challenge. The number of staff is also limited. Overcoming these issues will require establishing practical, sustainable systems for facility-wide IPC. In addition to providing opportunities to train staff across all roles in necessary skills, this will require collaborating with local healthcare institutions and other specialists.

Details

Keeping physicians up-to-date with the latest information

- Senior living facilities do not always have physicians on duty, and the number of physicians specializing in infectious diseases or AMR is limited. On top of this, physicians working at these facilities do not have many opportunities to undergo continuous education on infectious diseases or AMR. While in-house training and case review sessions provide physicians at healthcare institutions with opportunities to share knowledge, arranging similar opportunities in senior living facilities is challenging.
- Mechanisms for continuously sharing the latest findings on infectious diseases and AMR with physicians working in senior living facilities must be established. While the fourth edition of Guidelines for Antimicrobial Stewardship presented by the MHLW in 2022 includes sections on outpatient care, inpatient care, dental care, and AMR infections, it does not devote sufficient attention to medical care in senior living facilities. Content that is specific to medical care in senior living facilities should be included in these guidelines and related documents. Another effective option may be to provide portable, concise versions of the guidelines that allow for quick referencing when time is limited during medical consultations.

Developing specialized support for nursing staff

- Duties related to AMR control in healthcare institutions are shared among various professionals who each leverages their respective expertise. They include physicians, pharmacists, nurses, and medical technologists. In senior living facilities, however, the central roles are fulfilled by nursing staff. Despite limited staffing, they handle a wide range of duties, including managing pharmaceuticals, providing emergency first response, and making arrangements with government agencies and healthcare institutions.
- Experience in infectious disease or AMR response varies among nursing staff. While routine duties provide nurses with ample opportunities to build experience with infectious diseases such as influenza or COVID-19, there are some situations in which specialized knowledge is required to make decisions, such as when managing AMR pathogens or selecting antimicrobials. For this reason, some nurses working in senior living facilities who lack experience in IPC at acute care hospitals have reported encountering difficulties when implementing AMR control measures.
- One option for more effective responses may be to divide roles among nursing staff based on their respective backgrounds and expertise. There are examples of nursing staff applying their expertise to support IPC, such as when NPs handle initial responses to fever or perform infectious disease testing. There are also initiatives in which local training seminars are being held so nursing staff from senior living facilities and nurses from healthcare institutions can build face-to-face relationships.

- In some regions, there are new local initiatives to provide senior living facilities with specialized support. These initiatives include the establishment of dedicated consultation desks at local governments, or the dispatch of IPC teams from local healthcare institutions to assess IPC measures and provide advice. In particular, expectations are high for healthcare institutions with expertise in IPC (such as those eligible for level 1 enhanced infection control measures) to support local senior living facilities.
- Even if healthcare institutions have support systems for senior living facilities in place, specialized support is generally not provided until those facilities seek consultation or request help. This means the necessary assistance may not reach them unless they proactively reach out. Senior living facilities may also hesitate to consult relevant organizations, so relationships that make it easier to collaborate should be cultivated.

Securing opportunities for long-term care staff to learn about infectious diseases

- Through the care they provide on a daily basis, the duties of long-term care staff are closely related to IPC in senior living facilities. Many of their routine care activities directly contribute to infectious disease prevention, including oral hygiene and swallowing support, mealtime positioning, avoiding unnecessary urinary catheter use, managing toileting and fluid intake, skin and pressure injury care, and maintaining nutritional status. The cumulative impact of their dedication to these duties—including efforts to promote vaccinations—helps avoid situations in which the use of antimicrobials is required, thus underpinning AMR control in senior living facilities.
- On the other hand, programs for training certified care workers provide limited opportunities for participants to obtain basic knowledge regarding infectious diseases. One potential medium- to long-term option may be to expand content on infectious diseases in the course content or curriculum for certified care workers so the people whose roles uphold care on a daily basis can learn about IPC in a more systematic manner.
- As training programs for long-term care staff are generally centered on standard precautions, these programs have little time to devote to specifically covering AMR. An effective method of addressing this issue when teaching about AMR control is to design lessons that teach participants about AMR pathogens and how AMR control relates to routine care practices that contribute to IPC and antimicrobial stewardship.

Promoting IPC at the organizational level though facility directors, head supervisors, and other administrative staff

- IPC in senior living facilities sometimes requires leadership to make decisions based on a comprehensive view of overall facility operations. For example, there are times when facility decisions can place a psychological burden on residents and their families, such as when rearranging residents' rooms to help contain an outbreak. Such rearrangements also incur costs, so administrators are often responsible for adjusting costs and providing explanations on adjustments to residents and their families.
- The degree to which administrative staff are involved also affects whether IPC measures can be implemented on a facility-wide level. These measures are more easily advanced as facility-wide initiatives in facilities where administrative staff view IPC as a key issue for management and facility operations. In cases where involvement from administrative staff is limited, decision-making falls on facility staff, making IPC standards more reliant on the capabilities and motivation of individual staff members.
- Another duty of administrative staff members is to inform other staff members of information on training opportunities from government agencies, and to create environments that facilitate participation in training. Another one of their key roles is to encourage staff to apply what they learn through that training to procedures and routine care at the facility.

Developing a sustainable training environment that accommodates the characteristics of each job type and facility

- IPC standards vary by facility, with some of them still utilizing measures based on so-called "local rules." Rather than only relying on personal experiences or practices, developing basic principles and procedures to be shared across all types of professions and facilities will be important in minimizing differences among facilities.

- Within this context, mechanisms that can be used to educate any staff member on IPC are currently being developed. In 2026, the Japanese Society for Infection Prevention and Control launched the Certified Infection Preventionist (CIP) program, a new certification that is open to all job types. Existing certifications for infection management were primarily intended for specific professions, such as infectious disease specialists or certified infection control nurses. The CIP program teaches long-term care staff, administrative staff, and government officials about IPC measures in a staged manner that progresses from the basics to specialized information.
- Prefectural governments are also promoting practical training seminars tailored to real-world duties in senior living facilities. For example, these include hands-on training seminars in which active staff members map out routine care procedures and review them from the perspective of IPC. In another initiative, a prefectural government is providing reference materials and action cards online. Facilities can use these materials to hold their own IPC training seminars or exercises for group outbreaks. Another prefecture is using its website to provide videos on IPC measures for specific care scenarios, such as diaper changes or bathing assistance. While referring to existing examples such as these, further efforts should be devoted to developing instructional content and utilizing content delivery methods that are tailored to the characteristics of each profession and facility.
- There are also high expectations for the creation of environments that facilitate ongoing participation in training seminars for staff. For example, some report that it can be easier to encourage staff to attend external training seminars because they allow for business trips, which makes their priority among work duties more easily apparent compared to training provided in-house. However, training allowances are not always available, and securing staff who can substitute for people who are absent due to business trips or training sessions is often difficult. Simply increasing the number of training opportunities alone may lead to disparities among facilities or staff members due to the limited number of people who can attend. Full utilization of training opportunities will thus require providing on-site training with visiting instructors, developing environments in which staff can attend training during working hours, securing substitute staff, and fostering organizational cultures that support these efforts. Active consideration should also be given to mechanisms that integrate continuous learning into routine duties, such as by setting up online systems that provide staff members with access to consultations from relevant agencies and that allow staff members to receive ongoing feedback on actual cases.

2-5: Understanding Current Antimicrobial Usage in Senior Living Facilities

Key points

Promoting AMR measures in senior living facilities will require an understanding of the types of infections occurring within facilities, and which antimicrobials are being used, and in what amounts. These facilities use a combination of both health insurance and Long-Term Care Insurance to provide medical and long-term care services, which can make it difficult to get a full picture of actual antimicrobial usage based solely on existing medical claims data. However, some information on antimicrobial usage can be found in facility medical records. It will be necessary to explore ways of understanding the state of antimicrobial usage in senior living facilities using existing information alongside research, surveys, and related initiatives.

Details

Determining the scope of items recorded in long-term care claims data

- Reimbursements are calculated in the health insurance system on an item-by-item basis for specific items like medical services and medications administered, and details such as medication type, quantity, and duration of administration are recorded in medical claims data. Information is aggregated in the National Database of Health Insurance Claims and Specific Health Checkups of Japan (NDB), which can be used to track antimicrobial usage nationwide.
- However, since the Long-Term Care Insurance system is structured around the comprehensive evaluation of physical assistance and daily living support, tracking antimicrobial use within senior living facilities through the NDB is difficult. While long-term care claims include information on the number of times certain services are provided (such as bathing assistance or rehabilitation), they do not contain details on routine examinations, medication administration, and medical procedures.
    - For example, when full-time physicians provide routine medical care in long-term health care facilities, that care is covered by Long-Term Care Insurance and is included in the insured long-term care facility service fee. Although long-term care claims are filed, details on the specific medical procedures or prescriptions provided are not recorded in those claims.
    - The same applies to long-term care medical facilities. When full-time physicians provide routine medical care in long-term medical care facilities, that care is covered by Long-Term Care Insurance and is included in the long-term care facility service fee. Although long-term care claims are filed, details on the specific medical procedures or prescriptions provided are not recorded.

- Conversely, special nursing homes for the elderly are not categorized as facilities that deliver medical care, and routine medical care provided in such facilities is not covered by their facility service fees. When physicians[3] provide routine medical care in special nursing homes for the elderly, that care is covered by health insurance. Outpatient medical claims, pharmacy claims, and other medical claims are filed, and they include information like medication types, quantities, and duration of administration.[4]

- It must be noted that when a long-term health care facility provides on-site treatment for pneumonia, urinary tract infection, shingles, cellulitis, or the exacerbation of chronic heart failure, such treatments are not covered by service fees included in the long-term care reimbursement system, but they can be billed using the fee for in-facility care for specific diseases. Even in these exceptional cases, the only items included in long-term care claims data are name of the illness or injury, recuperation start date, number of reimbursement points, and treatment duration in days. Specific antimicrobial names or quantities used are not recorded.

Accounting for the coordination of health and Long-Term Care Insurance benefits when assessing current antimicrobial usage

- Another item that requires attention is the coordination of benefits between health and Long-Term Care Insurance. The Health Insurance Act and related regulations state that when an illness or injury is eligible for benefits from both Long-Term Care Insurance and health insurance, Long-Term Care Insurance takes precedence and health insurance benefits are not provided. While the optimal structure for coverage will require ongoing review, benefit coordination is a practical mechanism for avoiding duplicate benefits between health insurance and long-term care insurance.
- Conversely, this means that when antimicrobials are used in senior living facilities as part of the medical services covered by Long-Term Care Insurance, information on the antimicrobials used is not recorded in medical claims. With growing demand for data- and evidence-based policy-making, expectations are high for initiatives to capture actual antimicrobial usage in senior living facilities that take into full account the characteristics of each system and facility, as well as information available from long-term care claims and medical claims data.

Making effective use of information stored in medical examination records that include the fee for in-facility care for specific diseases

- Long-term health care facilities can bill for the fee for in-facility care for specific diseases when providing on-site treatment for any of the following five conditions: pneumonia, urinary tract infection, shingles, cellulitis, and exacerbation of chronic heart failure. To be eligible, they must enter a number of details into the medical record, such as the name of the condition diagnosed, date of diagnosis, medications or injections administered, and tests or procedures performed. Through this process, long-term health care facilities have accumulated a certain amount of detailed information on antimicrobial usage. Further utilization of this information is highly anticipated.
- However, facilities manage medical records on-site, making it difficult to determine antimicrobial usage patterns across facilities. One option for ascertaining usage status across facilities may be to analyze this data together with medical claims data or other existing sources of information.
- Eligibility requirements for level II of the fee for in-facility care for specific diseases already include precautions for AMR control. These requirements include taking precautions toward AMR pathogens when using antimicrobials, referring to guidelines and other resources, and ensuring that physicians have completed training on IPC, including for AMR pathogens.

3. Special nursing homes for the elderly are not obligated to have full-time physicians on staff. The physicians serving at such facilities are referred to as "staff physicians" who hold part-time or contracted positions. Their primary responsibilities are targeted toward providing residents with routine health management and medical guidance under the Long-Term Care Insurance system.
4. However, staff physicians are not eligible for initial consultation, follow-up consultation, or in-home care fees.

2-6: Data Infrastructure and Surveillance for Senior Living Facilities

Key points

In addition to medical claims data and records, the information systems and surveillance mechanisms currently being developed in this sector may also be useful in grasping current AMR control measures in senior living facilities. However, existing public information systems do not fully capture routine antimicrobial use in senior living facilities. Additionally, since the primary focus of current AMR surveillance systems is healthcare institutions, continuously tracking trends in bacterial species and AMR within senior living facilities is difficult. There is a need to identify how to best utilize the information infrastructure to support AMR surveillance in senior living facilities, including the options of expanding existing mechanisms to cover these facilities or to develop separate, tailored mechanisms. At the same time, mechanisms to support information sharing between senior living facilities and healthcare institutions must be examined so the former can access information obtained at healthcare institutions, such as residents' test results and antimicrobial use histories.

Details

Grasping the state of antimicrobial usage using the Long-term care Information system For Evidence (LIFE)

- A new system called Long-term Care Information System for Evidence (LIFE) that aims to increase long-term care service quality has been under development in recent years, and the initiative to gather data for LIFE has been expanded to reach facilities such as long-term health care facilities and special nursing homes for the elderly. Since the purpose of this system is to evaluate the quality of long-term care services for chronic conditions, data that is submitted is primarily centered on care-related items such as Activities of Daily Living (ADL), cognitive function, pressure injuries, elimination, and nutritional status. In addition, all facilities are not obligated to submit data to LIFE, but doing so is an eligibility requirement for certain long-term care fees like the additional fee for scientific long-term care system promotion.
- Although LIFE has a field for entering information on pharmaceuticals, its main intended purpose is to track continuous medication use and address polypharmacy. Furthermore, data is submitted approximately once every three months for the evaluation of chronic care service quality. From the perspective of stewardship, however, antimicrobials are often prescribed for short periods ranging from a few days to about ten days. Due to the frequency of LIFE data submissions, it would be difficult to continuously monitor short-term trends in antimicrobial usage with this system.

Building a surveillance system adapted to senior living facilities

- Antimicrobial use in healthcare institutions is tracked using the NDB, while the detection rates for AMR bacteria are monitored using the Japan Nosocomial Infections Surveillance (JANIS) system. There is also a collaborative platform for IPC called Japan Surveillance for Infection Prevention and Healthcare Epidemiology (J-SIPHE), which is used to share and compare surveillance data across regions. To improve surveillance in healthcare institutions, the scope of J-SIPHE has been expanded beyond large hospitals to include clinics.
- JANIS and J-SIPHE are mechanisms designed with the assumption that findings from microbiological testing will be continuously collected and utilized. However, there are few opportunities for regular microbiological testing in senior living facilities. Even when testing is performed in these facilities, the results are usually obtained from external testing facilities or collaborating healthcare institutions on an individual basis, making it difficult for senior living facilities to continuously collect and analyze findings on-site. Potential options to consider include incorporating senior living facilities in existing surveillance systems or establishing a separate mechanism tailored to senior living facilities.
- An initiative aiming to fill gaps in surveillance for senior living facilities has also been advancing. Since 2019, research teams funded by the MHLW's Scientific Research Grants and other such parties have been conducting PPSs on facilities such as long-term care health facilities at a rate of about once every three years. PPSs count how many residents are using antimicrobials at specific points in time and are an effective means of grasping the overall picture of antimicrobial usage in facilities. As PPSs do not require continuous or comprehensive data collection, they are being utilized as an effective option for understanding antimicrobial usage with limited resources.

- However, most PPSs being conducted today rely on manual processes. For example, staff may be asked to report antimicrobial use on designated days by filling out paper questionnaires. Given the burden they can place on staff at busy facilities, participation in PPSs is currently limited.[5] Additionally, PPSs are currently being implemented by research teams with no institutional framework in place for their continuous implementation. Future efforts will require a surveillance mechanism tailored to senior living facilities that makes full use of accumulated findings from past PPSs and that allows for continuous implementation while minimizing facility burden.

Sharing tests results and other findings between senior living facilities and healthcare institutions

- Because the types of tests that can be conducted on-site at senior living facilities are limited, staff do not always fully understand the results of tests or information on treatments that residents received at healthcare institutions. Most AMR testing is conducted at healthcare institutions, and when residents enter a senior living facility after a hospital stay or medical visit, those facilities are not always provided with the test results. This can result in cases where senior living facilities do not receive information about residents with histories of carrying bacteria resistant to specific antimicrobials, or in which past test results are not taken into account when selecting antimicrobials.
- If senior living facilities could access past test results, antimicrobial use histories, and other information from healthcare institutions, they could avoid duplicate tests and prescribe antimicrobials accordingly. Tests performed at senior living facilities are subject to restrictions regarding equipment and personnel who can perform testing. Methods to facilitate the efficient exchange of necessary medical information between these facilities and healthcare institutions must also be developed. This may include mechanisms that give senior living facilities access to electronic health records and other information resources.

2-7: The Administrative Infrastructure Supporting Senior Living Facilities

Key points

AMR control in senior living facilities is an issue that spans multiple legal frameworks including the Medical Care Act, the Long-Term Care Insurance Act, the Health Insurance Act, and the Act on the Prevention of Infectious Diseases and Medical Care for Patients with Infectious Diseases. In addition, senior living facilities vary widely in type, size, and the scope of medical care they can provide, and their governing bodies and support systems differ by region. Given these characteristics, expectations for senior living facilities must be defined in terms of AMR and IPC in both routine and emergency scenarios, as well as identify which parties will support such initiatives. Consideration should also be given as towhich system will be used to cover the costs of ensuring that necessary measures are implemented in a continuous manner, as well as clarify who will bear the financial burden or to what extent. Given this context, ongoing efforts must be made to develop an administrative infrastructure that upholds IPC in senior living facilities in a manner that is tailored to local circumstances.

Details

Building review systems that cut across ministries, agencies, and departments

- Measures for AMR control in senior living facilities span multiple systems. For example, the Medical Care Act covers the handling of facilities that deliver healthcare, as well as their on-site IPC. Measures for local infectious disease control are covered by the Act on the Prevention of Infectious Diseases and Medical Care for Patients with Infectious Diseases. Facility operations are under the jurisdiction of the Long-Term Care Insurance System. This division of jurisdictions means that multiple ministries, agencies, and departments are involved in senior living facilities, including the MHLW and the Ministry of Land, Infrastructure, Transport and Tourism (MLIT). Within the MHLW, these departments include the Health Policy Bureau; the Department of Infectious Disease Control, Health and Living Sanitation Bureau; and the Health and Welfare Bureau for the Elderly. Meanwhile, since policies related to housing for older adults fall under the jurisdiction of MLIT, MLIT is involved in serviced housing for the elderly.

5. Japan Association of Geriatric Health Services Facilities. (2023). *Fact-Finding Survey on the Current Status of Infectious Disease Treatment, Antimicrobial Usage, and Infection Control Measures in Senior Living Facilities: Point Prevalence Survey.* https://amr.jihs.go.jp/pdf/20230706_report.pdf

- Although senior living facilities are environments for daily living, the healthcare services they provide and their organizational structures vary from facility to facility. Their characteristics and the roles expected of them also vary significantly by region. There is a need to define the extent to which existing measures at healthcare institutions should be implemented for AMR control in senior living facilities in a manner that cuts across systems, and identify specific measures to implement. When doing so, the unique nature of senior living facilities as environments for daily living must also be kept in mind. Collaboration among ministries, agencies, and departments is highly anticipated, as is the creation of systems that enable the continuous review of the division of roles and the direction of AMR and IPC in senior living facilities.

Defining the division of duties across prefectural and local governments and clarifying sources of consultations

- At local governments, different departments are responsible for infectious disease response, the operation and supervision of senior living facilities, and the administration of Long-Term Care Insurance. Specifically, in municipalities with public health centers,[6] AMR control and infectious disease response are handled directly by the local government. In municipalities without public health centers, these measures are the responsibility of the prefectural public health center. For senior living facilities, approval for establishment and supervision are divided between prefectural and local governments based on facility type and scale.[7, 8] However, as the insurers in the Long-Term Care Insurance system, local governments are responsible for operations and management. The complex division of administrative roles makes it difficult for facilities to seek advice for problems they encounter during emergencies. Clarifying the points of contact where senior living facilities can seek advice on AMR control and infectious disease response as well as developing an environment that facilitates access to necessary support are both urgent priorities.

Developing systems for mutual support in regions

- When there is an infectious disease outbreak in a senior living facility, it can be difficult for the facility to manage the outbreak on its own. An important step in addressing this will be to establish mutual support systems in advance during non-emergency periods, and to ensure facilities can access the assistance they need from the government, local healthcare institutions, and other senior living facilities.
- Before these forms of support can function effectively, procedures for coordination within local governments and for the deployment of support staff must be defined. Duties are divided in some local governments, where infectious disease response is the responsibility of the health department while overseeing facilities and securing human resources are the responsibility of the welfare department. In such cases, departments must collaborate and coordinate to provide comprehensive support to senior living facilities in the event of an infectious disease outbreak. There are also items related to the dispatch of support staff that must be arranged in advance, during periods of non-emergency. These include employment status or how salaries and allowances will be handled. In some municipalities, the prefectural government and healthcare institutions have concluded agreements in which transportation costs and insurance fees associated with staff dispatch will be covered using public funds. While referring to existing examples such as these, it will be important to develop mechanisms that enable the smooth dispatch and onboarding of personnel during emergencies, that include provisions for reimbursements for support services, and that provide compensation for dispatched personnel.

6. Cities designated by government ordinance, core cities, cities operating public health centers by government ordinance, and special wards
7. Facilities with a capacity of 30 or more residents are classified as “Wide-Area Special Nursing Homes for the Elderly,” while those with a capacity of 29 or fewer residents are classified as “Community-Based Long-Term Care Welfare Facility for the Elderly.”
8. Specifically, long-term care health facilities and Wide-Area Special Nursing Homes for the Elderly are supervised by prefectural governments, while Community-Based Long-Term Care Welfare Facility for the Elderly are supervised by municipal governments.

Identifying how to best structure financial resources to support IPC

- If senior living facilities are required to implement certain IPC measures, it will also be necessary to determine which system will cover the costs. Efforts to further develop systems for supporting infectious disease control through the long-term care service fee schedule are currently advancing. For example, a new additional fee for enhanced infection control measures for senior living facilities has been introduced and it has become mandatory for facilities to formulate business continuity plans (BCPs) and conduct related training and exercises. There is still room for discussion on how to best distribute the burden of costs associated with items like routine testing, PPE, and the dispatch of emergency support personnel. In fact, the MHLW's guidelines for AMR control in senior living facilities recommend disposable PPE as a general rule, while also outlining disinfection methods for reuse. We must carefully consider how to strike a balance between desirable standards for IPC with measures that senior living facilities can implement continuously, and build societal consensus on these items.
- Instead of relying solely on Long-Term Care Insurance to cover IPC, it will be important to include other systems like health insurance and public funds and to clarify the scope of coverage for each system. After defining IPC standards for facilities, we must also define the roles of health insurance, long-term care insurance, and other public funds and examine how to best arrange funding resources to ensure sustainability.

3: Perspectives for Advancing AMR Measures in Senior Living Facilities

During our series of interviews on AMR control in senior living facilities, in addition to the seven points identified in this discussion paper, interviewees emphasized the importance of grounding efforts in the daily lives, wishes, and dignity of residents. During future efforts to further consider the seven discussion points, indicate specific policy options, and implement policies, in addition to paying sufficient attention to feasibility and sustainability for these systems and mechanisms, close attention must also be given to safety and peace of mind for all residents. In the final chapter of this discussion paper, we will outline perspectives that all types of facilities, professions, and roles should share when promoting AMR control in senior living facilities, regardless of their respective positions.

3-1: Finding a Balance Between Communal Living Environments and Personal Living Spaces

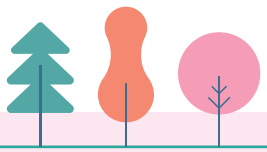
- While senior living facilities are communal environments where infectious diseases can spread easily, they are also homes where residents live their daily lives. This means that it is necessary to consider both the risk-based approach, which prioritizes preventing the spread of infections, and the rights-based approach, which emphasizes residents' rights and dignity. It is important to maintain quality of life (QOL) for residents while curbing the spread of disease.
- Since many residents in senior living facilities live with cognitive decline, IPC measures need to be tailored to each person. Some residents have difficulty keeping a mask on or practicing hand hygiene. In some cases, zoning or separating residents with infections from communal spaces may be necessary because of the building's layout or because some residents move about the facility independently. Decisions on restrictions on activities or use of communal areas should be made with ample consideration of the potential impact on behavioral and psychological symptoms of dementia (BPSD) or delirium.
- However, neglecting necessary IPC measures to over-emphasize unrestricted daily living carries the risk of allowing infections to spread in facilities. The spread of infections can result in the suspension of rehabilitation or daily activities, which can increase the likelihood of restricted Activities of Daily Living (ADL) for residents or impact facility operations. Appropriate IPC protects the lives of residents while contributing to a safe and reliable working environment for staff. One possibility may be to prioritize vaccinations and other options to reduce the risk of infection without restricting behavior, while providing adequate explanations to residents and their families.

3-2: Respecting Residents' Preferences

- When providing treatment or care for someone with an infection, in addition to making medically sound decisions, it is also important to ensure plans reflect how the affected person wishes to spend their time. In senior living facilities, many decisions need to take the resident's wishes into account. Such decisions include when to administer antimicrobials and when to provide a referral to a healthcare institution for treatment or hospitalization.
- In the *Japanese Respiratory Society (JRS) Guideline for the Management of Pneumonia in Adults 2024*, the JRS states that treatment plans for a condition which occurs frequently among residents of senior living facilities called Nursing- and Healthcare-Associated Pneumonia (NHCAP) should be developed based on the condition and daily life of the affected person. When treating or caring for someone with recurrent aspiration pneumonia, advanced disease, or advanced frailty, the wishes and QOL of the affected person should be given due consideration. On antimicrobials, the guidelines describe not only treatment with broad-spectrum agents, but also stress the importance of prioritizing symptom relief, taking into account the burden that treatment places on the person.
- To arrive at decisions on these items, it is important to check in with the affected person regularly about their wishes, and to share their feelings with their families as well as with healthcare and long-term care professionals. Using processes like Advance Care Planning (ACP), the affected person's preferences and values must be shared with others in advance and preparations must be made to ensure their wishes guide treatment and care, even if they become unable to express those wishes.

3-3: Building Consensus Through Meaningful Involvement

- Rather than having facility staff make unilateral decisions regarding IPC measures, it is important for residents to have meaningful involvement in the decision-making process, and this concept must be shared throughout each facility. Even when a resident has experienced cognitive decline, the act of explaining the situation to them and understanding their preferences is in itself significant, and helps preserve their dignity.



- In addition to physicians and nurses, long-term care staff and other staff members who interact with residents daily must understand IPC options and the need for IPC measures, and be able to explain those options and measures to residents in a manner that is easy to understand.

3-4: Preventing Stigma and Discrimination

- The experiences from the COVID-19 pandemic have shown that infectious diseases can easily give rise to stigma and discrimination toward individuals. A similar phenomenon can also occur with AMR infections, where the discovery that a person carries or is infected with an AMR pathogen can impact their daily life or decisions regarding their admission to facilities. In fact, there have been examples of people being denied admission because screening tests conducted at the time of admission found that they were carriers of AMR pathogens. Some facilities must exercise caution about who is admitted to prevent the spread of infection to other residents, to avoid overburdening staff, and to protect their reputation. In particular, difficulty finding an accepting facility can have a major impact on a person's future QOL if they live in a depopulated region, where long-term care options may be limited.
- To prevent prejudice and discrimination, it will be important for accurate knowledge on AMR pathogens to be shared throughout society. Steps must be taken to promote a better understanding of AMR pathogens. For example, people should understand that being a carrier is different from having an active infection and that carrying an AMR pathogen is not the fault of the affected individual.
- Instead of individual carrier status, there may also be methods of determining the presence of AMR pathogens in a facility or the community as a whole. For example, the spread of AMR pathogens can be detected without identifying specific individuals by conducting facility wastewater analysis to check for AMR genes.



Conclusion

Amidst global projections showing that AMR-related deaths among older adults may increase by approximately 146% worldwide by 2050, population aging and AMR control are shared challenges for the global community. In May 2026, the World Health Organization (WHO) published its first update in eleven years to the Global Action Plan on AMR, setting a new direction that emphasizes advancing IPC across all healthcare and long-term care settings, from healthcare institutions to senior living facilities. The Global Action Plan places clear emphasis on a preventive approach. Japan is set to update its National Action Plan on AMR in accordance with the Global Action Plan in 2028, and discussions on its revision are already underway.

A key action for advancing AMR control in senior living facilities effectively will be developing an integrated strategy encompassing not only insured long-term care facilities and senior living facilities, but a wide range of senior living environments, such as fee-based homes for the elderly, serviced housing for the elderly, and group homes. In addition, in the midst of population decline and increasing globalization, there is also likely to be growing diversity in the backgrounds and values of older adults as well as in the composition of the healthcare workforce. As such, it will become increasingly important to reflect the experiences and daily lives of all patients, people with lived experience of health concerns, and citizens when discussing the direction of AMR policies, and for countermeasures to be developed and implemented together with these parties.

In this discussion paper, we were unable to directly reflect the perspectives of residents, their families, or the professionals who provide long-term care on a daily basis. In future discussions regarding domestic AMR control, the revision of the NAP, and AMR control in senior living facilities in particular, opinions should be gathered using methods beyond interviews, including surveys and observations. Concrete deliberations should then take place through a collaborative process involving patients, people with lived experience of health concerns, citizens, and facility staff.

Leveraging Japan's experience as the world's first super-aged society, expectations are high for Japan to continue developing AMR control initiatives that uphold safe and secure living for older adults, that can serve as points of reference in global discussions, particularly for countries in the Asia-Pacific that are now entering a phase of rapid population aging.

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Interview participants

(Titles omitted, in Japanese syllabary order. Please note that affiliations are current as of the time of the interviews.)

Hiroki Ohge
(Professor, Department of Infectious Diseases, Hiroshima University Hospital)

Hanako Kurai
(Director, Department of Infectious Diseases, Shizuoka Cancer Center)

Mikio Goto
(Director, Infectious Disease Control Center, Department of Health and Welfare, Shizuoka Prefecture; Medical Director, Fuji Health and Welfare Center; Director, Fuji Public Health Center)

Hiromi Konno
(Head Nurse, Kojuen Long-Term Care Facility, Kashima Kose Hospital, JA Fukushima Health and Welfare Federation)

Kumiko Suzuki
(Specially-Appointed Researcher, AMR Clinical Reference Center, National Center for Global Health and Medicine, Japan Institute for Health Security)

Keisuke Suzuki
(Director, Pharmacy Department, Senzoku Geriatric Health Services Facility, Taito City Hospital; Representative, Pharmacy Division, Japan Association for Development of Community Medicine)

Yoshihiro Takayama
(Deputy Director, Department of Infectious Diseases and Community Care, Okinawa Chubu Hospital)

Masaki Tanabe
(Professor, Department of Infection Control and Infectious Disease Crisis Management, Graduate School of Medicine, Mie University)

Akira Hayashi
(Vice President, Kashima Kosei Hospital, JA Fukushima Health and Welfare Federation; Facility Physician, Kojuen Long-Term Care Facility)

Nobuaki Matsunaga
(Deputy Director, Chief, Division of Clinical Epidemiology, AMR Clinical Reference Centre, National Center for Global Health and Medicine, Japan Institute for Health Security)

Tsugunari Moribayashi
(Clinical Nurse, Yamabiko no Sato, Northwest Ibi Regional Medical Center, Japan Association for Development of Community Medicine)

Authors

Yui Kohno (Manager, Health and Global Policy Institute)
Shotaro Tsukamoto (Senior Associate, Health and Global Policy Institute)
Kai Shigeno (Senior Associate, Health and Global Policy Institute)
Eri Cahill (Associate, Health and Global Policy Institute)
Gail Co (Program Specialist, Health and Global Policy Institute)

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Health and Global Policy Institute (HGPI)
5-11-16, Roppongi, Minato-ku, Tokyo
(The International House of Japan)
106-0032 JAPAN
Tel: +81-3-4241-5020 Fax: +81-3-6859-9291
E-mail: info@hgpi.org