Japan

The Commonwealth Fund

International Health Care System Profiles

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Overview

Japan's health system is defined by its principles of universal health coverage, equity, free choice of provider, and community-oriented care.[1] Japan offers universal health coverage through a mandatory public insurance system. Private health insurance functions primarily as a supplement to the public system. Outcomes are strong: life expectancy in Japan, for instance, is one of the highest in the world.

However, the absence of a primary care gatekeeping system has contributed to inefficiencies, fragmented care, and an overreliance on hospitals — even for minor conditions. At the same time, Japan's health system struggles with challenges relating to mental health, suicide, and intensifying demographic pressures. With one of the world's fastest-aging populations and a shrinking workforce, sustaining the current model of health and social care presents growing fiscal and workforce challenges.[2]

Although Japan is known for its technological innovation, its health system has been slower than other countries to adopt digital solutions.[3] The government is now prioritizing the integration of digital health records, telemedicine, and remote care.[4]

HEALTH SYSTEM
BY THE NUMBERS

11%
Health care spending as a percent of GDP

84.1 years
Life expectancy at birth

100%
Public insurance coverage

Coverage and Access

Background and History

The Japanese health system originated with two parallel insurance plans: Employees' Health Insurance in 1922 for salaried workers, and Citizens' Health Insurance in 1938, later known as National Health Insurance, for self-employed people and rural residents. Enrollment was initially voluntary, leaving gaps in coverage. After World War II, democratization and a push for social solidarity led to the introduction of mandatory national health insurance, which was enacted in 1961. However, coverage was limited, and out-of-pocket costs for patients reached 50 percent.[5]

Economic growth in the postwar decades allowed for expanded benefits and reduced patient cost sharing. In 1973, the government introduced caps on out-of-pocket payments and temporarily made care free for the elderly. This laid the foundation for a longstanding emphasis on elder care.[6]

In 2013, health care was identified as a pillar of national revitalization, leading to the establishment of Medical Excellence Japan, which promoted global outreach and innovation.[7] In 2024, the Ministry of Health, Labour and Welfare (MHLW) reaffirmed the system's core values through its *Global Health Vision*, a strategic health policy document. Today, the system is defined by its principles of universal health coverage, equity, free choice of provider, and community-oriented care.[8]

The Role of Public Health Insurance

Universal health coverage in Japan is achieved through mandatory public insurance, consisting of Employees' Health Insurance for salaried workers and National Health Insurance for the self-employed, the unemployed, retirees, and for anyone who permanently resides in Japan for three months or more (including foreign nationals).[9] Coverage is required for all legal residents: citizens, permanent residents, and non-Japanese with visas valid for three months or more. Undocumented immigrants and short-term visitors are excluded from statutory coverage.[10]

The MHLW defines the benefits package and updates the national fee schedule every two years. All providers must adhere to this schedule, which standardizes pricing and access across public and private facilities.[11]

Employees' Health Insurance is divided into three plans: Health Insurance (operated either by the Japan Health Insurance Association, or by Society-Managed Health Insurance), Mutual Aid Associations, and Seamen's Insurance.[12] While there are differences by type of employer, each plan offers the same standardized coverage, including pharmaceuticals and dental care. National Health Insurance is administered by municipalities and covers those without Employees' Health Insurance eligibility.[13]

About 95 percent of households also hold private insurance to cover copayments or noncovered services.[14]

Services Covered by Public Health Insurance

The following services are covered by public health insurance, but copayments apply to all:[15]

- Preventive care
- Inpatient care
- Outpatient care
- Maternity care (emergency and cesarean section deliveries are covered, but nonurgent vaginal deliveries are not)
- Primary care
- Pharmaceuticals
- Dental care
- Mental health care
- Palliative care
- Long-term care (through long-term care insurance, *see Long-Term Care and Social Support*)
- Rehabilitative care
- Home visits.

Patients pay 10 to 30 percent of health care costs, depending on income and age. Most adults pay 30 percent; children and low-income seniors pay less. Individuals with certain chronic conditions or with low incomes are exempt.[16]

For maternity care, although nonurgent deliveries are not covered by public health insurance, the Childbirth and Childcare Lump-Sum Benefit applies regardless of delivery method. This benefit is a one-time payment of JPY 500,000 (USD 3,304) for every child and is generally paid to insured individuals to help cover delivery costs. To be eligible, pregnant women must be enrolled in public health insurance at the time of birth and have carried the pregnancy for at least four months.[17]

Safety Nets

To improve equitable access to health care, a range of measures target the reduction or elimination of copayments for certain groups and services:

- **High-cost medical expense benefit system.** This caps monthly out-of-pocket expenses for hospital, outpatient, and pharmacy expenses based on income and age.[18] For standard wage earners, the cap is JPY 80,100 (USD 529) plus a 1 percent coinsurance on expenses exceeding JPY 267,000 (USD 1,764). Lower-income groups face caps as low as JPY 57,600 (USD 380). Higher earners have base caps of up to JPY 252,600 (USD 1,669), plus 1 percent above the thresholds defined in the policy.[19]
- **Reduced coinsurance rates.** Standard coinsurance for working adults is 30 percent, but reduced rates of 20 percent apply to children under age 6 and to adults ages 70 to 74. Individuals over age 75 pay 30 percent if their taxable income is comparable to the current workforce and 10 percent for low-income earners.[20] Reductions do not apply to low-income adults under age 70 unless they qualify for public assistance.
- **Public assistance.** Individuals facing dire financial difficulties and qualify for public assistance under the Livelihood Protection Law (Seikatsu Hogo Hō) are fully exempt from all out-of-pocket medical costs, including coinsurance and prescription drug charges.[21]
- **Designated intractable disease subsidies (*nanbyō*).** Patients diagnosed with one of over 300 government-designated intractable diseases are eligible for subsidies that significantly reduce or cap out-of-pocket payments for approved treatments and medications.[22] Monthly copayments are limited to JPY 20,000 (USD 132), depending on household income, and may be waived entirely in some cases.[23] To qualify, the disease must be on the MHLW's official list and meet criteria related to rarity, chronicity, and treatment difficulty. Conditions such as ALS, Crohn's disease, ulcerative colitis, Parkinson's disease, and systemic lupus erythematosus are among those covered.[24]

The Role of Private Health Insurance

Private health insurance functions primarily as a supplement to the public system. It pays for services not covered by public insurance, including advanced treatments such as robotic surgery, and charges for private hospital rooms.[25]

Private insurance is purchased by individuals and often bundled with life or nursing care insurance. Premiums are eligible for a tax deduction under the life insurance deduction plan reducing both national and local tax liabilities.[26]

Although private health insurance is widespread, the functional scope of these policies is relatively narrow compared with those of many other high-income countries. Strict fee regulations, comprehensive public coverage, and a ban on mixed billing restrict private insurers from reimbursing copayments or offering faster access to services. Instead, policies typically provide financial support in the form of lump-sum payments, which households commonly use to cover lost income, transportation, childcare, or other indirect costs during illness.[27]

Cancer-related insurance is gaining popularity, with benefits that support out-of-pocket costs for uncovered therapies or that enable access to second opinions. Looking ahead, demand may continue to evolve as rising treatment costs and demographic pressures prompt changes in public insurance coverage.[28]

The Role of Government

The health system is centrally regulated by the MHLW, which oversees insurance policies, service delivery standards, workforce licensing, and the national fee schedule. It works closely with other ministries, including the Ministry of Finance, which provides fiscal oversight, and the Ministry of Education, Culture, Sports, Science and Technology, which oversees medical education.[29]

Policy is implemented across three levels of government: national, prefectural, and municipal. National authorities design and fund the system, with local governments handling most service delivery and administration, including the management of public hospitals and long-term care programs.[30]

Professional associations such as the Japan Medical Association and the Japanese Nursing Association play an active role in shaping policy, especially in areas related to clinical practice and workforce development.[31]

Integration and Care Coordination

The health system has historically lacked strong care coordination, particularly between hospitals and community settings. Patients can visit any provider without referral, which can lead to fragmented care and overreliance on hospitals.[32]

Integration efforts are evolving at both the local and national levels. The Community-Based Integrated Care System, promoted by the MHLW, is a cornerstone of this effort.[33] It aims to provide seamless medical, nursing, preventive, housing, and livelihood support within each municipality, enabling older adults to age in place. Additionally, policies such as the Regional Medical Care Vision encourage better regional coordination of hospital beds and services based on population needs.[34]

Prefectural governments operate central administrative offices that act as intermediaries between providers and insurers, facilitating claims processing and supporting more coordinated service delivery. Cross-subsidization mechanisms between insurance plans also help to stabilize financing across different patient populations.[35]

To address geographic disparities in access to care, particularly in typically underserved rural or remote areas, digital health initiatives are emerging. LEBER, for example, is a mobile health app that provides 24/7 access to online physician consultations (*see Innovation and Reform*).[36]

Japan's aging population has driven efforts to enhance coordination between hospital-based medical care and long-term care. The Long-Term Care Insurance (LTCI) system, introduced in 2000, formalized the role of care managers, who develop and oversee individualized care plans for home care, rehabilitation, or institutional services.[37]

Recognizing the challenges of transitioning older patients from the hospital to their community, the government introduced financial incentives and service fees to encourage coordinated discharge planning and information sharing between medical and long-term care providers.[38]

At the community level, community-based integrated care centers — staffed with health nurses, social workers, and care managers — have been established in nearly every municipal district (each serving about 20,000 residents) to act as coordination hubs for linking medical, welfare, and preventive services.[39]

Formal integration is limited, with structural alignment still ongoing; medical and long-term care services continue to function under separate insurance plans, provider networks, and administrative systems. For example, shared assessments, interoperable data exchange, and integrated planning remain the subject of policy discussions and have yet to become routine.[40]

Operations and Resources

Overview of the Delivery System

The health system offers universal coverage and free provider choice, allowing patients to access care at any facility without a referral.

- **Primary care.** Unlike most countries belonging to the Organisation for Economic Co-operation and Development (OECD), where primary care referrals are a structural requirement, Japan has no general practitioner (GP)-based entry point. Most patients in Japan go straight to hospitals, including tertiary centers, for everything from minor ailments to complex care.[41] Most hospitals are privately managed: about 70 percent are owned by private medical corporations, which also operate half of all hospital beds.[42]
- **Secondary care.** This comprises inpatient and routine specialty services provided in general hospitals.[43]
- **Tertiary care.** Critical Care Centers manage severe, complex cases and serve as training facilities for most of this care.[44]

Primary Care

Patients can visit any clinic or hospital, including tertiary centers, even for minor conditions. "Japan doesn't have a GP system, allowing patients to go directly to any hospital, including university hospitals. This is seen as a strength in terms of accessibility," says Ryoji Noritake of the Health and Global Policy Institute. This open-access model supports patient choice but contributes to hospital overuse and fragmented care.[45]

General practice and family medicine are relatively new to the Japanese health system: the Japan Primary Care Association (JPCA) introduced board certification for family medicine only in 2009. Typically, physicians train in internal medicine or pediatrics and set up local clinics. Only 1,126 physicians were formally certified in family medicine by the JPCA in 2022 — just 0.9 for every 100,000 people.[46]

Out-of-hours care is typically provided through a combination of hospital outpatient departments with on-call physicians, municipal emergency clinics (*kyūbyō shinryōsho*) for low-acuity cases, and after-hours clinics operated by local governments.[47] In some areas, home-visit services are also available to provide urgent care to patients who are unable to travel.[48]

Outpatient/Specialist Care

Secondary care includes both outpatient specialty care and hospital-based services, both of which are directly accessible to patients without referral.[49]

Under the national uniform fee schedule, consultation fees are the same regardless of setting or specialty — about JPY 2,700 (USD 18) for a first visit.[50] Large hospitals can charge a referral-free visit fee of between JPY 5,000 and JPY 7,000 (between USD 33 and USD 46) to discourage inappropriate use.[51]

Outpatient care is provided in private clinics run by specialists in fields such as internal medicine, surgery, and pediatrics. These function as primary care practices because there's no formal general practice specialty. There are also hospital outpatient departments, which handle everything from routine check-ups to specialized care.[52]

Private providers play a significant role: 81 percent of hospitals and over 96 percent of clinics are privately operated.[53] Most outpatient specialty care is provided in these clinics, but many patients still prefer hospital outpatient departments because of their perceived higher quality. This leads to overcrowding in hospitals and fragmented care.[54]

Japan had 274 doctors for every 100,000 people in 2022, higher than the average of 232 across the Western Pacific.[55] However, physicians are heavily concentrated in urban centers, leaving rural areas with limited access (*see Addressing Health Inequities*).[56]

Policymakers are increasingly focused on strengthening community-based pathways and reducing routine reliance on hospital outpatient services.[57]

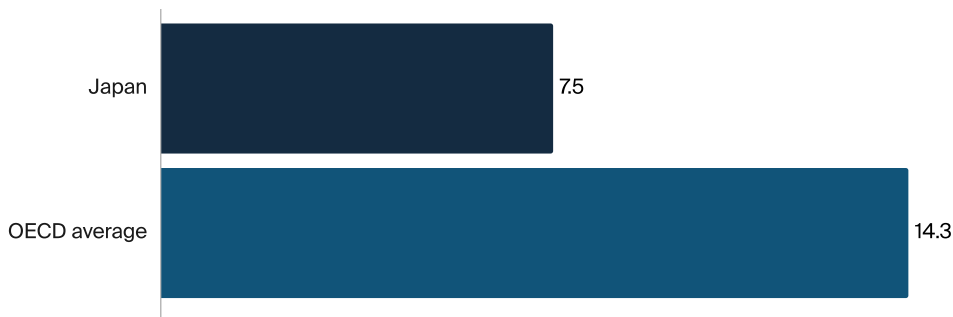
Physician Education and the Workforce

Japan has about 7.5 medical graduates for every 100,000 people, nearly half the OECD average.[58] At public universities, average annual tuition was JPY 535,800 (USD 3,540) in 2024; at private universities, it was JPY 880,000 (USD 5,814).[59]

Uneven distribution is a challenge, as most doctors practice in urban centers, leaving rural areas underserved. To address this, the government regulates the number of medical school slots and residency positions by region and uses targeted incentives to encourage physicians to practice in less-populated areas.[60]

The aging population and growing chronic disease burden place additional pressures on the health care workforce.[61] Nevertheless, there has been no significant recruitment of international physicians; in 2022, there were 2,349 foreign-trained doctors in Japan.[62]

Number of Medical Graduates per 100,000 People, 2021



Source: Health at a Glance 2025 (Organisation for Economic Co-operation and Development, November 13, 2025).

Hospitals

The hospital system is a mix of general, specialized, and psychiatric hospitals, all operating under the universal health insurance system. Hospitals are overwhelmingly privately managed: in 2025, about 70 percent were owned by private medical corporations, which also operated 56 percent of all hospital beds. Public hospitals, by comparison, operated just 17 percent of all hospital beds. The remainder (29%) were run by public or quasi-public bodies, including local governments and national agencies.[65]

The number of hospital beds is among the highest in high-income countries. In 2025, there were 1,450,322 hospital beds.[66] This translates to a bed density far exceeding the OECD average in 2021, reflecting the historically hospital-centric care model.[67]

Japan also has some of the longest hospital stays. In 2023, the average general care stay was 16 days, more than twice the OECD average of 7.7 days in 2021.[68] When long-term-care beds were included within hospitals, the average length of stay was 26 days.[69] Long hospital stays reflect structural factors rather than clinical need: hospitals often provide long-term rehabilitation and even social care, roles typically handled by nursing homes or home care in other countries.[70]

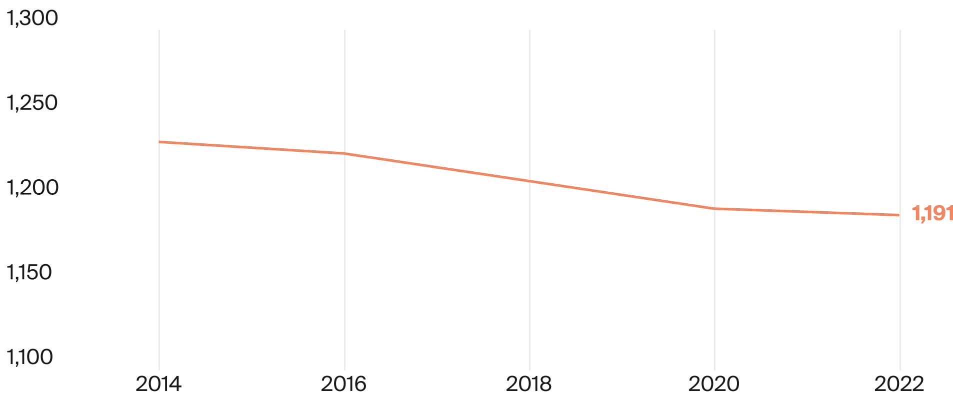
With an aging population and limited post-discharge support, hospitals also act as a default safety net for elderly patients. The result is inefficient use of hospital resources and delays in the development of integrated community-based care.[71] Policy discussions have centered on shifting care to the community and rebalancing the role of hospitals in managing chronic and aging-related conditions.[72]

HOSPITALS **BY THE NUMBERS**

In 2025, Japan had **1,191 hospital beds per 100,000 people**, compared with an OECD average of 420 per 100,000 in 2023.[63]

In 2022, there were **1,244 nurses and midwives per 100,000 people** (compared with an average of 434 across the Western Pacific).[64]

Number of Hospital Beds per 100,000 People, 2014–23



Source: Ministry of Health, Labour and Welfare of Japan, Table 2-22: Number of beds and beds per 100,000 population by type of bed, by year, distributed by MHLW, accessed December 3, 2025.

Mental Health Care

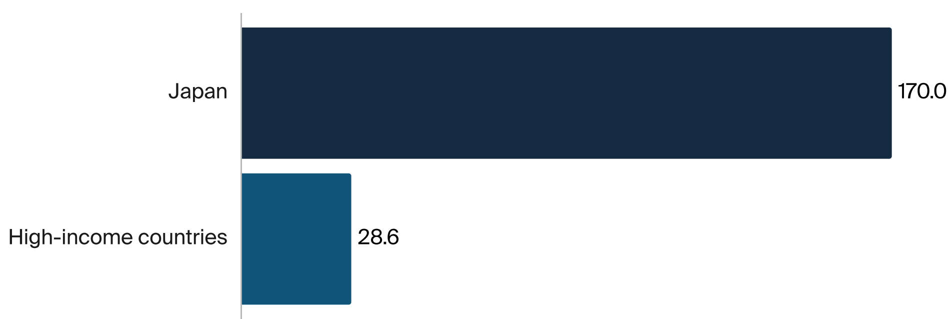
With a suicide rate of 21.5 deaths for every 100,000 people, Japan faces significant challenges in improving mental health.[76]

Mental health care is heavily reliant on extended inpatient treatment, especially in private psychiatric hospitals. In 2023, there were 289 psychiatric inpatients for every 100,000 people, and the bed occupancy rate was 81.6 percent.[77]

Outpatient mental health services are increasingly supported by the public welfare system. Patients typically pay about 10 percent of outpatient treatment costs, and the government covers the rest.[78] Local public health centers coordinate community mental health programs.[79]

The aging population is causing a rise in demand for dementia-related mental health services and reinforcing the need to shift from an inpatient-focused system to more flexible, community-based support.[80]

Number of Mental Hospital Beds per 100,000 People, 2020



Source: World Health Organization, *Mental Health Atlas 2020* (WHO, 2021).

MENTAL HEALTH CARE **BY THE NUMBERS**

There were **13 psychiatrists per 100,000 people** in 2020, higher than the average of nine for high-income countries.[73]

In 2023, there were **256 psychiatric hospital beds per 100,000 people.**[74]

In 2020, there were **112 mental health professionals per 100,000 people** — much higher than the average of 62 in high-income countries.[75]

Long-Term Care and Social Support

Japan's aging population has led to a rapid increase in long-term care costs, which tripled from JPY 3.6 trillion in 2000 (~USD 28.4 billion) to JPY 10.8 trillion in 2020 (~USD 84.4 billion).[81]

In 2000, Japan introduced Long Term Care Insurance (LTCI) - mandatory insurance offering coverage for both care in nursing homes and home-based care, with an emphasis on community-based care rather than institutional care.[82] LTCI covers adults age 65 and over, as well as those ages 40 to 64 who have specific age-related disabilities.[83] The program is funded through a mix of taxes and premiums paid by every citizen over age 40. Those eligible for LTCI pay a 10% copayment for services.[84] As more people become eligible for LTCI, the system has become increasingly expensive and difficult to maintain.[85]

The government's Community-Based Integrated Care System aims to bring together health, long-term care, prevention, housing, and livelihood support at the local community level to help older adults remain independent and close to home.[86]

Cost and Affordability

Health Care Spending Overview

Health care spending has nearly doubled over the past three decades, reaching JPY 468 billion (USD 3.1 billion) in 2022.[87] In 2023, health expenditure was 10.7 percent of gross domestic product (GDP), above the average of 8.1 percent for high-income countries.[88] "The aging population is an ongoing challenge," says Noritake, "both how we take care of an aging population and dealing with the challenge to the financial sustainability of the health care system." Individuals age 65 and over, who make up 29 percent of the population, accounted for 62 percent of spending.[89]

Most health spending comes from public funding (87%), with the remainder split between out-of-pocket payments (11%) and voluntary insurance (2%). This translates to a per capita spend of about USD 3,670, with USD 3,190 from government sources and the rest from out-of-pocket and voluntary payments.[90]

Health Care Spending as a Percentage of GDP, 2023

Source: The Global Health Observatory, Current health expenditure (CHE) as percentage of gross domestic product (GDP)(%), distributed by *World Health Organization,* accessed December 10, 2025.

Pharmaceutical Spending

Pharmaceutical spending made up 17.6 percent of health care spending in 2023, a figure that has remained fairly consistent over the past decade.[91] Per capita, about USD 847 was spent on pharmaceuticals in 2023.[92]

Japan has pursued several measures to lower drug costs:

- Since 2018, Japan has shifted from biennial to annual drug price revisions to align official prices more closely with market rates.[93]
- Reforms made in 2024–25 include newer repricing plans and stricter cost controls, including market expansion and cost-effectiveness-based pricing.[94]
- In 2025, the prices of nearly half of all publicly covered drugs will be reduced, targeting savings of about JPY 250 billion (USD 1.7 billion).[95]
- Generic drug uptake has been increased to help manage rising costs.[96]

Cost Sharing and Out-of-Pocket Spending

Patients are typically responsible for coinsurance payments of about 30 percent for most medical services. For children under age 6, coinsurance is 20 percent; for seniors ages 70 to 74, it's between 20 and 30 percent, depending on income; and for seniors 75 and over, the coinsurance rate is 10 percent and rises to 30 percent for those with high incomes.[97]

Out-of-pocket spending accounted for 12.2 percent of total health expenditures in 2023, below the average for high-income countries (19.3%) but an increase from 2022 (11.6%).[98] To protect patients from catastrophic expenses, there's a high-cost medical expense benefit system, which caps monthly out-of-pocket spending based on income.[99]

Out-of-pocket spending for noncovered services includes cosmetic procedures, infertility treatments, and some nonessential dental and vision care. However, core services — including hospital care, outpatient visits, mental health care, and pharmaceuticals — are universally covered, with copayments as the primary form of cost sharing.[100]

Percentage of Health Care Spending That Is Out of Pocket, 2023

Source: The Global Health Observatory, Out-of-pocket expenditure as percentage of current health expenditure (CHE)(%), distributed by World Health Organization, accessed December 10, 2025.

How Are Costs Contained?

At the center of cost-containment efforts is a uniform fee schedule set biennially by the MHLW.[101] This centralized price-setting prevents excessive charges by capping the fees that providers can bill for each medical service. In 2024, the government approved a modest 0.88 percent increase in general medical fees.[102]

Pharmaceutical costs are also managed through national price negotiations and profit caps. Under the National Health Insurance plan, drug companies can only apply a maximum 17 percent profit margin to covered drugs.[103]

Preventive care is also part of the cost-containment strategy. Regular health screenings, lifestyle education, and a national emphasis on healthy aging help reduce the long-term burden of chronic diseases. The low obesity rate of about 4 percent has played an indirect role in controlling the cost of obesity-related medical conditions.[104]

Quality and Outcomes

Health Outcomes

In 2023, life expectancy was 81 years for men and 87.2 years for women, about the same as the averages for high-income Asia-Pacific countries (81 years for men and 87.1 years for women).[114]

Noncommunicable diseases account for 85.3 percent of deaths. Communicable, maternal, perinatal, and nutritional conditions account for 9.9 percent of deaths, while injuries account for 4.7 percent.[115]

Mental health also remains an issue: Japan's suicide rate of 21.5 deaths for every 100,000 people exceeds the OECD average, with the highest rate being among unemployed men ages 40 to 59 who live alone (*see Mental Health Care*).[116]

Addressing Health Inequities

Japan's universal health coverage provides near-universal access to insured medical care, yet disparities persist along socioeconomic, geographic, and gender lines. Structural causes include the uneven distribution of workers between cities and rural areas, uneven municipal resources, the growth of nonregular employment, and persistent barriers to mental health and preventive services. During the COVID-19 pandemic, preexisting socioeconomic disparities widened. With mental health, for example, populations in the lowest-income group experienced more severe and prolonged declines in well-being.[117]

Regional health outcomes vary sharply. Prefectures such as Aomori, Akita, Kagoshima, and Okinawa show higher mortality from stroke, ischemic heart disease, and cancer — patterns linked to older populations, educational disparities, and lower incomes.[118] In contrast, Nagano, Shiga, and Kanagawa benefit from healthier diets, higher education levels, and stronger community-based health systems.[119]

HEALTH OUTCOMES BY THE NUMBERS

Average life expectancy was **84.1 years** in 2023 (compared with 81.1 in high-income countries).[105]

The avoidable mortality rate was **135 deaths per 100,000 people** in 2021.[106]

The top three causes of death in 2023 were:

- Malignant neoplasms: **316 deaths per 100,000 people**
- Heart disease: **191 deaths per 100,000 people**
- Senility: **157 deaths per 100,000 people**.[107]

The maternal mortality rate was **three deaths per 100,000 live births** in 2023 (compared with an average of 35 in the Western Pacific).[108]

The infant mortality rate was **two deaths per 1,000 live births** in 2023 (compared with an average of nine in the Western Pacific in 2023).[109]

In 2021, the share of the population with mental health disorders was **12 percent** (compared with an average of 16% in high-income countries).[110]

The suicide rate was **21.5 deaths per 100,000 people** in 2023 (compared with an average of 12 across high-income countries).[111]

Guns are responsible for **0.05 deaths per 100,000 people** in Japan.[112]

Six percent of adults were affected by obesity in 2022 (compared with 26% on average in high-income countries).[113]

Rural workforce shortages deepen inequities. Prefectures such as Iwate, Aomori, Fukushima, and Niigata rank among the lowest in physician density.[120] Rural prefectures in the Tohoku region are particularly affected, with severe shortages in emergency and surgical personnel.[121] Rural clinics frequently experience difficulty retaining physicians, as younger doctors commonly migrate to hospitals to obtain board certification, reinforcing urban-centered career patterns.[122] Geographical barriers also compound access issues, as rural residents in designated physician-shortage areas often live more than 30 minutes from major medical institutions, even with ordinary transportation.[123]

Women in precarious jobs or caregiving roles frequently report higher psychological distress and reduced use of preventive care.[124]

To address these inequities, the government has implemented the following measures:

- **Health Japan 21 (the third term).** This national strategy to reduce disparities in healthy life expectancy across prefectures led to improvements for men but not for women. Insights from this strategy have informed the development of the next National Health Promotion Plan.[125]
- **Child health subsidies.** All prefectures and municipalities now subsidize children's health care, reducing financial burdens on families and supporting early interventions that improve long-term outcomes.[126]

Innovation and Reform

Health Care Innovation

Regulatory updates have supported the development of digital therapeutics — software-based treatments designed to prevent, treat, or manage health conditions. Examples include CureApp SC for smoking cessation (approved in 2020) and CureApp HT for hypertension management (approved in 2022), both of which are now covered by public health insurance.[127] Collaborations with international companies, such as Welldoc's diabetes care app, have further expanded access to personalized digital health tools.[128]

Health Care Technology

Although Japan has a global reputation for technological excellence, it has been slow to adopt digital solutions in health care. However, there's a growing emphasis on using technology to improve patient outcomes and system efficiency.[129] Since 2021, residents have been able to get health care with their government-issued My Number Card. Each card is embedded with a chip that gives providers access to the patient's individual health records.[130] As of 2025, the My Number Card is the only form of health insurance identification.[131]

Use of telemedicine is also rising. This technology is expanding access in rural areas, with mobile medical units and remote consultations helping to bridge gaps in care.[132]

This profile reflects data as of February 2026. New or updated information may have become available since its release.

Notes

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