

# The Path to a Sustainable Healthcare System

Three Key Objectives  
for Public Deliberation



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# Introduction

As healthcare becomes more sophisticated and the senior population grows, maintaining and expanding an effective and efficient healthcare system with achieving both sustainability and the appropriate evaluation of healthcare innovation has become a pressing issue shared by many countries with public health insurance systems. Japan is no exception, and now needs a process of public deliberation to build societal consensus on which policy options will best enable a sustainable healthcare system to be handled down to future generations.

Domestic policy discussions on healthcare system sustainability have been progressing at the Council on Economic and Fiscal Policy and similar bodies since 2016. These discussions have mainly been centered on the drug pricing system and have produced a certain degree of success in curbing health spending. However, many have expressed concern that sufficient attention has yet to be devoted to evaluating innovation and ensuring access. It has also been pointed out that controlling the cost of drugs has taken precedence in the aforementioned discussions, while other items have yet to be examined in sufficient depth by society as a whole. These include the structure of benefits and burdens that support the sustainability of Japan's healthcare system, which is based on universal health insurance, or the future direction of said structure.

Other major issues include how to establish structured public deliberation to build societal consensus on healthcare system reform and how the process of arriving at that consensus should look. For many years, the Committee on Health Insurance of the Social Security Council has been discussing a review of the High-Cost Medical Expense Benefit system, focusing on an increase in out-of-pocket payments, but there has not always been sufficient involvement from patients and others with lived experience of health concerns over the course of those discussions. After intensive advocacy by patients and affected parties, it was decided that the Council's direction would be reconsidered in 2024. Moving forward, it will be essential to expand public deliberation and policy discussions so that they are no longer led only by parties like experts involved in healthcare system design or related organizations, but also involve broad stakeholders who participate with trust and conviction. Doing so will enable those discussions to transform into a genuine consensus-building process, in which responsibility is shared throughout society.

Japan, which has long been known for being a "medium welfare and low burden" society, has reached a major turning point. It is becoming more important to build societal consensus on a vision for Japan's future. Maintaining high levels of healthcare and welfare with a low burden has accumulated in the form of a budget deficit that will be a debt for future generations. The combined impacts of the growing sophistication of healthcare and the increasing number of senior citizens make it unrealistic to maintain high-quality healthcare services with low burdens. In

fact, allowing the existing system to remain in place may even prevent the continued provision of basic medical services.

Overcoming these circumstances will require reshaping Japan's healthcare system, which is based on universal health insurance, to accurately reflect reality. It will be important to identify which areas are supported by public health insurance, private health insurance, or self-reliance, and to then foster shared principles and perceptions regarding the boundaries separating healthcare that is supported by society and healthcare that is entrusted to the roles of individuals or the market. It is only when these concepts are broadly shared that it will be possible for a direction for discussions on benefits and burdens to be set and for progress to be made on determining the technical design of individual systems while maintaining consistency. Redesigning the scope of insurance benefits is not only a matter of systemic reform or technical considerations, but is also an endeavor that will reexamine the intended direction of society as a whole. As such, it will be vital to involve a diversity of citizens in addition to patients and other affected parties when building societal consensus.

At the same time, it will also be important to reexamine the shape of the health insurance system as a whole, including the social insurance premiums and out-of-pocket payments that support the healthcare system. To allocate a greater proportion of taxes and other public funds to healthcare and cover growing national healthcare expenditures, understanding must not only be obtained from patients and affected parties, but from all of society. This will also make it more difficult to build consensus. The combination of financial resources that is decided upon will be a direct reflection of society's decision as to who will bear what degree of burden and what kind of healthcare will be kept in place in the future.

A healthcare system is more than just health insurance and a healthcare provision system. It also serves as a foundation that supports people's lives and stability for society through an overlapping combination of healthcare, long-term care, welfare, employment, education, and mutual support in communities. Rather than relegating this burden to future generations, members of the working-age and senior generations must split responsibilities as their respective capacities allow, take action to prevent poverty and social exclusion, and address the exhaustion and strain on middle-class members of the working-age generation, on whom burden tends to concentrate. This will require commitment to collaboration with diverse stakeholders to forge new pathways and to build societal consensus.

In response to these circumstances, Health and Global Policy Institute (HGPI) held a series of discussions with representatives of industry, government, academia, and civil society to envision a sustainable healthcare system for the future as well as the best path forward. These recommendations present society with an approach for passing the healthcare system down to the next generation with peace of mind that is based on consensus among discussion members and encompasses the three perspectives of benefits, burdens, and the societal implementation process.

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Titles omitted; in no particular order

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# Reexamine the scope of insurance benefits in light of the growing sophistication of healthcare technology and the transition to a super-aging society

In Japan, various scientifically-proven pharmaceuticals and medical technologies are covered by public health insurance, and a system is in place that ensures everyone has access to the healthcare they need. Additionally, as a result of rapid technological progress and population aging, expectations and needs for healthcare continue to grow and expand. While it would be ideal to secure equal access to all forms of healthcare for all people, given the limited nature of financial resources, it is unrealistic to maintain benefits while keeping the burden low. If the current state of Japan's healthcare system remains unchanged, even basic medical services may become jeopardized. It is imperative that society conducts a review of the scope of publicly-guaranteed healthcare and determines how to best allocate resources.

However, the process of redesigning the scope of insurance benefits does not only consist of technical work. It will be crucial to design this system to avoid covering low-value healthcare based on evidence so resources can be concentrated on truly necessary healthcare. On the other hand, decisions regarding what forms of healthcare should be provided by public health insurance with support from society and what should be paid for out-of-pocket or left to private health insurance are closely linked to society's shared values. This is precisely why broad public deliberation on how to draw those lines must be held with the public, thereby simultaneously building societal consensus with a wide range of stakeholders, including patients and people living with health concerns.

## 1-1

### Exclude low-value healthcare and similar services from insurance coverage and concentrate resources on necessary healthcare

"Low-value healthcare" refers to medical practices that provide little or no benefit to patient health.<sup>※1</sup> Representative examples of such practices include prescribing antibiotics for the common cold (which is viral) or performing uncovered or unnecessary tests or procedures.<sup>※1</sup> Not only do such practices provide no benefit to patients, they often cause side effects and waste limited medical resources. To address this, movements to visualize low-value

healthcare and review the scope of insurance coverage are gaining momentum around the world. This movement has also spread to Japan, where efforts to define and list low-value healthcare have commenced. While Japan is still at a stage where there is room for further progress in terms of grasping the overall picture and developing systematic evaluations, there are already reports that certain forms of low-value healthcare tend to be provided more

often by certain physicians or in certain regions.<sup>※1</sup> In the future, it will be essential to establish evaluation criteria for the quantitative identification and assessment of low-value healthcare using real-world data (medical claims data, electronic medical records, etc.), as well as to utilize findings to improve these circumstances through continuous research.

Even if the impact on fiscal optimization over the short term may be modest, rapid steps should be taken to remove insurance coverage from and increase out-of-pocket payments for low-value healthcare. In addition to being a rational first step in allocating resources more appropriately, this will set a clear direction for maintaining and expanding a sustainable healthcare system through the message, “Public health insurance supports healthcare that is not of low value.” Focusing on pharmaceuticals, Japan has established a framework in which pharmaceuticals that receive regulatory approval are, in principle, promptly listed in the NHI Drug Price Standard and become eligible for public health insurance coverage. Once pharmaceuticals are listed, they generally remain covered by insurance in near perpetuity. In addition, partially because companies that manufacture and distribute pharmaceuticals are obligated to ensure stable supplies, the current structure of the system allows even pharmaceuticals with little real-world evidence of effectiveness to remain in use as long as coverage is not revoked. While procedures for removal from the NHI Drug Price Standard and rules for measures during transitional phases have been established

in recent years, the scope of eligible items and criteria for removal are still limited, and this system requires further review to address low-value healthcare.

The identification of low-value healthcare is based on medical criteria and usually does not include direct consideration of costs or burdens. Circumstances surrounding “medium-value healthcare,” or healthcare that cannot be clearly labeled as “low-value healthcare” but whose effectiveness is inadequate when measured against its cost and burden, are likely to become clear as evidence accumulates in the future. Using an independent and transparent framework, it will be important to evaluate medium-value healthcare in an objective and neutral manner that takes cost-effectiveness and financial impact into account, and to link findings to the process for building societal consensus. In this regard, a number of noteworthy initiatives have emerged in the international community. These include Choosing Wisely, in which healthcare professionals independently identify and disclose unnecessary medical services, or Pay for Performance (P4P) schemes, in which financial burdens are determined according to results obtained by medical facilities. There are high expectations for various parties in Japan including academic societies, professional associations, insurers, and patient advocacy groups to collaborate and steadily reflect knowledge obtained from similar initiatives when reviewing the scope of insurance benefits.

## 1-2

### Optimize benefits for pharmaceuticals and strike a balance between innovation and sustainability

As a result of progress in medical technology, pharmaceuticals with an unprecedented level of sophistication such as genomic and regenerative medicines are now emerging one after another. While such drugs are likely to have high therapeutic effects by providing complete cures or significant improvements to QOL, they are based on the latest research findings and other advances and come with high price tags. Their impact on medical costs and finances is becoming substantial. To address this situation, we require a system that is designed to allow for flexible adjustments in the usage or pricing of these drugs, considering factors like the balance between their cost and effectiveness, or how they relate to limited financial

resources. In Japan, discussions are now advancing on the need to consider usage restrictions or pricing revisions when a drug’s cost does not align with its effectiveness, or when it has a significant impact on public finances.

However, evaluating the balance between cost and effectiveness is no simple task. When comparing “one-shot” treatments which are likely to be highly effective with only a single administration and treatments that must be administered continuously over long periods, various factors must be comprehensively considered in addition to cost. These include the duration of their effects, how

they impact medical and long-term care expenses due to reduced rehospitalization or care needs, and their impact on employment or physical and mental burdens for patients, their families, and others close to them. Efforts are now underway to develop a framework for multifaceted, comparative evaluations of the most desirable options for the public healthcare system as a whole, and expectations are high for further progress in this area in the future.

Japan has established a system in which pharmaceuticals are generally listed in the NHI Drug Price Standard soon after regulatory approval, at which point they are granted public health insurance coverage. In discussions on revisions of the Health Insurance Act and other laws, the principle that insurance will provide 70% coverage (leaving 30% to be covered out-of-pocket) has been reaffirmed multiple times in supplementary provisions or resolutions. This has played a key role in protecting access to necessary healthcare. Yet, other countries have systems in which insurance coverage varies according to factors like medical importance or disease. While referring to examples from overseas, in the future, Japan should introduce a framework for insurance coverage that allows for the flexible adjustment of prices, coverage rates, and coverage periods based on patient outcome or safety data.

A comprehensive approach that addresses multiple aspects like price, quantity (volume used), and time (coverage period), in a combined manner will be important for maintaining a sustainable healthcare system. In Japan, efforts are advancing to enable the flexible use of certain high-cost pharmaceuticals within the

framework of public health insurance by narrowing down usage methods and patient eligibility through the establishment of facility standards or optimal usage guidelines, or through the use of the Mixed Medical Services Program (for Advanced Medical Care and Patient-Proposed Healthcare Services). However, the overall design of this system is still in a transitional phase, and principles and frameworks among systems must be made more consistent in areas such as the general prohibition of mixed medical services, the concept of universal health insurance, and the division of roles among public health insurance, private health insurance, and self-reliance. Furthermore, Social Determinants of Health (SDH) such as living environments and working conditions can have an extreme impact on certain diseases. Comprehensive and considerate systems must be designed for fields where variance in the medium- to long-term economic effects of medical treatments is likely to emerge.

In addition, a super-aging society requires society-wide discussions on the nature of healthcare for senior citizens. For example, despite the fact that Sweden has higher rates for value-added tax (or, consumption tax) and social security than Japan and has secured ample public funds for healthcare, Sweden is holding national discussions on guidelines for senior healthcare and is working to clarify the priority of healthcare. Similar steps should be taken in Japan. It will be important to first optimize the burden by securing revenue (including through taxes and social security premiums) or streamlining systems, and if financial leeway is still insufficient, to then examine the priority of benefits based on societal consensus.

## Distribute burden in a more equitable manner in anticipation of longer healthy life expectancy and population decline

Based on a system of social insurance that is mainly financed by insurance premiums and out-of-pocket payments, the social security system in Japan has contributed to the creation of a high-quality health insurance system. However, in FY2023, national health expenditures reached a new record high of 48.0915 trillion yen (or 8.1% of GDP),<sup>※2</sup> and due to the simultaneous issues of birthrate decline, population aging, and long-term economic stagnation, young people and members of the working-age generation are experiencing an even stronger sense of burden. On the other hand, people age 65 years and older make up 13.4% of the total workforce, and this proportion is steadily rising.<sup>※3</sup> It has also been reported that 66% of men and 53% of women wish to remain in the workforce after retirement age.<sup>※4</sup> Given these changes in society, rather than relying only on age, burden must be redesigned to a tiered structure while taking personal assets or health (or volume of healthcare use) into account.

### 2-1

#### Redefine “senior citizen” in relative terms that reflect the increase in healthy life expectancy

Recent studies suggest that physical function may be improving among senior citizens age 65 years and older.<sup>※4</sup> The “Guideline of Measures for Ageing Society” presented by the Government in 2018 states, “The general trend of determining 65 years old and over as ‘Older People’ by their age is no longer realistic.” In addition, the Japan Federation of Gerontological Societies and the Japan Geriatrics Society has recommended revising the definition of “senior citizen” or “elderly” to “75 years and older” twice, in 2017 and 2024.

Since the establishment of the Medical Care System for the Advanced Elderly in 2008, Japan’s systems have been designed with people categorized as “early-stage” elderly at ages 65 to 74 years and “advanced” elderly at ages 75 years and older. In principle, in Japan, out-of-pocket payment rates and other such rates are determined by age, but frameworks in which these rates are mainly determined by age are extremely rare among major OECD countries. In other words, this arrangement is unique to Japan. In the future,

while reviewing the long-established age 65 standard for determining who is a senior citizen, it will be necessary to set out-of-pocket payment rates and other such fees to increase in a graduated manner based on factors like personal health, employment status, and social participation. It may be feasible to consider what could be called a “sliding scale for health and longevity,” in which burden would be adaptable and in which “senior citizen” status or burden brackets would be redefined or adjusted according to changes in health status (or other factors) for the entire senior population. In addition, in 2025, the Expert Committee on the High-Cost Medical Expense Benefit System pointed out that even if out-of-pocket payment rates are revised for all senior citizens (or other specific age groups), the impact on health would be limited.<sup>※5</sup> However, when changing systems, it is important to be willing to obtain acceptance from society through gradual and thorough explanations while paying adequate attention to different financial systems among insurers as well as to diversity among senior households in terms of income and assets.

## 2-2

### Achieve a more equitable distribution of burden based on the ability-to-pay principle while taking income and assets into account

In principle, burdens in Japan's social security system have been determined according to income. This system allows the burden of insurance premiums to tend to concentrate on those of working age. Conversely, household financial assets are heavily skewed toward senior citizens, with people age 55 years and older holding over 70% of total household financial assets and people age 70 and over holding almost 40%.<sup>※6</sup> It has also been found that net financial assets are mostly held by a very small portion of the population, and that generational disparities in assets are growing. Furthermore, approx. 40% of households headed by senior citizens age 65 years and older are exempt from residence tax (including those whose taxation status is unknown),<sup>※7</sup> many of whom are also eligible for reductions of or exemptions from insurance premiums. Because residence tax burden is mainly determined by income, this system does not fully reflect the status of other assets. As the gap between actual burdens and ability to pay is becoming fixed, it will be crucial to rebuild this framework to create a highly equitable and flexible system for sharing the burden based on the ability-to-pay principle.

In essence, the ability-to-pay principle is a fundamental principle that fosters a sense of conviction and fairness throughout society.

However, as the distribution of assets becomes more skewed, it is becoming increasingly clear that there are limits to structuring burden based solely on income. Moving forward, we must review how burden is structured so it combines both income and assets as well as transition to an arrangement that elevates fairness among and within age groups, such as by redesigning systems for insurance premium reductions or exemptions.

Overseas, there are examples of personal identification numbers equivalent to Japan's My Number system being used to comprehensively grasp individual income and assets to determine benefits and burdens, to quickly and fairly distribute cash benefits, or to calculate medical expense deductions. As efforts to consider tax exemptions with benefits in Japan continue to advance, designing a more accurate and fair system is becoming increasingly important. To initiate full-scale efforts to restructure burdens for sustainability based on both income and assets, it will be vital for Japan to position the domestic personal identification system, the My Number system, as a foundation for society, as well as to make it mandatory for people to acquire My Number cards and link their financial account information to that system.

## 2-3

### Restructure burden around the premise that Japan has entered an era of population decline

After peaking in 2008, Japan's total population is projected to fall to under 100 million people by 2050.<sup>※3</sup> Over that same period, the working-age population (which includes people from 15 to 64 years of age) is also projected to decline to 55.4 million people, while the proportion of the population that is age 65 years and older will increase to 37.1%.<sup>※3</sup> These changes in Japan's demographic profile

mean that there will be fewer people who provide the financial resources that support the healthcare system and more people who that system supports. This will have major effects on the sustainability of the healthcare system and how its financial resources are arranged.

When Japan's national health expenditures reached a new record high of 48.0915 trillion yen (or 8.1% of GDP) in FY2023, 50.2% was covered by insurance premiums, 37.5% by public funds, and 11.8% by out-of-pocket payments and other sources.<sup>※2</sup> Despite the fact that the domestic social security system is based on social insurance, as this distribution makes clear, it is already highly dependent on public funds. Also, public finances provide a significant portion of funding for National Health Insurance (NHI) and the Medical Insurance System for the Advanced Elderly, both of which have high enrollment rates among senior citizens, while employee insurers are strained by providing simultaneous support for the mechanism for fairly adjusting insurance burdens for employees ages 65 to 74 and the implementation of Medical Care Assistance for the Elderly Aged 75 and Over. National healthcare expenditures are projected to increase to approx. 80 trillion yen (or approx. 10% of GDP) in 2040, when the senior population will start to peak,<sup>※8</sup> so it is predicted that public funds will comprise an even larger share of total healthcare financing in the future.

Conversely, as Japan's population declines, it will be extremely difficult to provide long-term, stable support for growing healthcare expenses with only insurance premiums from people of working-age and out-of-pocket payments from certain groups. Although public expenditures are partially covered by government bonds, issuing bonds passes the burden to future generations, posing an even greater risk to a society with a declining population. In light of these circumstances, it will be vital to review the overall structure of taxes, insurance premiums, and out-of-pocket payments and their respective ratios and to transition to an arrangement of financial resources that is sustainable and equitable within and among age groups.

To maintain stable healthcare finances and to avoid leaving an excessive burden for future generations, consumption tax (also known as value-added tax) will play a more important role than ever before. Taking a bird's-eye view of the tax system in Japan, income tax applies to individual income and is therefore easily influenced by trends in the economy, while introducing significant corporate income tax hikes makes it difficult to promote an active business sector in the midst of intensifying global competition. On the other hand, as consumption tax is a form of taxation in which the burden is broadly distributed regardless of employment status or age group, it provides an easy method of securing relatively stable tax revenue. It is also said to have little impact on economic activity. Finally,

consumption tax applies to temporary residents in addition to permanent residents of Japan, is a framework that is related to all healthcare system beneficiaries, and provides an easy method of distributing the burden fairly within and among age groups, even if there are changes in the population or socioeconomic demographics. This means consumption tax can be positioned as a social solidarity tax.

Despite these factors, Japan's standard consumption tax rate is only 10% (or 8% for daily necessities). Among OECD members, average value-added (consumption) tax rates range from 19% to 23%,<sup>※9</sup> so Japan's rate is relatively low compared to other major economies. There is room to increase the consumption tax rate to a certain degree to create a stable source of revenue for supporting the healthcare system without placing an excessive burden on future generations. In addition, the Consumption Tax Act currently limits the use of increased revenues from consumption tax hikes to four social security programs (for pensions, healthcare, long-term care, and child-rearing), and local consumption tax revenues are broadly allocated to the health and welfare sectors. In the future, after presenting this revenue in more easy-to-understand terms and clarifying the intent to allocate it to social security in a stable manner, calm discussions should be held on transitioning to a tiered revenue structure with a gradual increase in the consumption tax rate in view.

In addition to reinforcing ability-to-pay arrangements, another option for consideration as a tier in the financial resource structure is the introduction of flat-rate burdens based on the benefit-received principle. For example, one option would be to combine these two principles and charge a basic service fee (called a "Universal Health Coverage fee" or something similar) of a few hundred yen that everyone who visits a healthcare institution for medical services would pay regardless of income or age. This would be paid in addition to a fee determined according to their income based on the ability-to-pay principle. A framework that takes into account the needs of low-income individuals and the potential for such fees to discourage the use of medical services, introduces precautions to ensure that these fees are not designed or set in a manner that excessively discourages the use of medical services, and that distributes the cost burden of using medical resources throughout society will contribute to the maintenance and expansion of a sustainable healthcare system.

## Leave the next generation a healthcare system that is based on scientific evidence and the formation of societal consensus

Over six decades have passed since Japan established its universal health insurance system, and demographics and values in society have undergone major changes. Recent years have seen progress in the disclosure of information, and there is now an environment in which patients, others with lived experience of health concerns, and citizens can readily access policy information through meetings that are streamed or minutes that are published online. At the same time, factors such as progress in medical technology have led to involvement from a more diverse range of stakeholders in the healthcare system, and the interests of those stakeholders have become more complex. This growing complexity has also made the act of building consensus more difficult. Given these circumstances, scientific evidence-based frameworks for decision-making that are backed by trust and transparency are more important than ever before in leaving a sustainable healthcare system for the next generation.

### 3-1

#### Strengthen the social infrastructure for generating evidence through collaboration among parties like insurers or examination and payment agencies

The starting point for designing a sustainable healthcare system and forming societal consensus is Evidence Based Policy Making (EBPM). This requires an information infrastructure that enables the comprehensive recording and analysis of information related to health and medicine (such as medical claims data or medical examination information held by insurers or examination and payment agencies) on individuals over the life course.

To create that infrastructure, it will first be necessary to strategically extend retention periods for health and medical information. For most information, the designated retention period is currently about five years, but efforts to encourage the long-term utilization of information have recently emerged. For example, the MHLW approved a policy to extend retention periods for vaccination records to five years after death. The potential for such data is also demonstrated by the fact that the Japan Health Insurance

Association voluntarily began storing medical claims, medical examination, and medical interview data for approx. 40 million people for analysis. Rather than relying on the efforts of individual insurers for the maintenance and management of such health data, however, it should originally have been steadily implemented as a social system.

It will also be essential to link information across systems for different groups, such as those for senior citizens categorized as early-stage and those for the advanced elderly. In the existing system, people transition between systems each time they change jobs, retire, or switch insurers at age 75, leading to fragmentation. This makes it difficult to analyze information for individuals throughout the life course. In the future, Reimbursement Services and other bodies that are central in healthcare digital transformation (DX) must develop a collaboration platform that

connects insurers and build a framework that can track health and medical information, insurance enrollment history, and qualification information in an integrated manner.

Standardizing and elevating the quality of health and medical information will also be crucial. Currently, details regarding the costs and content of medical services are gathered from billing data, mainly from medical claims (or, medical service fee reimbursement statements), which are compiled on a monthly basis and managed by each facility. This creates limitations when attempting to analyze the content and progress of each medical service in a precise and timely manner. In addition, differing specifications and code systems used for electronic medical records and medical claims computers among vendors and healthcare institutions hinder analyses that span healthcare institutions. The focus of efforts to popularize electronic medical records should be shifted to popularizing a standardized form of electronic medical records, and an integrated national database that allows analyses to be performed on specific medical services across healthcare institutions should be built. This will make it possible to clarify how effective certain treatments are for specific patient groups using

clinical information gathered on a daily basis. This will be directly connected to the review of insurance benefits and planning for preventive measures and will serve as a foundation for the more effective allocation of limited resources.

A framework for linking this information base to actual policy improvements will also be necessary. Establishing analysis and research capacity within each insurer and systematically collaborating with universities and research institutions will make it possible to continuously generate knowledge that is based on data. Using the National Database of Health Insurance Claims and Specific Health Checkups of Japan (NDB) and the My Number system, the national Government should also identify a feedback loop of data utilization in which knowledge crystallized from health and medical information is used to improve the design of insurance benefits, revise medical service fees, and inform the planning of preventive measures. Having such a cycle function in a manner that is visible to the public will build understanding toward the act of entrusting one's personal data through the My Number system and make the healthcare system more transparent and trustworthy overall.

## 3-2

### Visualize a multi-tracked system and consolidate shared operations for greater efficiency and transparency

While Japan's healthcare system has consistently achieved good results under the framework of universal health insurance coverage, it has a multi-tracked arrangement in which multiple insurers provide coverage in parallel based on job type, employment status, age, and area of residence. This is one result of the healthcare system's history of flexibly responding to diversification in society, particularly for employment practices. However, this has made it that much more difficult for people to obtain an intuitive understanding of the system as a whole, creating an obstacle for citizens to properly understand the relationship between benefits and burdens or to actively participate in policy discussions.

In addition to visualizing healthcare finances, addressing this issue will also require visualizing the structure of the healthcare system as a whole. One condition for holding constructive discussions and building consensus on benefits and burdens will be for each citizen

to understand the positioning of the scheme to which they belong by providing an outline of the roles, financial structures, and member characteristics of insurance schemes including the NHI, society-managed health insurance schemes (for both those that include single companies and those that include multiple companies), the Japan Health Insurance Association, Mutual Aid Associations, and the Medical Care System for the Advanced Elderly.

At the same time, even with a multi-tracked system, shared tasks must be consolidated across insurers wherever possible to elevate efficiency and transparency in order to allocate limited human and financial resources to health services that suit the real-world circumstances of enrollees. In particular, examining and paying insurance benefits is a core function of both insurers and examination and payment agencies, so there is significant room to simultaneously reduce workloads and improve quality by

standardizing and digitalizing these functions. In the current system, medical claims are double-checked. For example, claims might undergo examination from examination and payment agencies followed by review from insurers. To a degree, this has been effective in correcting inappropriate medical claims, but a system in which the same medical claims are reviewed separately by multiple bodies leads to greater administrative workloads and costs.

Steps should be taken in the future to standardize the examination and payment process for insurance benefits nationwide, to refine

the scope of examinations, and to develop more sophisticated examination logic using AI and other digital technologies. There have been reports of evaluation bodies performing more evaluations while maintaining personnel numbers by using AI to sort medical claims and focus manpower on those with high potential for evaluation. As the time for updating the current system approaches, it will be important to develop and adopt a joint system that is based on these results as soon as possible and to reallocate the extra capacity generated through that transition to health services.

## 3-3

### **Establish opportunities for national conversations and encourage involvement from young people and members of the working-age generation**

Dialogue forums that allow people from different generations or positions to express the future they envision and create a shared vision through dialogue will be vital for ensuring sustainability for the social security system. Up to this point, policy discussions have been led by economic organizations, professional associations, and senior citizens' groups, but in recent years, there has been a steady increase in participation among patients, others with lived experience of health concerns, and citizens. Expectations are high for the future establishment of a framework that allows young people and members of the working-age generation to participate more proactively in discussions.

In particular, forums that allow broad stakeholders to discuss issues that concern the entire healthcare system, such as the National Council on Social Security System Reform, are of great significance in reflecting the will of society as a whole, and their establishment

would be eagerly welcomed. In addition to encouraging involvement for people from many age groups through public dialogue forums, the proactive introduction of online platforms and other new frameworks for enabling public deliberation and consensus building should also be considered in the future. Creating an environment in which all participants can offer comments with peace of mind and proactively participate in policy formulation will also allow the impact of current policies on future generations to be more accurately reflected. Trust in the healthcare system is nurtured through transparent decision-making and consensus building. By gathering scientific evidence and holding repeated public dialogues, we should learn to recognize our responsibility to pass the healthcare system down to the next generation as a public good that is shared by all of society and fulfill our role as the current generation.

# In conclusion

These recommendations indicate a direction for building societal consensus on how to achieve a sustainable healthcare system from the three perspectives of benefits, burdens, and the societal implementation process. As these perspectives are closely interlinked, we cannot expect to make substantial progress by only choosing one. Rather than adopting the negative stance that we must suppress benefits due to fiscal restraints, it is important that we advance discussions with a positive attitude and ask, "Which option should we pick now to hand high-quality healthcare down to the next generation?" Analyses that are rooted in scientific evidence and constructive discussions that encompass diverse perspectives will both be vital in achieving this. Japan's healthcare system has generated globally-renowned results based on the principle of universal health coverage. It is our sincere hope that these recommendations will contribute to social dialogue in the future to ensure this precious societal asset is handed down to the next generation.

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