

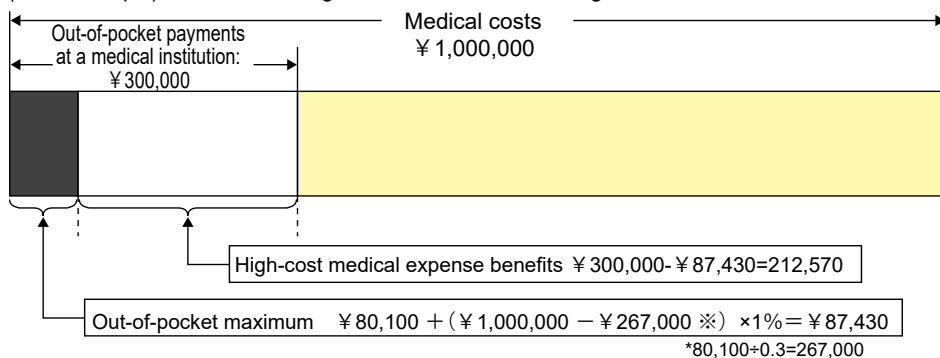
Medical care system for the elderly aged 75 and over	(Implementing bodies)	19,785	10% (20% for those earning more than a certain amount) (30% for persons with more than a certain amount of income)	(average annual income: over approximately 11.60 million yen) ¥252,600 + (medical expenses – ¥842,000) x1%	Same as above	Same as above, except for • Recipients of old-age Welfare Pensions Per meal ¥110	• Funeral expenses, etc.	Calculated using the amount of the per capita rate and income ratio of insured persons provided by wide area unions	• About 10% of benefits, expenses, etc. are borne as insurance premiums (Breakdown of public funding) National : Prefectures Municipalities 4 : 1 : 1
	Wide area unions for medical care system for the elderly aged 75 and over 47			(average annual income: between about 7.70 million yen and about 11.60 million yen) ¥167,400 + (medical expenses – ¥558,000) x1% (average annual income: between about 3.70 million yen and about 7.70 million yen) ¥80,100 + (medical expenses – ¥267,000) x 1% (average annual income: under approximately 3.70 million yen) ¥57,600 outpatient (per person) ¥18,000(¥144,000/year) (Household exempted from residence tax) ¥24,600, outpatient (per person) ¥8,000 (Especially household with lower income among household exempted from residence tax) ¥15,000, outpatient (per person) ¥8,000 • Reduced payment for multiple high-cost medical care (average annual income: over approximately 11.60 million yen) ¥140,100 (average annual income: between about 7.70 million yen and about 11.60 million yen) ¥93,000 (average annual income: between about 3.70 million yen and about 7.70 million yen) ¥44,400 (average annual income: under approximately 3.70 million yen) ¥44,400						• About 10% of benefits, expenses, etc. are borne as insurance premiums

- (Note) 1. Insured persons of medical care system for the elderly aged 75 and over are individuals aged 75 and over, and persons aged 65 to 74 who are certified as having a specific disability by a wide area union.
2. Persons with a certain amount of income include those with a taxable income of ¥1.45 million (monthly income of ¥280,000 or more) or persons whose total amount of gross income, etc. after deducting the basic amount of insured persons belonging to the 70-74 age group households is ¥2.10 million or more. However, those in households of two or more elderly with a taxable income of less than ¥5.20 million, and those of a elderly single-person household with a taxable income of 3.83 million and those with a total old income not more than ¥2.10 million are excluded. Lower income households exempted from residence tax is considered to be those with a pension income of ¥800,000 or less, etc.
3. Fixed-rate national subsidy for National Health Insurance shall be at the same level as that for the Japan Health Insurance Association-managed Health Insurance for those exempt from application of Health Insurance and those newly subscribed to the National Health Insurance on and after September 1, 1997.
4. The sums in the breakdown may not equal the total due to rounding.
5. The premium rate of Seamen's Insurance is the rate after the deduction resulting from the measure to reduce the burden of insurance premiums for insured persons (0.2%).

Detailed Information 1 Outline of the High-Cost Medical Expense Benefits System

- The system is designed to relieve the burden of out-of-pocket medical payments on household finances. Under this system, patients pay their share of medical costs at medical institutions until they reach their out-of-pocket maximum and then claim for the amount exceeding their monthly maximum with the insurer to receive reimbursement.
- (*1) A benefit-in-kind system has been introduced for inpatient treatment, ensuring that patients do not have to pay medical expenses at a medical institution after their out-of-pocket expenses reach the maximum.
- (*2) A benefit-in-kind system for outpatient treatment was introduced in April 2012. It applies to patients whose expenses for outpatient treatment at the same medical institution exceed their out-of-pocket maximum.
- An out-of-pocket maximum is set based on the insured person's annual income.

(Case example) Persons under age 70 with the annual earnings between about ¥ 3.7 million and about ¥ 7.7 million (30% coinsurance)



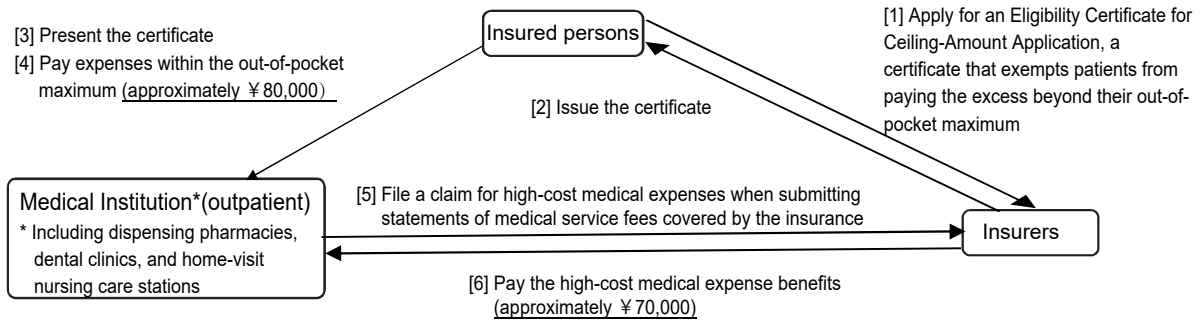
(Note) The High-Cost Medical Expense Benefits System allows for the aggregation of medical expenses at multiple hospitals and clinics. This means that monthly out-of-pocket payments at different medical institutions can count toward a single out-of-pocket maximum and that the total amount exceeding the monthly limit is covered by the system. (However, persons under 70 are eligible for the benefits only when they make out-of-pocket payments of ¥21,000 or more per month per medical institution.)

Detailed Information 2 Response to the Benefit-in-Kind System for Outpatient Treatment

○ In addition to the benefit-in-kind system covering high-cost inpatient treatment, the system covering high-cost outpatient treatment was introduced in April 2012 to reduce the burden of patients paying higher prices for drugs and other services. Under this system, when out-of-pocket payments for outpatient treatment in a month at the same medical institution exceed a patient's monthly out-of-pocket maximum, the patient does not need to pay any excess at the medical institution, but the insurer does. The patient also does not need to file claims with the insurer to receive reimbursement.

* Patients using their My Number card as a health insurance card do not have to follow the procedure [1] - [3] below, since they are exempt from paying the excess beyond their out-of-pocket maximum without presenting their Eligibility Certificate for Ceiling-Amount Application.

Medical expense ¥500,000 (30 % coinsurance) Annual income: about ¥3.7 million –about ¥7.70 million for persons below 70 years old



- [1] Insured persons or their proxy applies to their insurer for an Eligibility Certificate for Ceiling-Amount Application.
- [2] The insurer issues the certificate to the insured persons based on their household income category.
- [3] The insured persons present the certificate at medical institutions
- [4] Medical institutions do not collect medical fees exceeding the out-of-pocket maximum when they calculate out-of-pocket expenses of insured persons, etc. on an individual basis and those expenses reach the maximum.
* However, insured persons need to pay 1% of the medical costs exceeding their monthly out-of-pocket maximum each time they visit a medical institution.
- [5] Medical institutions file claims for high-cost medical expenses exceeding the insured persons' out-of-pocket maximum with the insurer when submitting statements of medical services fees covered by the insurance.

Detailed Information 3 Outline of the Benefits System for High Combined Expenses for Medical Treatment and Long-term Care

○ The system allows insurers to pay any excess to a household when its total out-of-pocket payments per year (from August 1 to July 31 of the following year) for services covered by medical insurance and long-term care insurance are high and exceed the household's out-of-pocket maximum. Its aim is to reduce insured persons' out-of-pocket payments.

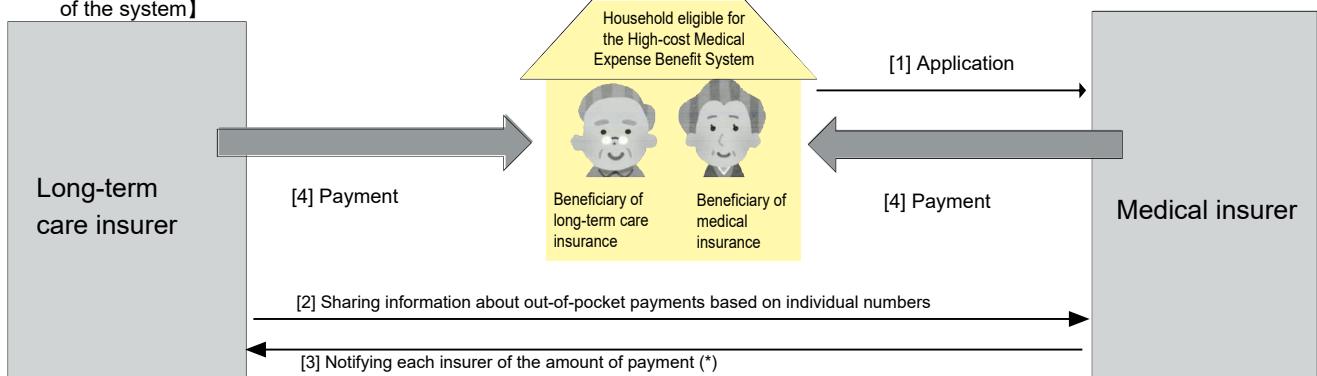
[1] Requirements: When the total out-of-pocket payments for services covered by medical insurance and long-term care insurance per household exceed the out-of-pocket maximum, the insurers of those insurance programs pay any excess to the household. The household in this context means the one defined by the medical insurance system and the maximum amount is set based on the household's income category.

[2] Maximum amount: The maximum amount is set based on insured persons' income and age.

[3] Payment: The medical insurer and the long-term care insurer both pay their share calculated based on the ratio of out-of-pocket payments made by the household for services the household's members covered by the same medical insurance received.

**High combined expenses for medical treatment and long-term care* paid by the medical insurer are called "high combined expenses for (preventive) long-term care and medical treatment" when paid by the long-term care insurer.

【Visual representation of the system】

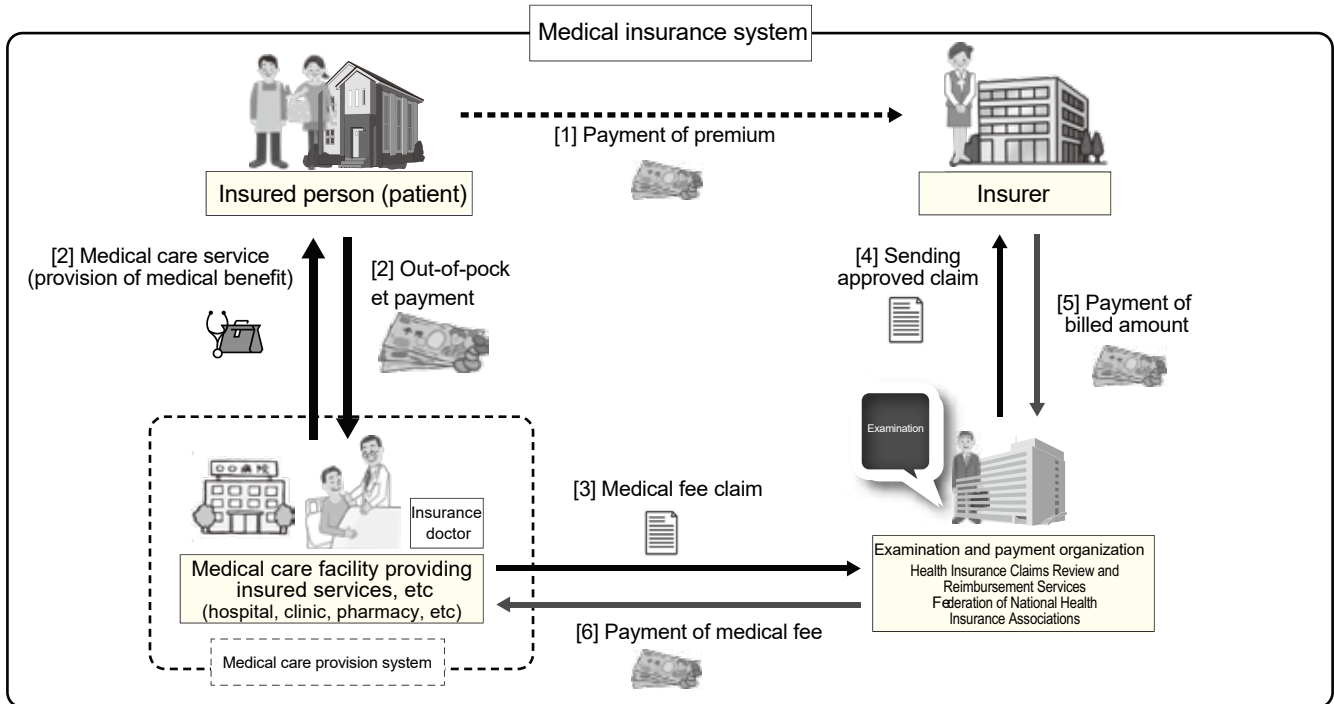


(*) Based on data obtained through information sharing stated in [2] in the visual representation above, the medical insurer calculates the total annual amount of out-of-pocket expenses paid by the household of a beneficiary /beneficiaries and determines the benefit amount. The insurer then divides the benefit amount based on the ratio of out-of-pocket payments made by the household for services its members received and notify how much each of the insurers involved should pay.

Insured Medical Treatment System

Overview

Conceptual Chart of Insured Medical Treatment



Medical fees are classified into three types: medical, dental, and dispensing fees.

The medical fee is calculated by adding stipulated numbers of points for the individual medical activities provided (so-called "fee-for-service system"). The unit price for one point is ¥10. For a typhlitis hospitalization case, for example, the first visit fee, the hospitalization fee multiplied by the length of stay (days), the typhlitis surgery fee, the test fee and the drug fee are added to one another and a medical care facility providing insured services will receive the amount less the patient's out-of-pocket payment from the examination and payment organization.

Negotiations with the Minister of Finance regarding the revision of medical fees for FY2024 (December 20th, 2023)

1. Medical Service Fee + 0.88 % (Effective on June 1st, 2024)

- ① Special measures to implement +2.5% of base salary level in FY2024 and +2.0% of base salary level in FY2025 for nursing staff, hospital pharmacists, and other health care-related positions (excluding those who fall under* below) + **0.61%**
- ② Raising the standard amount of meals (30 yen per meal) for hospitalization (of which, in principle, the patient pays 30 yen per meal, and for low-income patients, 10 - 20 yen per meal, depending on income bracket, etc.) + **0.06%**
- ③ Efficiency and appropriateness of management fees, reorganization of prescription fees, etc., with a focus on lifestyle-related diseases ▲ **0.25%**
- ④ Revisions other than ①~③ + **0.46%**(* Includes measures contributing to wage increases for those working physicians, working dentists, pharmacists working in pharmacies, clerical staff, and those working in dental laboratories under 40 years of age(+ about 0.28%))

Change rate by department : Medical + 0.52%, Dental + 0.57%, Pharmaceutical compounding + 0.16%

2. NHI drug price, etc.

- ① NHI drug price ▲ 0.97 % (Effective on April 1st, 2024)
- ② Material price ▲ 0.02 % (Effective on June 1st, 2024)

- * Further evaluation of innovation, including maintenance of drug prices for innovative new drugs and enhancement of usefulness system evaluation.
- * Including special measures for recalculation of unprofitable products as a response to rapidly rising raw material costs and to secure stable supply of generic drugs, etc. (Target: about 2,000 products)
- * In order to further evaluate innovation, etc., review the nature of insurance benefits for long-listed products.

⇒ Introduce a system of selective medical care and cover up to three-fourths of the price difference from the highest price range of generic drugs for those whose generic drugs have been on the market for at least 5 years or whose generic drug substitution rate is at least 50% (effective on October 1st, 2024).

3. System reform items related to medical service fees, NHI prices, etc.

From the viewpoint of improving the system for efficient provision of quality medical care, etc., the following items should be steadily reformed, based on discussions at the Central

Social Insurance Medical Council.

- Effective utilization of medical information through promotion of medical DX, etc.
- Optimization of basic Pharmaceutical compounding fees, etc.

In addition, the allocation method will be devised to ensure that the increase will lead to a base salary increase of 2.5% in FY2024 and 2.0% in FY2025 for those working in the medical field. In addition, we will ascertain the actual status of wage increases for healthcare workers, trends in prices including food costs, and business conditions as a result of this revision.

Summary of Basic Policies for Revision of Medical Service Fee in FY2024

Basic recognition of the revision

- ▶ Actions based on the impact of rising prices and wages, business conditions, the need to secure human resources, and the impact of patient and insurance premium burdens
- ▶ Responding to issues surrounding healthcare, such as the realization of an all-generation social security system, strengthening the coordination of medical, nursing care, and welfare services for the disabled, and responding to emerging infectious diseases, etc.
- ▶ Realization of high-quality medical care through promotion of medical DX and innovation, etc.
- ▶ Ensuring the stability and sustainability of social security systems, and harmonization with the economy and public finances

Basic Perspectives and Specific Directions for Revision

(1) Promote human resource recruitment and work style reforms, taking into account the current employment situation

[Key issues]

[Examples of Specific Directions]

- Efforts to secure human resources and raise wages for healthcare workers
- Improve the work environment so that each profession can fully demonstrate their high level of expertise, promote task sharing/task shifting, team approach to healthcare
- Evaluation of efforts to promote the use of ICT to improve operational efficiency and to improve other severe work environments, such as long working hours
- From the viewpoint of ensuring regional medical care and functional differentiation, secure necessary emergency medical care system, etc., including a review to ensure the effectiveness of reduced working hours.
- Expansion of evaluations based on diverse work styles
- Addressing the maldistribution of medical personnel and resources

(3) Promotion of safe, reliable, and high-quality medical care

[Examples of specific directions]

- Response in light of rising prices, including food and utility costs
- Evaluation of systems for safe and secure medical care for patients
- Promoting evaluation that also focuses on outcomes
- Appropriate evaluation of areas that require priority attention (pediatric care, perinatal care, emergency care, etc.)
- Promotion of effective and efficient disease management and prevention of serious illnesses in response to the increase in lifestyle-related diseases, etc.
- Prevention of serious oral diseases, enhancement of response to declining oral function, and promotion of dental care that takes quality of life into consideration
- Appropriate evaluation of pharmacies according to their community-based functions, promotion of the shift of pharmacy and pharmacist services from object-centered to person-centered, and evaluation of hospital pharmacist services
- Promote evaluation of the role of pharmacies as drug supply centers with functions that meet the needs of patients and residents in the community, taking into account the management situation of pharmacies, etc.
- Appropriate evaluation of innovations with a view to transforming the structure of the pharmaceutical industry and ensuring a stable supply of pharmaceuticals, etc.

(2) Deepening and promotion of regional comprehensive care systems and differentiation and strengthening of medical functions, including medical DX, with a view to post-2025, and promotion of collaboration

[Examples of specific directions]

- Effective utilization of medical information through promotion of medical DX and telemedicine
- Efforts to deepen and promote community-based comprehensive care systems, including the promotion of medical care that takes into account daily life
- Coordination and promotion of rehabilitation, nutrition and oral management
- Evaluation of inpatient care according to the patient's condition and medical functions considered necessary
- Functional differentiation and strengthening of outpatient care, etc.
- Efforts to establish a regional medical care delivery system that can respond to emerging infectious diseases, etc.
- Evaluation of the functions of the family doctor, family dentist, and family pharmacist
- Ensure high quality home medical care and home nursing care

(4) Improving the stability and sustainability of the healthcare insurance system through greater efficiency and appropriateness

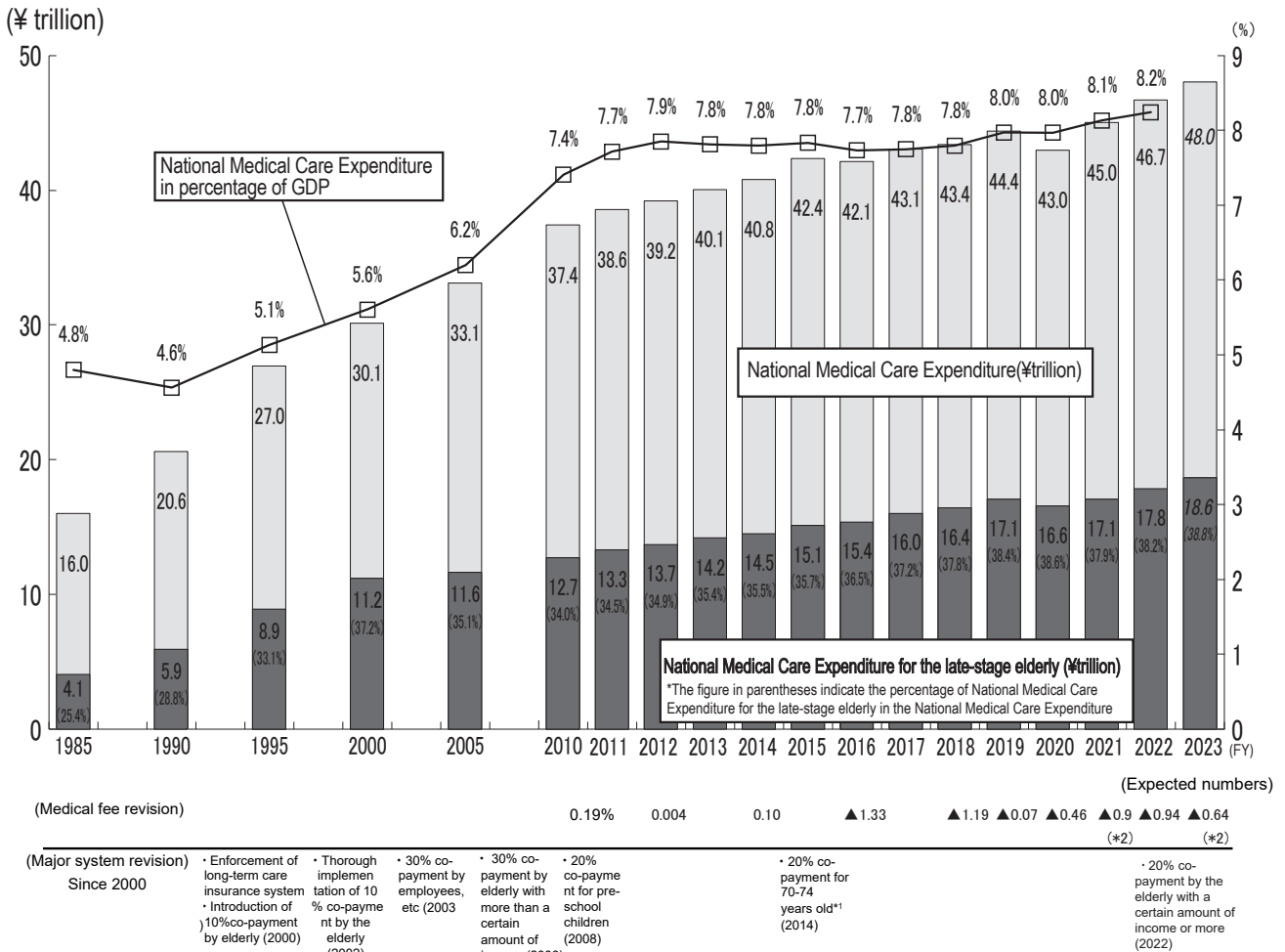
[Examples of specific directions]

- Promotion of the use of generic drugs and biosimilars, review of insurance benefits for long-listed products, etc.
- Utilization of cost-effectiveness evaluation systems
- Appropriate valuation based on actual market prices
- Effective use of medical information through promotion of medical DX, promotion of telemedicine (reiterated)
- Evaluation of inpatient care based on the patient's condition and medical functions considered necessary (reiterated)
- Functional differentiation and reinforcement of outpatient care, etc. (reiterated)
- Promotion of effective and efficient disease management and prevention of serious illness in response to the increase in lifestyle-related diseases, etc. (reiterated)
- Promotion of proper use of pharmaceuticals through collaborative efforts by physicians, hospital pharmacists, and pharmacy pharmacists
- Promote evaluation of the role of pharmacies as drug supply centers with functions that meet the needs of local patients and residents, taking into account the management situation of pharmacies and other factors (reiterated).

Health Expenditure

Overview

Changes in Health Expenditure



<Year-on-year growth rate of National Medical Care Expenditure>

(%)

	1985	1990	1995	2000	2005	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023
National Medical Care Expenditure	6.1	4.5	4.5	▲1.8	3.2	3.9	3.1	1.6	2.2	1.9	3.8	▲0.5	2.2	0.8	2.3	▲3.2	4.8	3.7	2.9
National Medical Care Expenditure for the late-stage elderly	12.7	6.6	9.3	▲5.1	0.6	5.9	4.5	3.0	3.6	2.1	4.4	1.6	4.2	2.5	3.8	▲2.9	3.1	4.5	4.5
GDP	7.2	8.6	2.6	1.4	0.8	1.5	▲1.0	▲0.1	2.7	2.1	3.3	0.8	2.0	0.2	0.0	▲3.2	2.7	2.3	—

(Note) 1. GDP is based on the national accounting announced by the Cabinet Office.

2. Medical expenses for the elderly (seniors) were medical expenses for the elderly up until March 2008 before the implementation of the late-stage elderly medical care system, and medical expenses for the late-stage elderly from April 2008 onwards after the implementation of the system.

3. National medical expenses (and those of FY2023 for the advanced elderly. The same applies hereinafter) in FY2023 are estimates including the actual performance. The expenses for FY2023 are estimated by multiplying the national medical expenses for FY2022 by the rate of increase in approximate medical expenses in FY2023 (figures written in italics in the table above).

*1. The budget freezing measure for co-payment ratios of persons aged 70 to 74 was lifted (10%→20%). 20% is applied to persons who reached 70 years of age in April 2014 or after and the ratio of 10% is left unchanged for persons who reached 70 years of age in March 2014 or before.

*2 For FY2021 and FY2023, the medical expenses of the relevant fiscal year were used to convert the impact of NHI drug price revision into a rate relative to medical expenses.

Detailed Data 1 Health Expenditures of OECD Countries (2022)

Country	Total medical care expenditure in GDP (%)		Per capita medical care expenditure		Remarks
		rank		rank	
United States	16.5	1	12,742	1	
Germany	12.6	2	8,541	4	
France	11.9	3	6,924	10	
Switzerland	11.7	4	9,044	2	
Japan	11.4	5	5,424	19	
New Zealand	11.3	6	6,293	15	
Canada	11.2	7	6,845	12	
Austria	11.2	8	7,623	5	
United Kingdom	11.1	9	5,867	17	
Belgium	10.8	10	6,994	8	
Sweden	10.5	11	7,009	7	
Portugal	10.5	12	4,521	25	
Netherlands	10.1	13	7,277	6	
Chile	10.0	14	3,186	30	
Australia	9.9	15	6,892	11	
Spain	9.7	16	4,534	24	
Finland	9.7	17	5,856	18	
Slovenia	9.6	18	4,710	21	
Denmark	9.5	19	6,665	14	

Country	Total medical care expenditure in GDP (%)		Per capita medical care expenditure		Remarks
		rank		Rank	
Korea	9.4	20	4,637	22	
Iceland	9.1	21	6,020	16	
Italy	9.0	22	4,736	20	
Czech	8.8	23	4,633	23	
Greece	8.5	24	3,214	29	
Norway	7.9	25	8,636	3	
Slovakia	7.7	26	3,128	31	
Latvia	7.6	27	3,098	32	
Columbia	7.6	28	1,630	37	
Israel	7.3	29	3,694	27	
Lithuania	7.2	30	3,723	26	
Costa Rica	7.2	31	1,769	35	
Estonia	7.0	32	3,236	28	
Hungary	6.7	33	3,000	34	
Poland	6.4	34	3,066	33	
Ireland	6.1	35	6,730	13	
Mexico	5.7	36	1,401	38	
Luxembourg	5.6	37	6,933	9	
Turkiye	3.7	38	1,660	36	

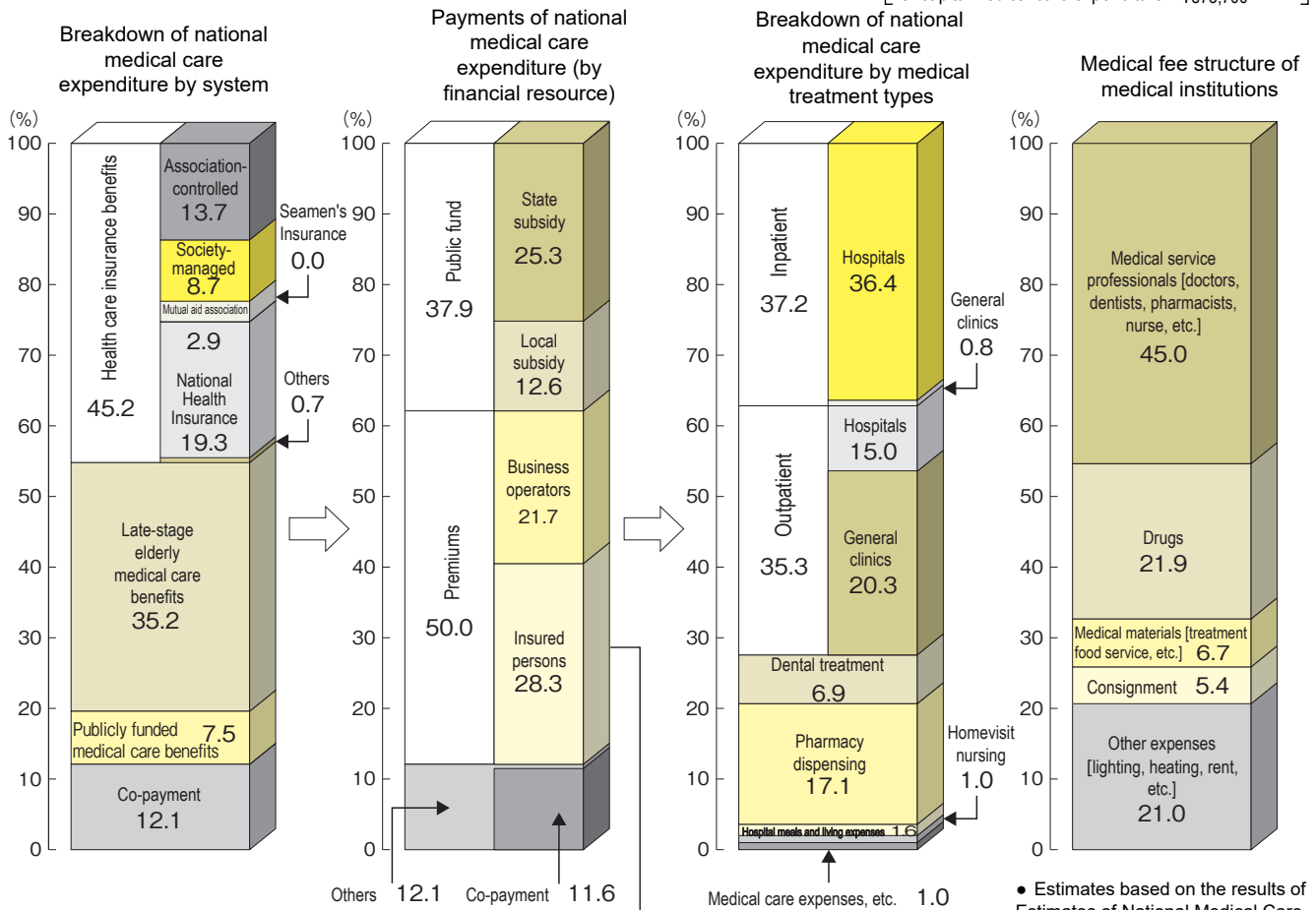
OECD average	9.2		5,313	
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Source: "OECD Data Explorer"

(Note) The rank in this table indicates the rank among OECD member countries.

Detailed Data 2 Structure of National Medical Care Expenditure (FY 2022)

National medical care expenditure ¥46,696.7 billion
Per capita medical care expenditure ¥373,700



• Insured persons' burden includes National Health Insurance premiums

• Estimates based on the results of Estimates of National Medical Care Expenditure FY2022 and Survey on Economic Conditions in Health Care (2022), etc.

Detailed Data 3

Changes in National Medical Care Expenditure and Percentage Distribution

Year	Estimated amount	National medical care expenditure(¥100 million)									Dental medical fess	Pharmacy dispensing medical fees	Hospital meals and living expenses	Medical treatment fees at health service facilities for the elderly	Home-visit nursing medical fees
		General medical fees	Hospitals	General clinics	Inpatient medical fees	Hospitals	General clinics	Outpatient medical fees	Hospitals	General clinics					
National medical care expenditure(¥100 million)															
1962	6,132	5,372	2,948	2,424	2,344	2,072	272	3,028	875	2,153	759	...	...	...	...
1965	11,224	10,082	5,499	4,583	4,104	3,635	469	5,978	1,864	4,113	1,143	...	...	...	...
1970	24,962	22,513	12,121	10,392	8,799	7,801	998	13,714	4,320	9,394	2,448	...	...	...	...
1975	64,779	59,102	32,996	26,106	25,427	22,640	2,787	33,675	10,356	23,319	5,677	...	...	...	...
1980	119,805	105,349	62,970	42,379	48,341	43,334	5,007	57,008	19,636	37,372	12,807	1,649	...	...	...
1985	160,159	140,287	92,091	48,195	70,833	65,054	5,778	69,454	27,037	42,417	16,778	3,094	...	...	...
1990	206,074	179,764	123,256	56,507	85,553	80,470	5,082	94,211	42,786	51,425	20,354	5,290	...	666	...
1995	269,577	218,683	148,543	70,140	99,229	94,545	4,684	119,454	53,997	65,456	23,837	12,662	10,801	3,385	210
2000	301,418	237,960	161,670	76,290	113,019	108,642	4,376	124,941	53,028	71,913	25,569	27,605	10,003	...	282
2001	310,998	242,494	164,536	77,958	115,219	110,841	4,378	127,275	53,695	73,580	26,041	32,140	9,999	...	324
2002	309,507	238,160	162,569	75,591	115,537	111,180	4,357	122,623	51,389	71,234	25,875	35,297	9,835	...	339
2003	315,375	240,931	164,077	76,854	117,231	112,942	4,289	123,700	51,135	72,565	25,375	38,907	9,815	...	348
2004	321,111	243,627	164,764	78,863	118,464	114,047	4,417	125,163	50,717	74,446	25,377	41,935	9,780	...	392
2005	331,289	249,677	167,955	81,722	121,178	116,624	4,555	128,499	51,331	77,167	25,766	45,608	9,807	...	431
2006	331,276	250,468	168,943	81,525	122,543	117,885	4,658	127,925	51,058	76,867	25,039	47,061	8,229	...	479
2007	341,360	256,418	173,102	83,316	126,132	121,349	4,782	130,287	51,753	78,534	24,996	51,222	8,206	...	518
Percentage distribution (%)															
1962	100.0	87.6	48.1	39.5	38.2	33.8	4.4	49.4	14.3	35.1	12.4	...	...	...	...
1965	100.0	89.8	49.0	40.8	36.6	32.4	4.2	53.3	16.6	36.6	10.2	...	...	...	...
1970	100.0	90.2	48.6	41.6	35.2	31.3	4.0	54.9	17.3	37.6	9.8	...	...	...	...
1975	100.0	91.2	50.9	40.3	39.3	34.9	4.3	52.0	16.0	36.0	8.8	...	...	...	...
1980	100.0	87.9	52.6	35.4	40.3	36.2	4.2	47.6	16.4	31.2	10.7	1.4	...	...	...
1985	100.0	87.6	57.5	30.1	44.2	40.6	3.6	43.4	16.9	26.5	10.5	1.9	...	...	...
1990	100.0	87.2	59.8	27.4	41.5	39.0	2.5	45.7	20.8	25.0	9.9	2.6	...	0.3	...
1995	100.0	81.1	55.1	26.0	36.8	35.1	1.7	44.3	20.0	24.3	8.8	4.7	4.0	1.3	0.1
2000	100.0	78.9	53.6	25.3	37.5	36.0	1.5	41.5	17.6	23.9	8.5	9.2	3.3	...	0.1
2001	100.0	78.0	52.9	25.1	37.0	35.6	1.4	40.9	17.3	23.7	8.4	10.3	3.2	...	0.1
2002	100.0	76.9	52.5	24.4	37.3	35.9	1.4	39.6	16.6	23.0	8.4	11.4	3.2	...	0.1
2003	100.0	76.4	52.0	24.4	37.2	35.8	1.4	39.2	16.2	23.0	8.0	12.3	3.1	...	0.1
2004	100.0	75.9	51.3	24.6	36.9	35.5	1.4	39.0	15.8	23.2	7.9	13.1	3.0	...	0.1
2005	100.0	75.4	50.7	24.7	36.6	35.2	1.4	38.8	15.5	23.3	7.8	13.8	3.0	...	0.1
2006	100.0	75.6	51.0	24.6	37.0	35.6	1.4	38.6	15.4	23.2	7.6	14.2	2.5	...	0.1
2007	100.0	75.1	50.7	24.4	36.9	35.5	1.4	38.2	15.2	23.0	7.3	15.0	2.4	...	0.2

Year	Estimated amount	Medical fees of medical treatment	National medical care expenditure(¥100 million)									Dental medical fess	Pharmacy dispensing medical fees	Hospital meals and living expenses	Home-visit nursing medical fees	Medical care expenses, etc.
			Hospitals	General clinics	Inpatient medical fees	Hospitals	General clinics	Outpatient medical fees	Hospitals	General clinics						
National medical care expenditure(¥100 million)																
2008	348,084	254,452	172,298	82,154	128,205	123,685	4,520	126,247	48,613	77,634	25,777	53,955	8,152	605	5,143	
2009	360,067	262,041	178,848	83,193	132,559	128,266	4,293	129,482	50,582	78,900	25,587	58,228	8,161	665	5,384	
2010	374,202	272,228	188,276	83,953	140,908	136,416	4,492	131,320	51,860	79,460	26,020	61,412	8,297	740	5,505	
2011	385,850	278,129	192,816	85,314	143,754	139,394	4,359	134,376	53,421	80,954	26,757	66,288	8,231	808	5,637	
2012	392,117	283,198	197,677	85,521	147,566	143,243	4,323	135,632	54,434	81,197	27,132	67,105	8,130	956	5,597	
2013	400,610	287,447	201,417	86,030	149,667	145,523	4,144	137,780	55,894	81,886	27,368	71,118	8,082	1,086	5,509	
2014	408,071	292,506	205,438	87,067	152,641	148,483	4,158	139,865	56,956	82,909	27,900	72,846	8,021	1,256	5,543	
2015	423,644	300,461	211,860	88,601	155,752	151,772	3,980	144,709	60,088	84,622	28,294	79,831	8,014	1,485	5,558	
2016	421,381	301,853	214,666	87,187	157,933	154,077	3,856	143,920	60,589	83,332	28,574	75,867	7,917	1,742	5,427	
2017	430,710	308,335	219,675	88,660	162,116	158,228	3,888	146,219	61,447	84,772	29,003	78,108	7,954	2,023	5,287	
2018	433,949	313,251	224,435	88,816	165,535	161,705	3,831	147,716	62,730	84,986	29,579	75,687	7,917	2,355	5,158	
2019	443,895	319,583	230,236	89,347	168,992	165,209	3,783	150,591	65,027	85,564	30,150	78,411	7,901	2,727	5,124	
2020	429,665	307,813	222,715	85,098	163,353	159,646	3,707	144,460	63,069	81,391	30,022	76,480	7,494	3,254	4,602	
2021	450,359	324,025	232,664	91,361	168,551	164,849	3,702	155,474	67,815	87,659	31,479	78,794	7,407	3,929	4,725	
2022	466,967	338,225	239,821	98,434	173,524	169,863	3,661	164,731	69,958	94,773	32,275	79,903	7,290	4,633	4,610	
Percentage distribution (%)																
2008	100.0	73.1	49.5	23.6	36.8	35.5	1.3	36.3	14.0	22.3	7.4	15.5	2.3	0.2	1.5	
2009	100.0	72.8	49.7	23.1	36.8	35.6	1.2	36.0	14.0	21.9	7.1	16.2	2.3	0.2	1.5	
2010	100.0	72.7	50.3	22.4	37.7	36.5	1.2	35.1	13.9	21.2	7.0	16.4	2.2	0.2	1.5	
2011	100.0	72.1	50.0	22.1	37.3	36.1	1.1	34.8	13.8	21.0	6.9	17.2	2.1	0.2	1.5	
2012	100.0	72.2	50.4	21.8	37.6	36.5	1.1	34.6	13.9	20.7	6.9	17.1	2.1	0.2	1.4	
2013	100.0	71.8	50.3	21.5	37.4	36.3	1.0	34.4	14.0	20.4	6.8	17.8	2.0	0.3	1.4	
2014	100.0	71.7	50.3	21.3	37.4	36.4	1.0	34.3	14.0	20.3	6.8	17.9	2.0	0.3	1.4	
2015	100.0	70.9	50.0	20.9	36.8	35.8	0.9	34.2	14.2	20.0	6.7	18.8	1.9	0.4	1.3	
2016	100.0	71.6	50.9	20.7	37.5	36.6	0.9	34.2	14.4	19.8	6.8	18.0	1.9	0.4	1.3	
2017	100.0	71.6	51.0	20.6	37.6	36.7	0.9	33.9	14.3	19.7	6.7	18.1	1.8	0.5	1.2	
2018	100.0	72.2	51.7	20.5	38.1	37.3	0.9	34.0	14.5	19.6	6.8	17.4	1.8	0.5	1.2	
2019	100.0	72.0	51.9	20.1	38.1	37.2	0.9	33.9	14.6	19.3	6.8	17.7	1.8	0.6	1.2	
2020	100.0	71.6	51.8	19.8	38.0	37.2	0.9	33.6	14.7	18.9	7.0	17.8	1.7	0.8	1.1	
2021	100.0	71.9	51.7	20.3	37.4	36.6	0.8	34.5	15.1	19.5	7.0	17.5	1.6	0.9	1.0	
2022	100.0	72.4	51.4	21.1	37.2	36.4	0.8	35.3	15.0	20.3	6.9	17.1	1.6	1.0	1.0	

Source: "Estimates of National Medical Care Expenditure", Health Insurance Bureau, MHLW

(Note)

1. With the launch of long-term care insurance system in April 2000, some of the expenses that were subjected to national medical care expenditure were transferred to long-term care insurance fees and are no longer included in national medical care expenditure on and after FY 2000.
2. Pharmacy dispensing was included in outpatient medical fees until they were newly classified as a separate item in FY1977.
3. Figures until FY2005 indicate "hospital meal expenses" (total amount of hospital meal expenses and standard co-payment) and figures since FY2006 indicate the total amount of hospital meal expenses, standard co-payment for meal expenses, hospital living expenses, and standard co-payment for living expenses.
4. Medical treatment fees at health service facilities for the elderly are not included in national medical care expenditure on and after FY 2000 because these fees are those who are certified for long-term care need.
5. "Medical fees of medical treatment" and "medical care expenses, etc." were included in "general medical fees" until they were newly classified as a separate item in FY 2008.

	FY	Total	Medical fees			Dispensing	Hospital meals and living	Home-visit nursing	Medical treatment etc.	Health service facilities for the elderly	
			Inpatient	Outpatient	Dental						
Actual amount (¥100 million)	FY 1983	33,185	31,966	17,785	13,405	776	640	.	.	579	.
	FY 1984	36,098	34,645	19,725	14,025	895	689	.	.	764	.
	FY 1985	40,673	38,986	22,519	15,433	1,034	785	.	.	902	.
	FY 1986	44,377	42,445	24,343	16,924	1,178	902	.	.	1,030	.
	FY 1987	48,309	46,104	26,247	18,605	1,252	1,037	.	.	1,168	.
	FY 1988	51,593	49,138	27,798	19,975	1,365	1,133	.	.	1,296	26
	FY 1989	55,578	52,573	29,400	21,743	1,430	1,312	.	.	1,441	253
	FY 1990	59,269	55,669	30,724	23,315	1,630	1,457	.	.	1,523	619
	FY 1991	64,095	59,804	32,325	25,705	1,773	1,689	.	.	1,633	970
	FY 1992	69,372	64,307	35,009	27,249	2,049	1,992	.	5	1,626	1,442
	FY 1993	74,511	68,530	36,766	29,536	2,228	2,529	.	29	1,535	1,888
	FY 1994	81,596	72,501	38,235	31,790	2,476	3,133	1,855	86	1,439	2,582
	FY 1995	89,152	75,910	38,883	34,319	2,708	3,909	4,678	174	1,224	3,259
	FY 1996	97,232	82,181	42,314	36,789	3,078	4,620	4,816	323	1,094	4,198
	FY 1997	102,786	85,475	44,205	37,965	3,305	5,606	4,869	479	1,073	5,285
	FY 1998	108,932	88,881	46,787	38,584	3,511	6,900	4,967	657	1,101	6,426
	FY 1999	118,040	94,653	49,558	41,181	3,915	8,809	5,115	858	1,169	7,436
	FY 2000	111,997	94,640	48,568	41,871	4,200	10,569	4,612	235	1,271	670
	FY 2001	116,560	97,954	50,296	43,243	4,416	12,462	4,677	191	1,277	-2
	FY 2002	117,300	97,155	51,198	41,434	4,522	13,913	4,689	192	1,352	-1
	FY 2003	116,524	95,653	51,828	39,609	4,216	14,711	4,645	174	1,342	-1
	FY 2004	115,764	94,429	52,048	38,371	4,010	15,143	4,654	190	1,348	-0
	FY 2005	116,444	94,441	52,867	37,726	3,848	15,777	4,679	205	1,342	-0
	FY 2006	112,594	91,492	51,822	36,129	3,540	15,579	3,970	225	1,329	-0
FY 2007	112,753	91,048	52,167	35,524	3,357	16,245	3,877	239	1,345	-	
FY 2008	114,146	91,558	53,009	35,029	3,520	17,035	3,850	264	1,439	-0	
FY 2009	120,108	95,672	55,594	36,381	3,698	18,717	3,914	289	1,517	.	
FY 2010	127,213	101,630	59,994	37,654	3,981	19,631	4,015	318	1,620	.	
FY 2011	132,991	105,409	62,170	38,980	4,260	21,489	4,029	341	1,725	.	
FY 2012	137,044	108,751	64,094	40,139	4,518	22,111	4,012	404	1,767	.	
FY 2013	141,912	111,837	65,599	41,484	4,753	23,798	4,028	461	1,788	.	
FY 2014	144,927	114,063	67,121	41,978	4,963	24,488	4,024	529	1,823	.	
FY 2015	151,323	118,083	69,219	43,643	5,221	26,698	4,063	616	1,862	.	
FY 2016	153,806	121,143	71,393	44,259	5,491	26,017	4,058	723	1,865	.	
FY 2017	160,229	126,372	74,905	45,695	5,772	26,996	4,155	839	1,867	.	
FY 2018	164,246	130,712	77,685	46,921	6,106	26,490	4,207	983	1,854	.	
FY 2019	170,562	135,733	80,577	48,692	6,464	27,527	4,257	1,150	1,895	.	
FY 2020	165,681	131,743	78,666	46,929	6,148	26,886	4,063	1,373	1,617	.	
FY 2021	170,763	136,482	80,751	49,134	6,597	26,972	4,015	1,642	1,652	.	
FY 2022	178,379	143,571	85,168	51,380	7,023	27,152	4,011	1,994	1,651	.	

(Note) 1. Terms are defined as follows.

a. Medical fees: Expenses paid for medical care services received at insurance medical care facilities. (excluding insurance pharmacies, etc.). (Benefit in kind)

b. Dispensing: Refers to the expenses paid when receiving medicine at an insurance-covered pharmacy (Benefit in kind)

c. Hospital Meals and living: Meal and living expenses during hospitalization. (Benefit in kind)

d. Home-visit nursing: Expenses paid for home-visit nursing care services by the specified service providers. (Benefit in kind)

e. Medical treatment, etc.: Expenses paid for prosthetic devices or treatment by judo therapists in accordance with Articles 77 and 83 of the Act on Assurance of Medical Care for Elderly People. (Benefit in cash)

f. Health services facilities for the elderly: Expenses paid for facility treatment at health service facilities for the elderly. (Benefit in kind)(Not applicable after March 2000)

g. Expenses include co-payment, standard co-payment for meal/living expenses, and basic fees of home-visit nursing.

2. The figures up to March 2008 are for those subjected to medical services that are provided in the Health and Medical Services Act for the Aged.

3. The figures for FY2008 include delayed requests for health expenditure for the elderly from April 2008 to February 2009.

4. The figures for FY2011 do not include the Great East Japan Earthquake related health expenditure, etc. (¥4.5 billion of the total of estimated payment requests and health expenditure of unknown insurers).

5. The figures for FY2016 do not include the medical expenses related to the 2016 Kumamoto Earthquake (¥50 million of the total estimated payment requests and health expenditure of unknown insurers).

6. The figures for FY2018 do not include the health expenditure, etc. related to the damage of Typhoon No. 7 and Heavy Rain Event of August 2018 associated with the rain front, the 2018 Hokkaido Eastern Iburi Earthquake and Typhoon No. 21 (¥0.4 billion of the total of estimated payment requests and health expenditure of unknown insurers).

7. The figures for FY 2019 do not include medical expenses, etc. related to the damage caused by Typhoon No. 15 and No. 19 in 2019 (200 million yen in total for estimated billing payments and for medical expenses for unknown insurers).

8. The figures for FY 2020 do not include medical expenses etc. related to the damage caused by rainstorm in July 2020 (400 million yen in total for estimated billing payments and for medical expenses for unknown insurers).

Source "Annual report on the medical-care system for the latter-stage elderly", Health Insurance Bureau, MHLW

Financial Status of Health Insurance System

Overview

Finance Status of the Health Insurance System (FY 2022 Settled Account)

(Unit: ¥100 million)

		Government-managed Health Insurance/JHIA-managed Health Insurance	Society-managed Health Insurance	National Health Insurance (municipalities)	Seamen's Insurance	Medical care system for the elderly aged 75 and over
Operating revenue	Premium (tax) revenue	100,421	84,888	22,478	319	14,865
	National treasury contribution	12,456	27	30,567	29	53,065
	Prefectural contribution	—	—	10,408	—	16,375
	Municipal contribution	—	—	5,884	—	14,115
	Grants for late-stage elderly	—	—	—	—	67,178
	Grants for early-stage elderly	—	0	35,397	—	—
	Retirement grants	—	—	▲4	—	—
	Others	187	1,144	123,083	1	290
Total		113,063	86,059	227,814	350	165,888
Operating expenditure	Insurance benefit expenses	69,519	44,903	86,244	205	164,749
	Late-stage elderly support coverage	20,557	19,641	15,082	69	—
	Levies for early-stage elderly	15,310	14,413	40	24	—
	Contributions for retirees	1	0	—	0	—
	Others	3,388	5,733	126,227	8	1,126
	Total		108,774	84,691	227,594	306	165,875
Balance of ordinary revenue and expenditure		4,289	1,368	220	43	13

		Government-managed Health Insurance/JHIA-managed Health Insurance	Society-managed Health Insurance
Non-operating revenue	Deferred repayment of state subsidy	-	-
	Non-operating subsidy for benefits, etc.	-	559
	Adjustment premium revenue	-	1,239
	Subsidies to financial adjustment programs	-	1,168
	Transfer from reserves, etc. and surplus carried forward	-	4,690
	Others	30	118
	Total		30	7,778
Non-operating expenditure	Contribution to financial adjustment programs	-	1,233
	Others	-	156
	Total		-	1,389
Balance of non-operating revenue and expenditure		30	6,389 (1,698)
Balance of total revenue and expenditure		4,319	7,756 (3,066)
Reserve fund, etc.		47,414	63,022

- (Note) 1. The above figures indicate medical service revenue and expenditure.
 2. The operating revenue of the National Health Insurance (operated by municipalities) is the total amount of special account of the municipalities or prefectures. The current account includes an extra-legal transfer from the Municipal General Account for use in covering the settlement of accounts.
 3. The amounts of the national subsidy, etc. for National Health Insurance (operated by municipalities) and the late-stage medical care system for the elderly were adjusted in the following fiscal year.
 4. The figures in parentheses for the Society-managed Health Insurance indicate the net balance between non-operating revenue and expenditure and the balance between total revenue and expenditure, but exclude transfers from reserves, etc. and surpluses carried forward.
 5. Reserve fund, etc. indicates reserves for the Japan Health Insurance Association-managed Health Insurance. It includes reserves, a reserve fund (¥5,721.8 billion), and assets such as land and buildings, etc. for the Society-managed Health Insurance.
 6. In the non-operating revenue of the Japan Health Insurance Association-managed Health Insurance, operation account surplus at the end of FY2020 was added to FY2021 settlement of accounts.
 7. The balance of total revenue and expenditure for the Japan Health Insurance Association-managed Health Insurance and Society-managed Health Insurance indicates the sum of the balance of operating revenue and expenditure and the balance of non-operating revenue and expenditure.
 8. The figures may not equal the total, or balance of accounts may vary due to rounding.

Source: Health Insurance Bureau, MHLW

(2) Medical Care Provision System

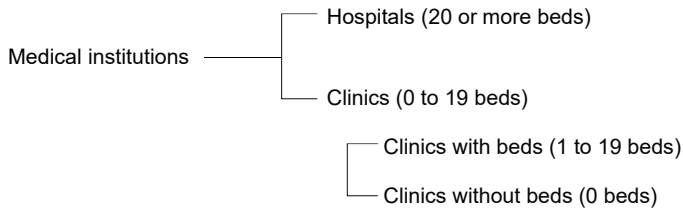
Types of Medical Institutions

Overview

Types of Medical Institutions

1. Hospitals, Clinics

The Medical Care Act restricts the sites of medical practice to hospitals and clinics. Hospitals and clinics are classified as follows: hospitals are medical institutions with 20 or more beds and clinics are those with no beds or 19 or less beds.



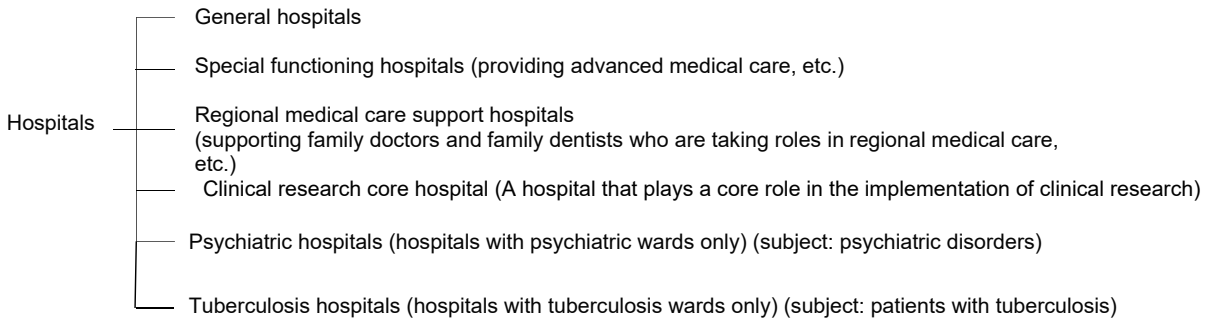
Hospitals are required to provide truly scientific and appropriate treatment to injured or sick people and are expected to have substantial facilities.

There is no strict regulation on facilities for clinics with 19 or less beds compared to hospitals.

2. Types of Hospitals

The Medical Care Act provides requirements (staff deployment standards, facility standards, responsibilities of managers, etc.) that are different from general hospitals for hospitals with special functions (special functioning hospitals, regional medical care support hospitals, clinical research core hospital) and accepts hospitals that satisfy requirements to use the name.

In addition, separate staff deployment standards and facility standards are provided for some beds in consideration of differences in subjects of patients (patients with psychiatric disorders or tuberculosis).



Detailed Information 1

Outline of Special Functioning Hospitals

Purpose

As part of efforts to systematize medical facility functions, the Minister of Health, Labour and Welfare approves individual hospitals having capabilities of providing advanced medical care, development of advanced medical technologies, and conducting advanced medical care training.

Roles

- Provide advanced medical care
- Develop/evaluate advanced medical technologies
- Conduct advanced medical care training

Requirements for Approval

- Having capabilities of providing, developing, evaluating, and conduct training of advanced medical care
- Providing medical care to patients who are referred to by other hospitals or clinics (maintaining the incoming referral rate of at least 50% and the outgoing referral rate of at least 40%)
- Number of beds Must have 400 or more beds.
- Staff deployment
 - Doctors Twice as many as ordinary hospitals, etc. In addition, half the number of doctors specified by the staff More than half of the doctors placement criteria must b from deployment standards must be any of the 15 specialists.
 - Pharmacists The minimum standard is 1/30 of the number of patients. (That for ordinary hospitals is 1/70 of the number of patients)
 - Nurses, etc. The minimum standard is 1/2 of the number of patients. (That for ordinary hospitals is 1/3 of the number of patients)
 - Deployment of at least one registered dietitian
- Facilities Must have intensive care units, sterile rooms, and drug information management rooms.
- Improvement of patient safety management system
 - Placement of staff responsible for patient safety management
 - Placement of full-time doctors, pharmacists and nurses in the patient safety management department
 - Mandatory reporting of all death cases, etc.
 - Establishment if a department to decide the suitability of medical provision using high-difficulty new medical technology and unapproved new medicines
 - External audits by the Audit Committee
- Professing 16 specified clinical areas in principle.
- Having at least 70 papers written in English published annually in refereed journals, etc.
- Regarding specific function hospitals corresponding to specific areas such as cancer, separate approval requirements are set for the advocacy of clinical department, introduction rate, reverse introduction rate, etc.

*The number of approved hospitals (as of April 1, 2025) 88 Hospitals

Detailed Information 2

Regional Medical Care Support Hospital System

Purpose

Given the viewpoint that it is desirable to provide care to patients in their neighborhood area, a specific function hospital was founded subject to the 1997 revision of the Medical Care Act, as a hospital of supporting family doctors and dentists in charge of regional medical care provision for referral patients and joint utilization of medical devices, etc., as well as a hospital ensuring regional medical care. The approval of the foundation is given by the concerned prefectural governor individually.

Roles

- Provide medical care to patients on referral (including the reverse case in which patients are referred to family doctors)
- Implement shared use of medical devices
- Provide emergency medical care
- Conduct training for regional medical professionals

Requirements for Approval

- Principal entity of foundation: Government prefecture municipality social medical corporation medical corporation, etc. in principle
- Providing medical care mainly to referred patients (meeting one of the following)
 - [1] Incoming referred rate of at least 80%
 - [2] Incoming referred rate of at least 65% and outgoing referred rate of at least 40%
 - [3] Incoming referred rate of at least 50% and outgoing referred rate of at least 70%
- Having the ability to provide emergency medical care
- Securing a system to enable doctors, etc. in regions to use buildings, facilities, and devices, etc.
- Holding trainings for those engaged in regional medical care at least 12 times annually
- Having at least 200 hospital beds in principle and facilities appropriate for being regional medical care support hospitals, etc.

*The number of approved hospitals (as of the September, 2024) 707 Hospitals

Detailed Information 3

Outline of Clinical Research Core Hospital System

Purpose

As part of efforts to systematize medical facility functions, the Minister of Health, Labour and Welfare approves individual hospitals having capabilities of playing a core role in the implementation of clinical research.

Roles

- Design a plan for a specified clinical research and conduct it
- Play a leading role in the implementation of a specified clinical research in case where it is conducted in cooperation with another hospital or clinic
- Provide another hospital or clinic with consultations on the implementation of specified clinical researches and necessary information, advice or another type of assistance
- Provide trainings on specified clinical researches

Requirement of Approval

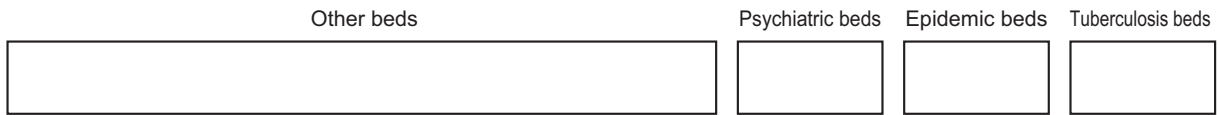
- Number of specified clinical researches conducted (in the past three years)
 - Number of specified clinical researches conducted by its own.....8 or more clinical trials led by doctors or 4 or more clinical trials led by doctors and 40 or more specified clinical researches
 - Number of specified clinical researches conducted jointly with different facilities.....2 or more clinical trials led by doctors or 20 or more specified clinical researches
- Number of papers on specified clinical researches (in the past three years)45 cases or more
- Number of cases where assistance was provided for specified clinical researches conducted by other medical institutions (in the past year)15 cases or more
- Training on high-quality clinical researches
 - Number of workshops held for persons who conduct specified clinical researches (in the past year)6 times or more
 - Number of workshops held for persons who support specified clinical researches (in the past year)6 times or more
 - Number of workshops held for members of Certified Review Board (in the past year) 3 times or more
- Having 10 or more specified clinical departments
- Number of hospital beds: Having at least 400 hospital beds
- Staff deployment
 - Doctors and dentists: 5 persons or more
 - Pharmacists: 5 persons or more
 - Nurses: 10 persons or more
 - Clinical research coordinators, etc.: 24 persons or more
 - Data managers: 3 persons or more
 - Biological statisticians: 2 persons or more
 - Persons who have experience in working in pharmaceutical affairs approval examination bodies: 1 person or more
- Facilities: Must have clinical research facilities with equipment to ensure accuracy of researches and intensive care units
- The requirements for approval concerning the number of new specified clinical researches conducted and the number of papers on specified clinical researches are separately set for clinical research core hospitals that deal with specific areas.

* The number of approved hospitals (as of April 1, 2025) 15 Hospitals

Detailed Information 4

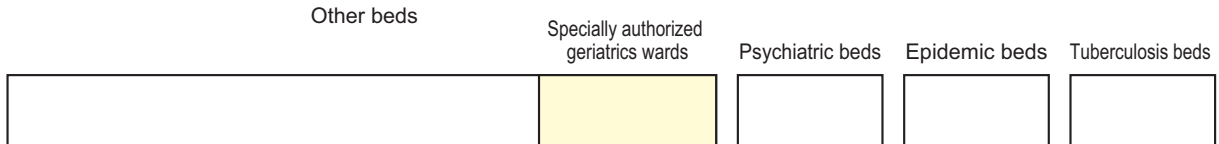
Revision of Bed Classification

[At the beginning (from 1948)]



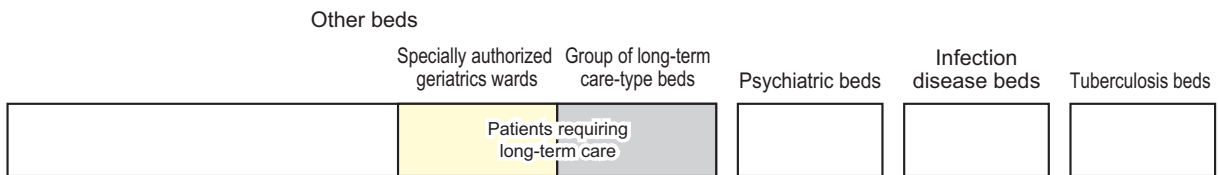
- Progress of aging
- Changes in disease structure

[Introduction of specially authorized geriatrics wards (1983)]



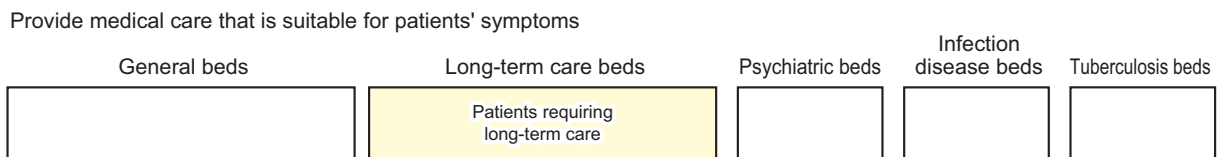
- In order to cope with the progress in aging and changes in disease structure, it was necessary to create facilities to provide medical care not only for elderly but for "patients requiring long-term care" in general.

[Creation of long-term care-type bed group system (1992)]



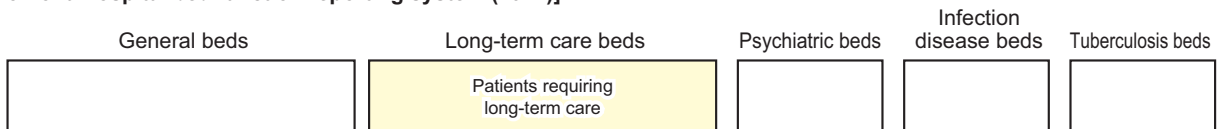
- The number of patients requiring long-term care increased due to changes in disease structure caused by the rapid progress in the birth rate decline and aging. Although various systems have been created, including long-term care-type bed group system, patients with various symptoms are still intermingled.

[Creation of general beds and long-term care beds (2000)]



- In order to promote division/cooperation of medical functions, identifying and analyzing information on medical functions implemented by the respective medical institutions in regions is important.

[Creation of a hospital bed function reporting system (2014)]



A system for selecting one of highly acute phase, acute phase, recovery phase, and chronic phase functions and reporting the function of general hospital beds and long-term care beds in each hospital ward was created.

Trends with Medical Institutions

Overview

Changes in Number of Medical Institutions (Hospitals and Clinics)

Year	Hospitals	National (regrouped)	Public (regrouped)	Others (regrouped)	General clinics	Dental clinics
1877	159	12	112	35		
1882	626	(330)		296		
1892	576	(198)		378		
1897	624	3	156	465		
1902	746	4	151	591		
1907	807	5	101	691		
1926	3,429	(1,680)		1,749		
1930	3,716	(1,683)		2,033		
1935	4,625	(1,814)		2,811	35,772	18,066
1940	4,732	(1,647)		3,085	36,416	20,290
1945	645	(297)		348	6,607	3,660
1950	3,408	383	572	2,453	43,827	21,380
1955	5,119	425	1,337	3,357	51,349	24,773
1960	6,094	452	1,442	4,200	59,008	27,020
1965	7,047	448	1,466	5,133	64,524	28,602
1970	7,974	444	1,388	6,142	68,997	29,911
1975	8,294	439	1,366	6,489	73,114	32,565
1980	9,055	453	1,369	7,233	77,611	38,834
1985	9,608	411	1,369	7,828	78,927	45,540
1990	10,096	399	1,371	8,326	80,852	52,216
1995	9,606	388	1,372	7,846	87,069	58,407
1996	9,490	387	1,368	7,735	87,909	59,357
1997	9,413	380	1,369	7,664	89,292	60,579
1998	9,333	375	1,369	7,589	90,556	61,651
1999	9,286	370	1,368	7,548	91,500	62,484
2000	9,266	359	1,373	7,534	92,824	63,361
2001	9,239	349	1,375	7,515	94,019	64,297
2002	9,187	336	1,377	7,474	94,819	65,073
2003	9,122	323	1,382	7,417	96,050	65,828
2004	9,077	304	1,377	7,396	97,051	66,557
2005	9,026	294	1,362	7,370	97,442	66,732
2006	8,943	292	1,351	7,300	98,609	67,392
2007	8,862	291	1,325	7,246	99,532	67,798
2008	8,794	276	1,320	7,198	99,083	67,779
2009	8,739	275	1,296	7,168	99,635	68,097
2010	8,670	274	1,278	7,118	99,824	68,384
2011	8,605	274	1,258	7,073	99,547	68,156
2012	8,565	274	1,252	7,039	100,152	68,474
2013	8,540	273	1,242	7,025	100,528	68,701
2014	8,493	329	1,231	6,933	100,461	68,592
2015	8,480	329	1,227	6,924	100,995	68,737
2016	8,442	327	1,213	6,902	101,529	68,940
2017	8,412	327	1,211	6,874	101,471	68,609
2018	8,372	324	1,207	6,841	102,105	68,613
2019	8,300	322	1,202	6,776	102,616	68,500
2020	8,238	321	1,199	6,718	102,612	67,874
2021	8,205	320	1,194	6,691	104,292	67,899
2022	8,156	316	1,195	6,645	105,182	67,755
2023	8,122	317	1,191	6,614	104,894	66,818

Source: 1875-1937: "Annual Report of Public Health", Ministry of Internal Affairs

1938-1952: "Annual Report of Public Health", Ministry of Health and Welfare

From 1953 on: "Survey of Medical Institutions", Health Statistics Office to the Councilor, Director-General for Statistics, Information System Management and Industrial Relations, MHLW

(Note) The figures in parentheses indicate the total number of public sector medical institutions.

Detailed Data 1

Changes in Number of Hospitals by Establishing Organization and Number of Beds

	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023
Total	8,605	8,565	8,540	8,493	8,480	8,442	8,412	8,372	8,300	8,238	8,205	8,156	8,122
National	274	274	273	329	329	327	327	324	322	321	320	316	317
Public medical institutions	1,258	1,252	1,242	1,231	1,227	1,213	1,211	1,207	1,202	1,199	1,194	1,195	1,191
Social insurance organizations	121	118	115	57	55	53	52	52	51	49	47	47	46
Medical corporations	5,712	5,709	5,722	5,721	5,737	5,754	5,766	5,764	5,720	5,687	5,681	5,658	5,658
Private	373	348	320	289	266	240	210	187	174	156	137	126	107
Others	867	864	868	866	866	855	846	838	831	826	826	814	803
20-99 beds	3,182	3,147	3,134	3,092	3,069	3,039	3,007	2,977	2,945	2,970	2,956	2,913	2,916
100-299 beds	3,877	3,882	3,873	3,873	3,888	3,890	3,905	3,906	3,892	3,828	3,818	3,822	3,801
300-499 beds	1,090	1,087	1,083	1,091	1,098	1,095	1,089	1,081	1,062	1,046	1,040	1,033	1,024
500+ beds	456	449	450	437	425	418	411	408	401	394	391	388	381

Source: "Survey of Medical Institutions", Health Statistics Office to the Councilor, Director-General for Statistics, Information System Management and Industrial Relations, MHLW

Detailed Data 2 Changes in Number of Hospitals by Hospital Type

	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023
Total	8,605	8,565	8,540	8,493	8,480	8,442	8,412	8,372	8,300	8,238	8,205	8,156	8,122
Psychiatric hospitals	1,076	1,071	1,066	1,067	1,064	1,062	1,059	1,058	1,054	1,059	1,053	1,056	1,057
Tuberculosis sanatorium	1	1	-	-	-	-	-	-	-	-	-	-	-
General hospitals	7,528	7,493	7,474	7,426	7,416	7,380	7,353	7,314	7,246	7,179	7,152	7,100	7,065

Source: "Survey of Medical Institutions", Health Statistics Office to the Councilor, Director-General for Statistics, Information System Management and Industrial Relations, MHLW

Detailed Data 3 Changes in Number of Beds by Bed Type and Number of Beds per Hospital

	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023
Total	1,583,073	1,578,254	1,573,772	1,568,261	1,565,968	1,561,005	1,554,879	1,546,554	1,529,215	1,507,526	1,500,057	1,492,957	1,481,183
Psychiatric beds	344,047	342,194	339,780	338,174	336,282	334,258	331,700	329,692	326,666	324,481	323,502	321,828	318,921
Infectious disease beds	1,793	1,798	1,815	1,778	1,814	1,841	1,876	1,882	1,888	1,904	1,893	1,909	1,911
Tuberculosis beds	7,681	7,208	6,602	5,949	5,496	5,347	5,210	4,762	4,370	4,107	3,944	3,863	3,744
Long-term care beds	330,167	328,888	328,195	328,144	328,406	328,161	325,228	319,506	308,444	289,114	284,662	278,694	273,745
General beds	899,385	898,166	897,380	894,216	893,970	891,398	390,865	890,712	887,847	887,920	886,056	886,663	882,862
Number of beds per hospital	184.0	184.3	184.3	184.7	184.7	184.9	184.8	184.7	184.2	183.0	182.8	183.1	182.4

Source: "Survey of Medical Institutions", Health Statistics Office to the Councilor, Director-General for Statistics, Information System Management and Industrial Relations, MHLW

Detailed Data 4 Changes in Bed Utilization Rate and Average Length of Stay by Bed Type

	Bed utilization rate												
	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023
Total	81.9	81.5	81.0	80.3	80.1	80.1	80.4	80.5	80.5	77.0	76.1	75.3	75.6
Psychiatric beds	89.1	88.7	88.1	87.3	86.5	86.2	86.1	86.1	85.9	84.8	83.6	82.3	81.6
Infectious disease beds	2.5	2.4	3.0	3.2	3.1	3.2	3.3	3.6	3.8	114.7	343.8	571.2	160.8
Tuberculosis beds	36.6	34.7	34.3	34.7	35.4	34.5	33.6	33.3	33.2	31.5	28.9	27.4	26.8
Long-term care beds	91.2	90.6	89.9	89.4	88.8	88.2	88.0	87.7	87.3	85.7	85.8	84.7	84.1
General beds	76.2	76.0	75.5	74.8	75.0	75.2	75.9	76.2	76.5	71.3	69.8	69.0	70.8
Long-term care beds for nursing care	94.6	93.9	93.1	92.9	92.1	91.4	90.9	91.3	90.7	88.1	85.9	80.4	75.8

	Average length of stay												
	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023
Total	32.0	31.2	30.6	29.9	29.1	28.5	28.2	27.8	27.3	28.3	27.5	27.3	26.3
Psychiatric beds	298.1	291.9	284.7	281.2	274.7	269.9	267.7	265.8	265.8	277	275.1	276.7	263.2
Infectious disease beds	10.0	8.5	9.6	8.9	8.2	7.8	8.0	8.3	8.5	9.8	10.1	10.5	13.3
Tuberculosis beds	71.0	70.7	68.8	66.7	67.3	66.3	66.5	65.6	64.6	57.2	51.3	44.5	42.1
Long-term care beds	175.1	171.8	168.3	164.6	158.2	152.2	146.3	141.5	135.9	135.5	131.1	126.5	119.6
General beds	17.9	17.5	17.2	16.8	16.5	16.2	16.2	16.1	16.0	16.5	16.1	16.2	15.7
Long-term care beds for nursing care	311.2	307.0	308.6	315.5	315.8	314.9	308.9	311.9	301.4	287.7	327.8	307.8	295.7

Source: "Hospital Report", Health Statistics Office to the Councilor, Director-General for Statistics, Information System Management and Industrial Relations, MHLW

- (Note) 1. The figures for March 2011 only include only the reported number of patients for 11 institutions (one in Kesen medical district, one in Miyako medical district of Iwate Prefecture, two in Ishinomaki medical district and two in Kesennuma medical district of Miyagi Prefecture, and five in Soso medical district of Fukushima Prefecture) due to the effect of the Great East Japan Earthquake.
2. The figures for April 2016 include the number of patients except for one institution in Kumamoto prefecture (Aso medical area) which didn't submit the report due to the impact of the 2016 Kumamoto earthquake.
3. The figures for July and August 2018 include the number of patients except for one institution in Hiroshima Prefecture (Osan Medical Area) which didn't submit the report due to the impact of the heavy rain in July 2018.
4. Due to the effects of the rainstorm in July 2020, in the reports for June and July 2020, only the number of patients reported was tallied for one hospital in Kumamoto Prefecture (Kuma Medical Area).
5. The number of inpatients refers to the number of patients who are in the hospital at 24:00 each day, regardless of the number of approved (designated) beds. For this reason, the number of inpatients in infectious disease beds may exceed 100% due to the inclusion of those in general beds as an emergency measure.

Overview of National Hansen's Disease Sanatoriums and National Hospital Organization, etc.

Overview

Overview of National Hansen's Disease Sanatoriums and National Hospital Organization, etc.

[National Hansen's Disease Sanatoriums]

- (1) 718 persons are admitted in 13 National Hansen's Disease Sanatoriums nationwide (as of May 1, 2024).
- (2) National Hansen's Disease Sanatoriums provide mainly Hansen's disease aftereffects and medical care and health care related to lifestyle diseases for those as a result of aging.

(Reference) Number of facilities

Classification	Number of facilities	Number of persons admitted
National Hansen's Disease Sanatoriums	13	718

Classification	Number of facilities	Students quota (persons)
Training schools for nurses (National Hansen's Disease Sanatoriums)	2	80

[National Hospital Organization]

- (1) National Hospital Organization is an independent administrative agency established and based on the "Act on the National Hospital Organization, Independent Administrative Agency" (Act No. 191 of 2002).
- (2) National Hospital Organization utilizes nationwide hospital networks and provides examination, treatment, clinical study, education, and training in an integrated manner for medical care requiring risk management and active contribution by the government, medical care in the area of safety net that is not always implemented by other establishing entities, and medical care for 5 diseases and 6 businesses with regional needs taken into consideration.

(Reference) Number of hospitals (as of April 1, 2025)

Institutions	Number of hospitals	Number of beds
National Hospital Organization	140	51,439

[National Research Center for Advanced and Specialized Medical Care]

- (1) National Research Centers for Advanced and Specialized Medical Care compose of 5 research-type national research and development agency established by shifting from National Centers for Advanced and Specialized Medical Care to non-public officer type independent administrative agencies under the "Act on National Research and Development Agency to Carry Out Research on Advanced Specialized Medical Services" (Act No. 93 of 2008)
- (2) National Research Centers for Advanced and Specialized Medical Care conduct comprehensive and unitary surveys, research and development of technology as well as providing medical treatment associated with such diseases and training for specialized medical professionals on diseases with a great impact on people's health such as cancer, cerebral apoplexy, and cardiac diseases

(Reference) Number of hospitals (as of April 1, 2025)

Institutions	Specialized diseases, etc.	Number of hospitals	Number of beds
National Cancer Center	Cancer and other malignant neoplasm	2	1,005
National Cerebral and Cardiovascular Center	CVDs including cardiac diseases, cerebral apoplexy, and hypertension	1	550
National Center of Neurology and Psychiatry	Mental diseases, neurological diseases, muscular diseases, mental retardation and other developmental disorders	1	486
National Center for Child Health and Development	Child health and development (pediatric care, maternity, paternal medicine, etc.)	1	490
National Center for Geriatrics and Gerontology	Geriatrics and gerontology (senile dementia, osteoporosis, etc.)	1	383

[Japan Institute for Health Security]

- (1) Japan Institute for Health Security is a special corporation established based on the "Act on Japan Institute for Health Security" (Act No. 46 of 2023)
- (2) In order to ensure appropriate medical care for infectious and other diseases, Japan Institute for Health Security conducts surveys, research, analysis, and technology development, as well as providing advanced and specialized medical care closely related to these activities, and trains human resources with regard to the cases that particularly require the collection of cases overseas and other international surveys and research, and cases that are related to international cooperation in prevention and medical care.

(Reference) Number of hospitals (as of April 1, 2025)

Institutions	Number of hospitals	Number of beds
Japan Institute for Health Security	2	1,133

(Reference) Number of facilities (as of April 1, 2025)

Classification	Number of facilities	Students quota (persons)
National College of Nursing (Japan Institute for Health Security)	1	400

[Japan Community Healthcare Organization]

- (1) Japan Community Healthcare Organization is an independent administrative agency established and based on "Act on the Japan Community Healthcare Organization, Independent Administrative Agency" (Act No. 71 of 2005).
- (2) Japan Community Healthcare Organization (JCHO) has a wide variety of medical functions, covering advanced emergency to chronic stages. Also, one of the main traits of JCHO is that about half of its hospitals have long-term care health facilities attached to them. Through utilization of such facilities and collaboration with regional medical personnel, JCHO provides medicine and care that are needed in regional communities, covering 5 diseases, 6 businesses, rehabilitation, and house care, etc., mutually complementing each other.

(Reference) Number of facilities (as of March 1, 2025)

Classification	Number of facilities	Number of beds
Hospital	57	15,035

Classification	Number of facilities	[Admission capacity]
Long-term care health facilities	23	2,190

Classification	Number of facilities	[Student capacity]
Nursing School	2	240

Medical Professionals

Overview Number of Physicians, etc.

The number of Physicians and dentists are increasing every year. As of December 31, 2022, there are 327,444 Physicians and 101,919 dentists.

Number of Medical Professionals

• Physicians	327,444 persons
• Dentists	101,919 persons
• Pharmacists	253,198 persons

Source: "Statistics of Physicians, Dentists and Pharmacists 2022", Health Statistics Office to the Councilor, Director-General for Statistics, Information System Management and Industrial Relations, MHLW

* Doctors and dentists are employees in medical facilities. Pharmacist are employees in pharmacies or medical facilities.

• Public health nurses	67,226 persons
• Midwives	41,608 persons
• Nurses	1,320,420 persons
• Assistant nurses	304,771 persons

Source: Calculated by the Nursing Division, the Health Policy Bureau, MHLW, based on the "Survey of Medical Institutions (Static Survey) 2020" and the "Report on Public Health Administration and Services (Biennial Report) 2020".

• Physical therapists (PT)	107,839.3 persons
• Occupational therapists (OT)	53,604.8 persons
• Orthoptists	11,142.0 persons
• Speech language hearing therapists	18,805.4 persons
• Orthotists	120.6 persons
• Clinical radiologic technologists	58,006.7 persons
• Medical technicians	69,719.9 persons
• Clinical engineers	32,774.6 persons
• Registered dietitian	27,849.8 persons
• Dietitian	5,531.3 persons

Source: "Survey of Medical Institutions (Static Survey) 2023", Health Statistics Office to the Councilor, Director-General for Statistics, Information System Management and Industrial Relations, MHLW * Full-time equivalent numbers

• Dental hygienists	145,183 persons
• Dental technicians	32,942 persons
• Massage and shiatsu practitioners	118,913 persons
• Acupuncturists	131,486 persons
• Moxibustion practitioners	129,478 persons
• Judo therapists	77,632 persons

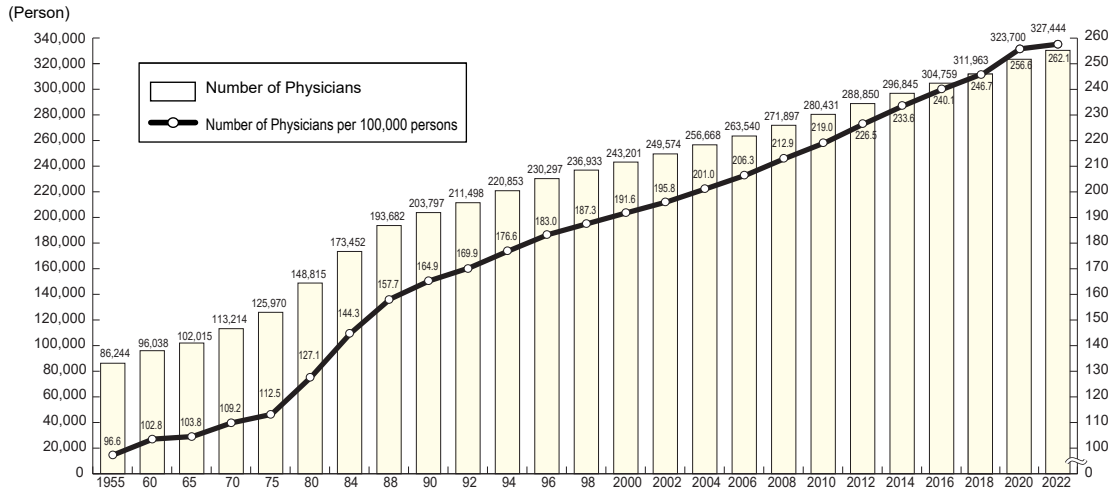
Source: "Report on Public Health Administration and Services 2022", Administrative Report Statistics Office to the Councilor, Director-General for Statistics, Information System Management and Industrial Relations, MHLW (Data published as of June 30, 2025)

• Emergency life-saving technicians	75,947 persons
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Source: Health Policy Bureau, MHLW (as of March 31, 2025)

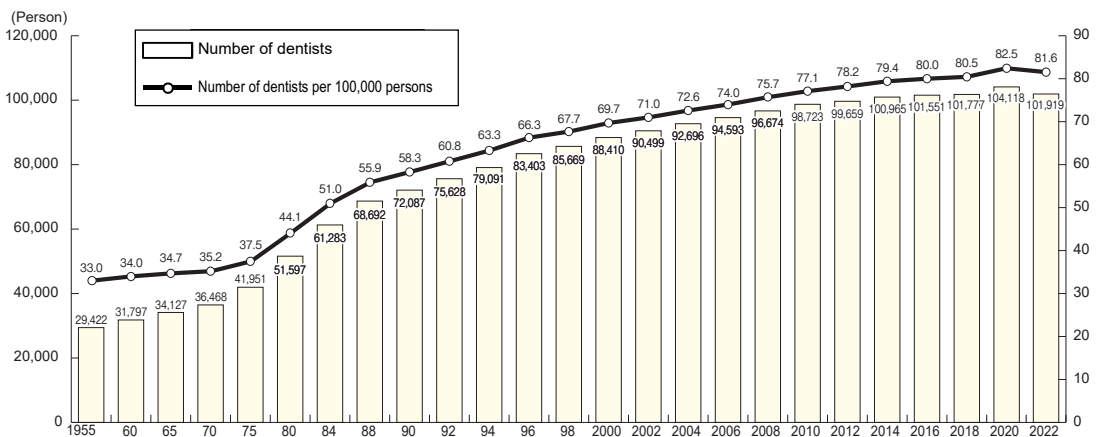
* Number of registered licensees

Detailed Data 1 Changes in Number of Physicians



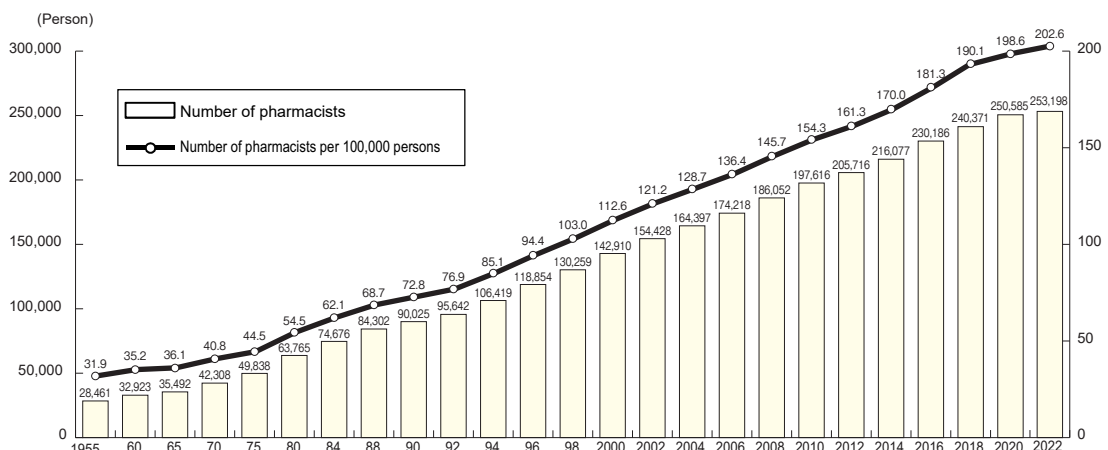
Source: "Statistics of Physicians, Dentists and Pharmacists", Health Statistics Office to the Councilor, Director-General for Statistics, Information System Management and Industrial Relations, MHLW
* Medical facility employees

Detailed Data 2 Changes in Number of Dentists



Source: "Statistics of Physicians, Dentists and Pharmacists", Health Statistics Office to the Councilor, Director-General for Statistics, Information System Management and Industrial Relations, MHLW
* Medical facility employees

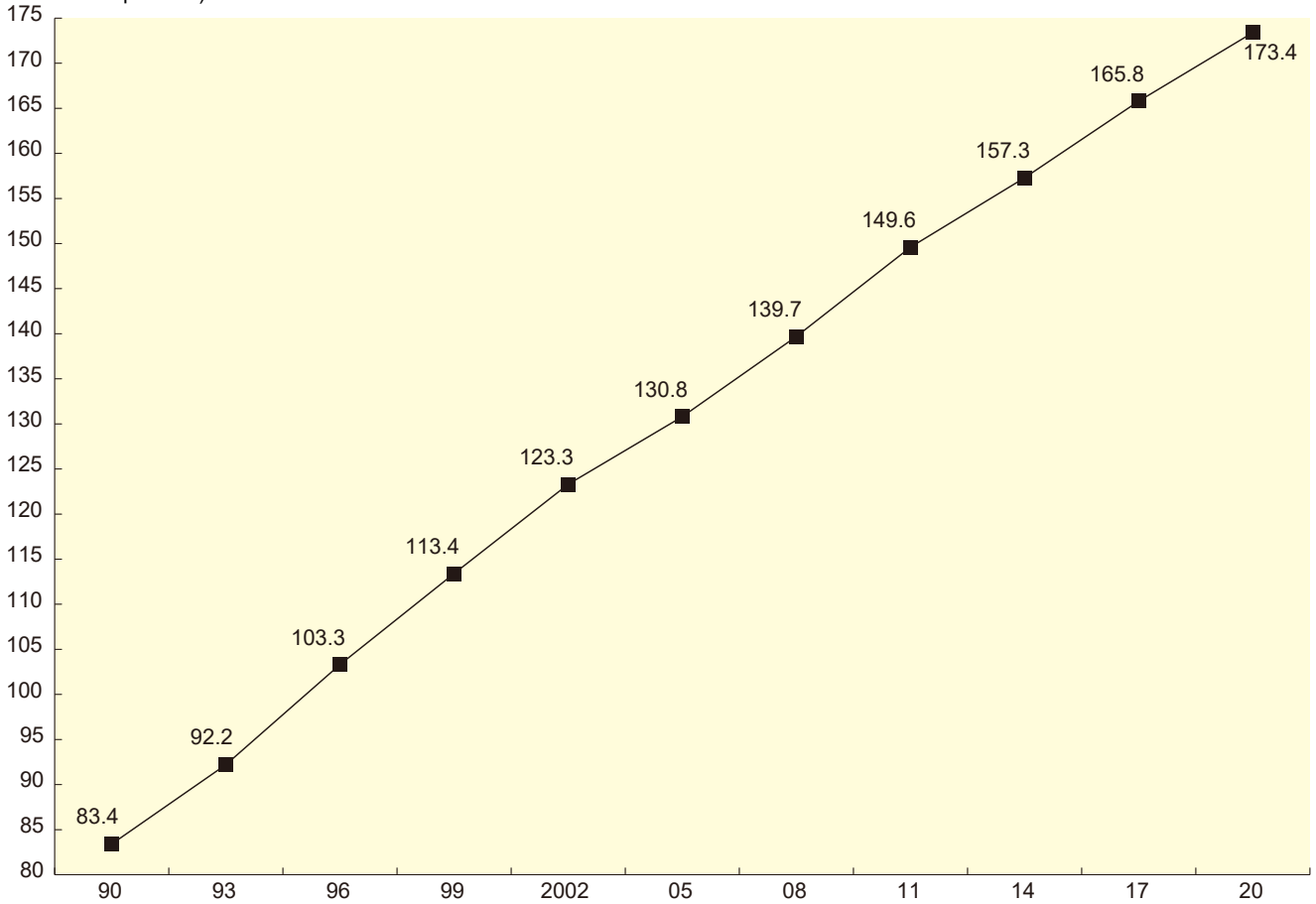
Detailed Data 3 Changes in Number of Pharmacists



Source: "Statistics of Physicians, Dentists and Pharmacists", Health Statistics Office to the Councilor, Director-General for Statistics, Information System Management and Industrial Relations, MHLW
* Pharmacy or Medical facility employees

Detailed Data 4 Changes in Number of Nursing Personnel

(10 thousand persons)



Source: Calculated and estimated by the Nursing Division of the Medical Administration Bureau of the MHLW, based on the "Survey of Medical Institutions (Static Survey)", "Report on Public Health Administration and Services (Biennial Report)" and "Hospital Report (Employee Form)", MHLW

Conforming Rate to the Statutory Number of Doctors and Nurses Designated in the Medical Care Act and Sufficiency Status (Results of FY2021 On-Site Inspection)

Detailed Data 1 Regional Conforming Rates

(Unit: %)

Classification \ Region	Nationwide	Hokkaido Tohoku	Kanto	Hokuriku Koshinetsu	Tokai	Kinki	Chugoku	Shikoku	Kyushu
Doctors	98.3	95.5	98.7	97.6	99.2	99.5	98.1	97.7	98.8
Nurses	99.4	99.3	98.9	99.1	99.4	99.4	99.4	100.0	99.9

Detailed Data 2 Nationwide Achievement Status

	Hospitals with insufficient number of doctors	Hospitals with sufficient number of doctors	Total
Hospitals with sufficient number of nurses	5,379 (97.1)	83 (1.5)	5,462 (98.6)
Hospitals with insufficient number of nurses	45 (0.8)	8 (0.6)	53 (1.4)
Total	5,424 (97.9)	91 (2.1)	5,515 (100.0)

(Note) The figures represent the number of hospitals (excluding dental hospitals) and the figures in parentheses represent the percentage.

(Explanation of terms)

- **Numerical standards:** The statutory number of doctors and nurses to be placed in a hospital is prescribed by the Medical Care Act.
- **Conforming rate:** The percentage of hospitals satisfying the statutory number of doctors/nurses among hospitals in which an on-site inspection has been conducted is defined as the conforming rate.
- **Sufficient/insufficient:** Of hospitals in which an on-site inspection has been conducted, those satisfying the numerical standards are counted as "sufficient" and those not satisfying the numerical standards are counted as "insufficient".

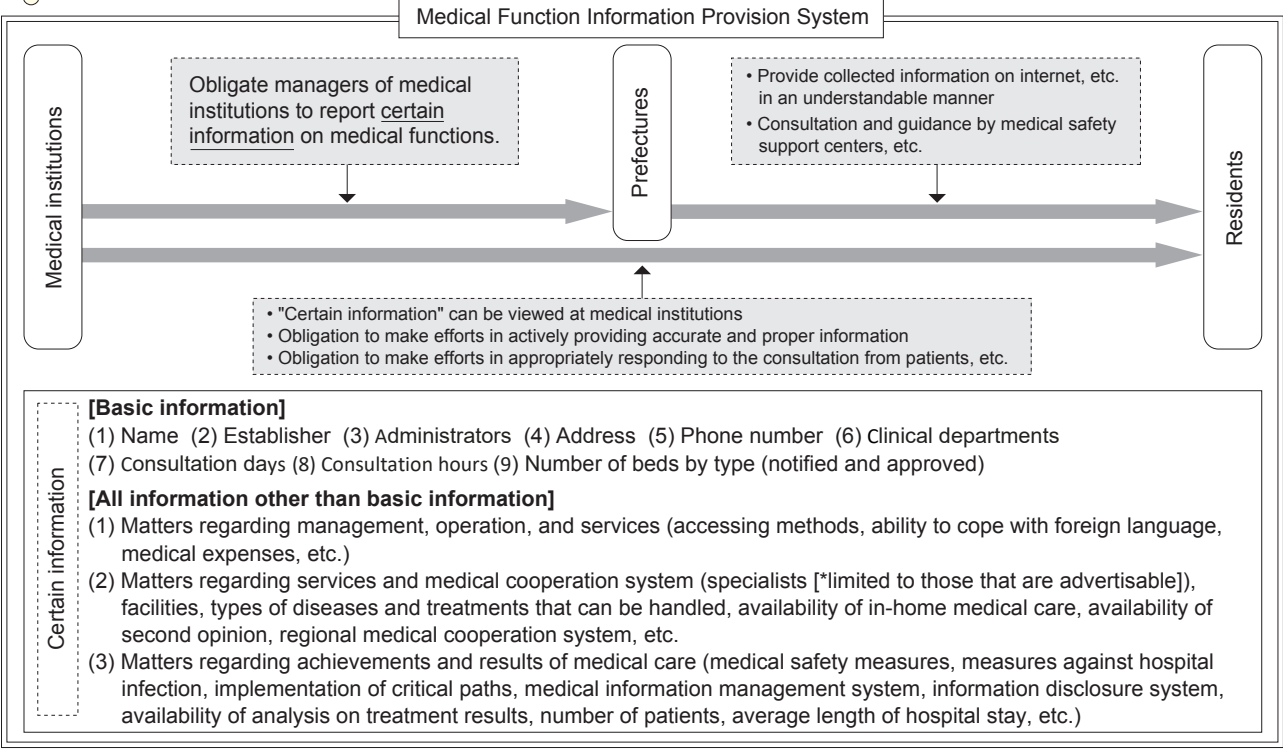
Provision of Medical Function Information

Overview

Creation of Medical Function Information Provision System

Enforced April 1, 2007

Create a system to obligate medical institutions to report certain information on medical functions to prefectures and prefectures to collect the information and provide it to the public in an understandable manner (a similar system is created with pharmacies)



Provision of documented explanation at the time hospitalization (Medical Care Act) (revised in 2006)

Legally establish in the Medical Care Act that managers of hospitals and clinics formulate, issue, and explain treatment plans at the beginning/end of hospitalization.

[Overview of the revised system]

Obligation to provide treatment plans at the beginning of hospitalization

- Managers of medical institutions are obliged to prepare, issue, and appropriately explain treatment plans describing treatments to be provided to patients during hospitalization.
- In so doing, managers are obliged to make efforts in reflecting knowledge of medical professionals of hospitals/clinics and facilitate organic cooperation with them.

- (Items to be described in the treatment plan)
- ◆ Name, date of birth, and gender of the patient
 - ◆ Name of a doctor or dentist who is in charge of providing treatment to the patient
 - ◆ Specify disease or injury that caused hospitalization and main symptoms
 - ◆ Plans for providing examinations, surgeries, medications, and other treatments during hospitalization
 - ◆ Other items designated by the Ordinances of the Ministry of Health, Labour and Welfare

Obligation to make efforts in providing recuperation plans at the end of hospitalization

- Managers of medical institutions are obliged to make efforts in preparing, issuing, and appropriately explaining recuperation plans describing matters regarding required health care, medical care, and welfare services after discharge.
- When doing so, managers are obliged to make efforts in cooperating with health care, medical care, and welfare service providers.

[Effects] • Improved information provision to patients • Improved informed consent • Promotion of team medical care
 • Enhanced cooperation with other medical institutions (so-called adjustment function for leaving hospital)
 • Promotion of evidence-based medicine (EBM), etc.

Medical Care Plan

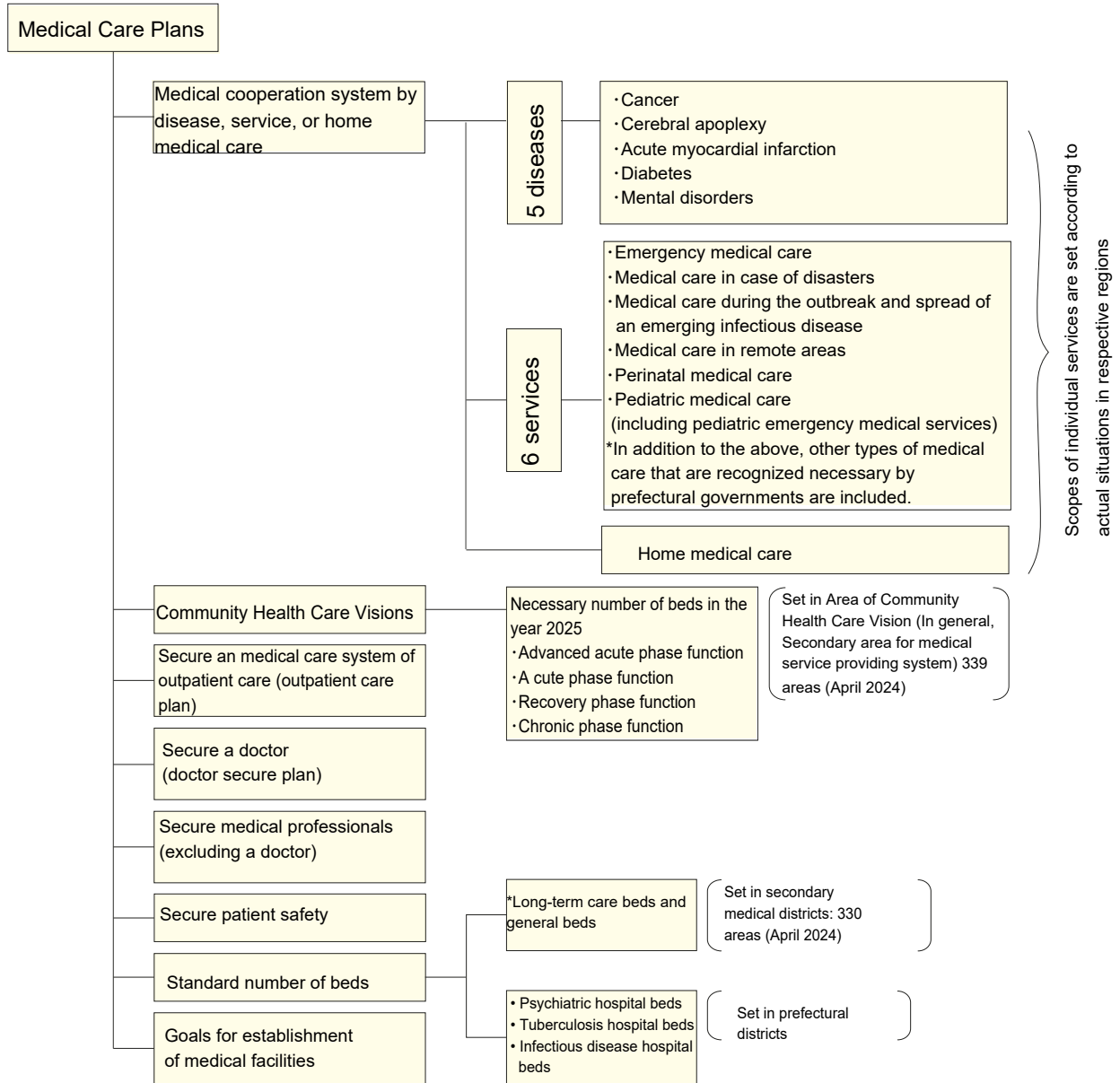
Overview

Overview of Medical Care Plan

1. Purpose

Establish a system for providing high quality and appropriate medical care efficiently by realizing continued medical care in communities through promoting a division of roles and cooperation of medical functions.

2. Contents



3. Status of standard number of beds and number of existing beds

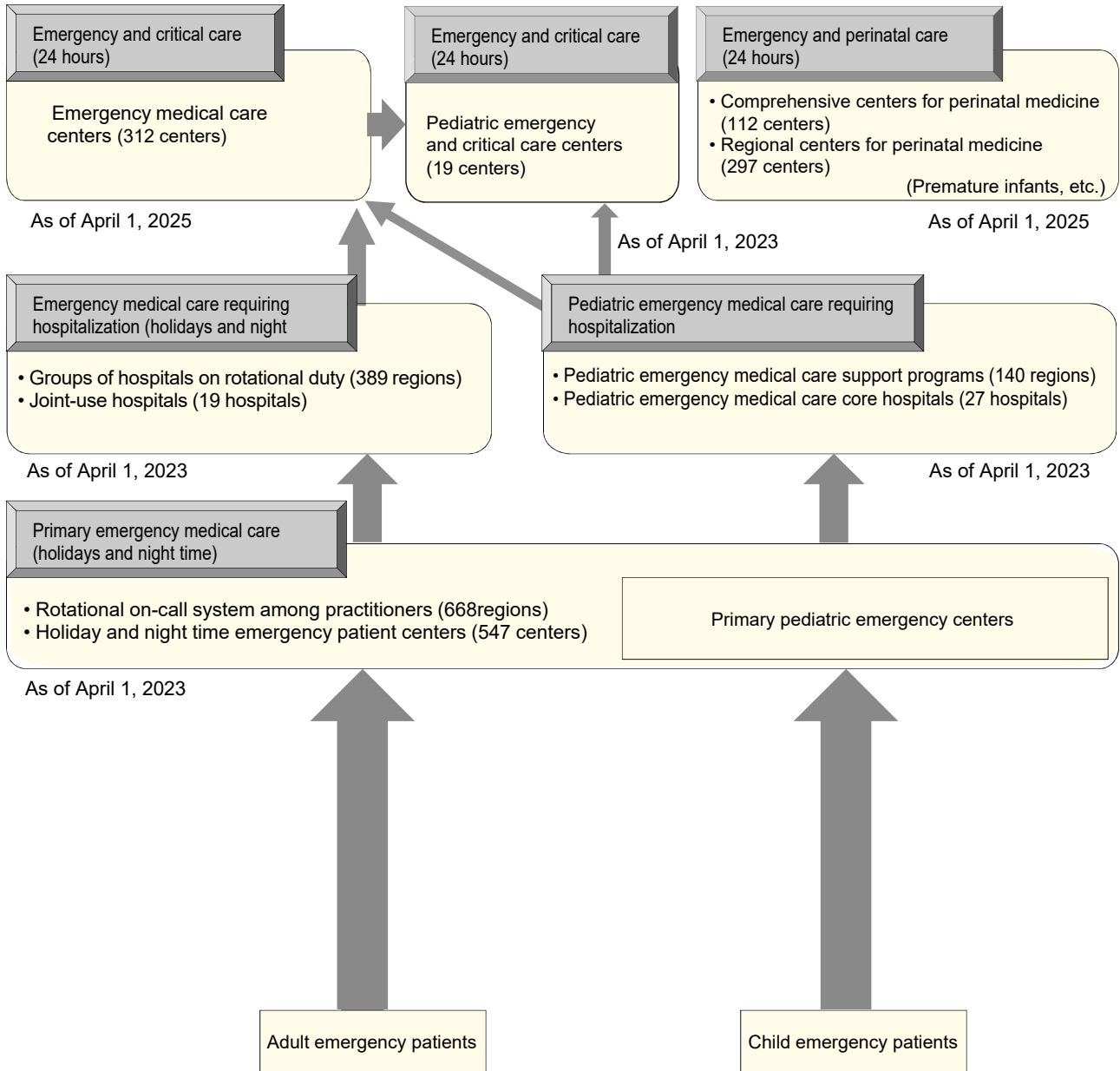
(Unit: beds, as of April, 2024)

Classification	Standard number of beds	Number of existing beds
Long-term care beds and general beds	1,091,352	1,181,258
Psychiatric hospital beds	265,903	322,197
Tuberculosis hospital beds	2,225	3,608
Infectious disease hospital beds	1,932	1,913

Emergency Medical Service System

Overview

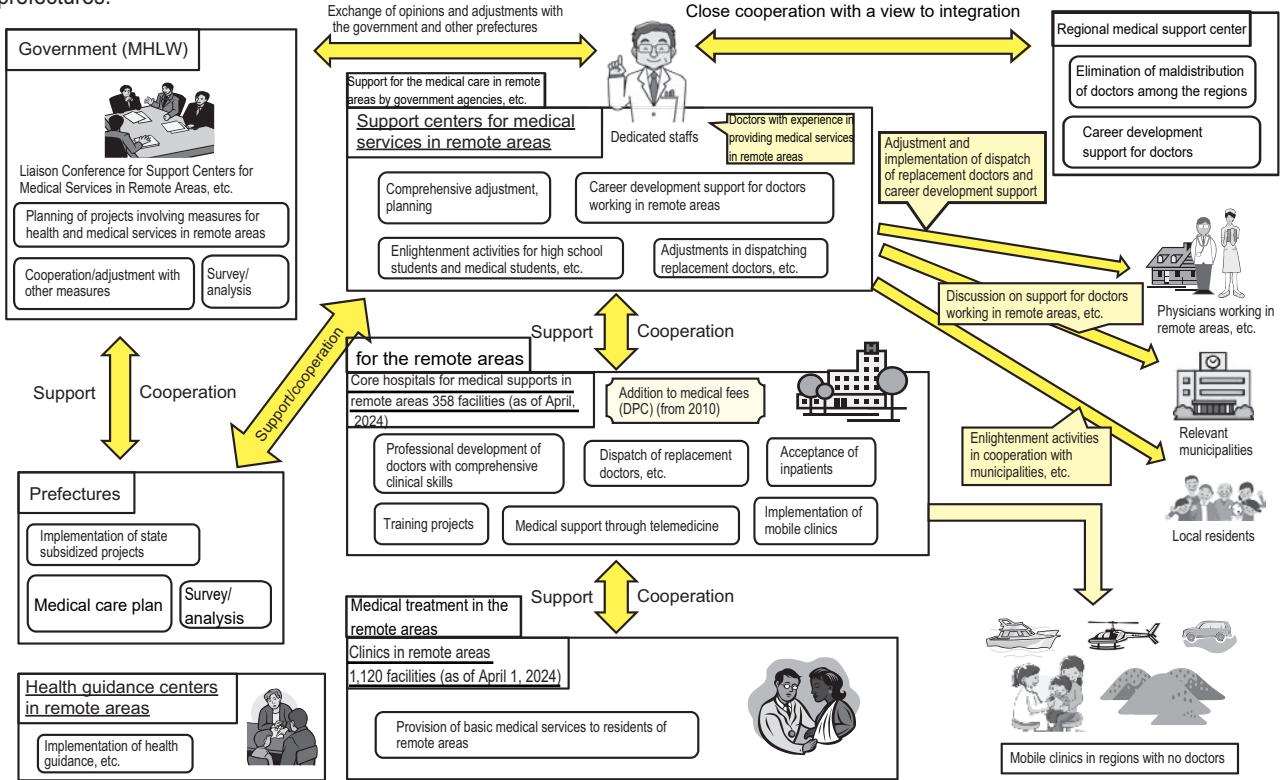
Structural Chart of Emergency Medical Service



Medical Services in Remote Areas

Overview Structural Chart of Measures for Health and Medical Services in Remote Areas

Establish an effective, efficient, and sustainable system that can provide medical services in remote areas mainly via prefectural support centers for medical services in remote areas in cooperation with governments, physicians working in remote areas, facilities and institutions engaged in medical services in remote areas, and residents of remote areas, and through studying advanced cases in other prefectures.



Current Status of Measures for Health and Medical Services in Remote Areas

1. Efforts to build the medical system in remote areas

The medical system in remote areas, which has been taken measures in the remote area health care plan until 2017, shall be formulated integrally with the medical care plan from 2018, and the medical system in remote areas shall be enhanced while further coordinating with other services.

Survey year	Regions with no doctors	Subject population (10,000 persons)
1973	2,088	77
1984	1,276	32
1999	914	20
2004	787	16.5
2009	705	13.6
2014	637	12.4
2019	590	12.7
2022	557	12.2

* Regions with no medical facilities
In which population of 50 or more people live within a radius of approximately 4 km from the major location of the region and it is not easy to use a medical facility.

2. Status of Establishment

- (1) Prefectural office to support medical services in remote areas (subject to assistance for operational expenses)
Scheduled to be established/operated in 40 prefectures as of April 1, 2024
- (2) Core hospitals for medical services in remote areas (subject to assistance of operational expenses, facility establishment expenses, and equipment installment expenses)
358 hospitals are designated as of April 1, 2024
- (3) Clinics for medical services in remote areas (subject to assistance of operational expenses, facility establishment expenses, and equipment installment expenses)
1,120 clinics (including National Health Insurance direct managed clinics) are established as of April 1, 2024

Patient Safety Measures

Overview

Patient Safety Measures

[Basic idea] Implement respective measures with great respect being paid to the viewpoint of patient safety and healthcare quality improvement taking into consideration report of the study group on patient safety measures (June 2005).

<Key Suggestions>

[Improved healthcare quality and patient safety]

- In addition to hospitals and clinics with beds, the systematization of establishment of certain safety management systems in clinics with no beds, dental clinics, maternity clinics, and pharmacies has been institutionalized
([1]Decision of safety management guideline manual, [2] implementation of training on patient safety, and [3] internal report on tendency of infection, etc.)
- Improved measures against hospital acquired infection in medical institutions
([1] Decision of guidelines/manuals for preventing hospital acquired infection, [2] implementation of training on hospital acquired infection, [3] internal report on tendency of infection, and [4] establishment of committee on hospital acquired infection (only in hospitals and clinics with beds))
- Security of medicine/medical device safety
([1] clarification of responsibilities regarding safety use, [2] establishment of processes regarding safety use, and [3] scheduled maintenance check on medical devices)
- Improved quality of medical professionals
- Obligation for administratively punished medical professionals to take re-education training

[Thorough implementation of preventive measures against recurrence through investigation/analysis ofcauses of medical accident cases, etc.]

- Thorough implementation of preventive measures against recurrence through investigation/analysis of causes of accident cases
- Discussion on reporting system of medical related deaths, investigation system of cause of medical related deaths, and out-of-court dispute resolution system in medical areas

[Promotion of information sharing with patients and the public and active participation from patients and the public]

- Promotion of information sharing with patients and the public and independent participation from patients and the public
- Systematization of medical safety support centers

[Roles of the government and local governments on patient safety]

- Clarification of responsibilities of the government, prefectures, and medical institutions and roles of patients and the public, etc.
- Establishment of laws and regulations, promotion of research, and provision of financial support, etc.

<Measures>

- Enhancement of patient safety management system (revision of law in 2006, etc.)
- Establishment of additional medical fees to promote a patient safety management system (from 2006)
- Obligation of establishment of hospital acquired infection control system (revision of Ministry Ordinance in 2006)
- Obligation of placement of responsible persons regarding safety use of medicine/medical devices, etc. (revision of Ministry Ordinance in 2006)
- Work guidelines for patient safety managers and guidelines for formulating training programs (amended on March 2020)
- Obligation for punished medical professionals to take re-education training (revision of law in 2006, etc.)
- Systems to provide medical care using highly difficult new medical technologies or unapproved new pharmaceuticals, etc. (revised ministerial ordinance in 2016)
- Securing a system for the safety management of medical radiation (revised ministerial ordinance in 2019)

- National Database of Medical Adverse Events. (from FY2004)
- Model projects for investigation/analysis of deaths related to medical practices (from FY2005)
- Training projects for developing human resources to engage in coordination/mediation of medical disputes (FY2006)
- Discussion on investigation of causes and prevention of recurrences of deaths caused by medical accidents, etc. (from April 2007 to December)
- Japan Obstetric Compensation System for Cerebral Palsy (from January 2009)
- Liaison Conference of Alternative Medical Dispute Resolution Organizations (from March 2010)
- Discussion on utilization of autopsy imaging for determination of cause of death (from September 2010 to July 2011)
- Discussion on ideal no-fault compensation system that will contribute to the improvement of medical care quality (from August 2011 to June 2013)
- Enforcement of Medical Accident Investigation System(October 2015~)

- Promotion of Patient Safety Action (PSA) (from FY2001)
- Systematization of patient safety support centers (revision of law in 2008, etc.)
- “Guidelines for the Operation of the Patient Safety Support Center” (amended in 2022)
- Work guidelines for medical communication promoters and guidelines for formulating their training programs (January2013)

- Comprehensive support projects of patient safety support centers (from FY2003)
- Clarification of responsibilities of the government, local governments, and medical institutions (revision of law in 2006)
- Addition of the “issues concerning the assurance of patient safety” to the medical care plan (from the 5th medical care plan 2008)
- Research for promoting patient safety management system (scientific research of health, labour and welfare)

Improved Quality of Doctors

Overview

History of Clinical Training System

- **1948 1-Year internship system after graduation started** (1-year program necessary to be qualified for National Examination)
- **1968 Creation of clinical training system** (effort obligation of more than 2 years after obtaining medical license)



[Issues of the conventional system]

1. Training was voluntary
2. Training programs were not clearly defined
3. Mainly focused on straight training for specialized doctors
4. Remarkably large disparities existed among institutions
5. Insufficient guidance system
6. Insufficient evaluation of training achievements
7. Unstable status/work conditions " part-time jobs
8. Heavy concentration of interns in large hospitals in urban areas

○ **2000 Revision of the Medical Practitioners Act and the Medical Care Act** (Making clinical training compulsory)

○ **2004 Enforcement of the new system**

○ **2010 Revision of the system**

○ **2015 Revision of the system**

○ **2020 Revision of the system**

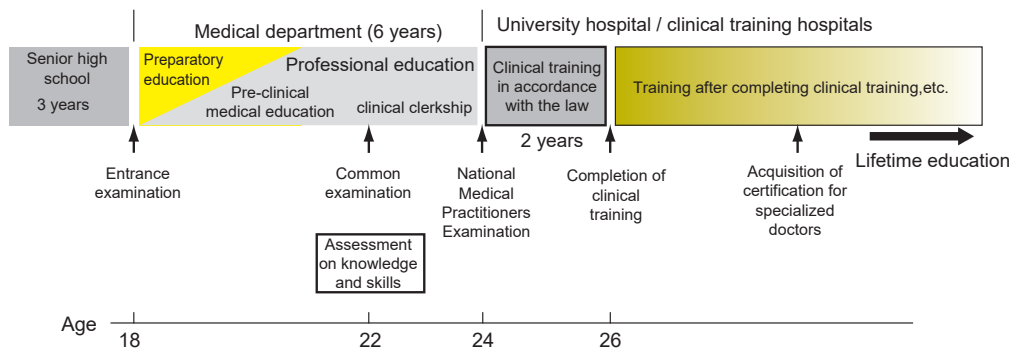
○ **2025 Revision of the system**

Overview of Clinical Training System

1. Medical Education and Clinical Training

○ Article 16-2 of the Medical Practitioners Act

Doctors to engage in clinical practice must take clinical training in hospitals attached to universities with medical training courses or hospitals designated by the Minister of Health, Labour and Welfare for no less than 2 years.



2. Basic Ideas of Clinical Training

(Ministerial Ordinance on clinical training provided in paragraph 1, Article 16-2 of the Medical Practitioners Act)

Clinical training must offer doctors the opportunity to cultivate the appropriate bedside manner and acquire basic diagnosis and treatment abilities while recognizing the social role to be fulfilled by medicine and medical services regardless of their future specialty so that they can provide appropriate treatment for injuries and diseases that frequently occur.

3. Status of Execution

Changes in the number of clinical residents employed and the proportion of employment in the six metropolitan prefectures (Tokyo, Kanagawa, Aichi, Kyoto, Osaka, Fukuoka) and other prefectures

FY	Number of employments	Proportion of employment in the six metropolitan prefectures	Proportion of employment in other prefectures
2004	7,372	47.8%	52.2%
2020	9,279	41.3%	58.7%
2021	9,023	40.8%	59.2%
2022	9,165	40.7%	59.3%
2023	9,388	39.9%	60.1%
2024	9,460	40.2%	59.8%

* The new clinical training program began in FY2004.

Outline of 2020 System Reform

(1) Comprehensive Doctor training before and after graduation

- Set up outcomes, measures and evaluation applicable for medical education model core curriculum.

(2) Outcomes, measures and evaluation

- As outcomes, set up 'basic value as a doctor (professionalism)', 'capabilities, abilities' and 'basic diagnosis task' and 'ensure basic medical examination for admission, out-patient, emergencies and regional medicines'.
- As measures, make surgery, pediatrics, gynecology and obstetrics and psychiatry compulsory in addition to internal medicine, emergency, regional medicine and add that it includes the training for out-patients.
- Standardize the evaluation considering the continuity with model core curriculum.

(3) The modality of clinical training hospital

- Make three-stage evaluation to four-stage for visiting survey of core hospitals which may have challenges and delete the designation from hospitals which do not show any improvement.
- Make the training for those who are in charge of program compulsory.
- Recommend strongly the third party evaluation.

(4) Stable assurance of regional medical

- Compress the recruiting ration up to 1.05 times and limit the maximum for calculating recruiting number of admission quota of medical department.
- As for the part of regional positions, etc., recruit differently from general matching.
- For setting up the designation and application number of clinical training hospital, prefectural governments will hear from regional medical measures committees, first.

(5) Responses to diminishing international competitiveness on basic researches

- Set up courses for capacity building and training for basic doctors in university hospitals which are basic clinical training hospitals. Separate applicants from general applications and separate selection from the general matching.

*Conduct required reviews within five years after the enforcement of this system review.

Outline of 2025 System Revision

(1) Outcomes, measures, and evaluation

- From 2020, set up outcomes, measures, and evaluation applicable for medical education model core curriculum.
- As insufficient time has passed since the start of clinical training based on the "Goals, Strategies, and Evaluation of Clinical Training" and it is difficult to evaluate it, the system will not be revised in this system review.

(2) Appropriate clinical training hospitals

- Even hospitals located on remote islands with an annual inpatient count of less than 2,700 may be designated as core clinical training hospitals under certain conditions.
- With regard to the special program in pediatrics and obstetrics, the number of weeks of clinical training in pediatrics or obstetrics and gynecology shall be 12 weeks or more.

In addition, core clinical training hospitals with a recruitment capacity of 20 or more for clinical training will, in principle, be required to establish special programs for pediatrics and obstetrics, while they will be able to change their training programs to focus on clinical training in required medical departments where there is a shortage of doctors in the prefecture.

(3) Maintaining and improving the quality of clinical training

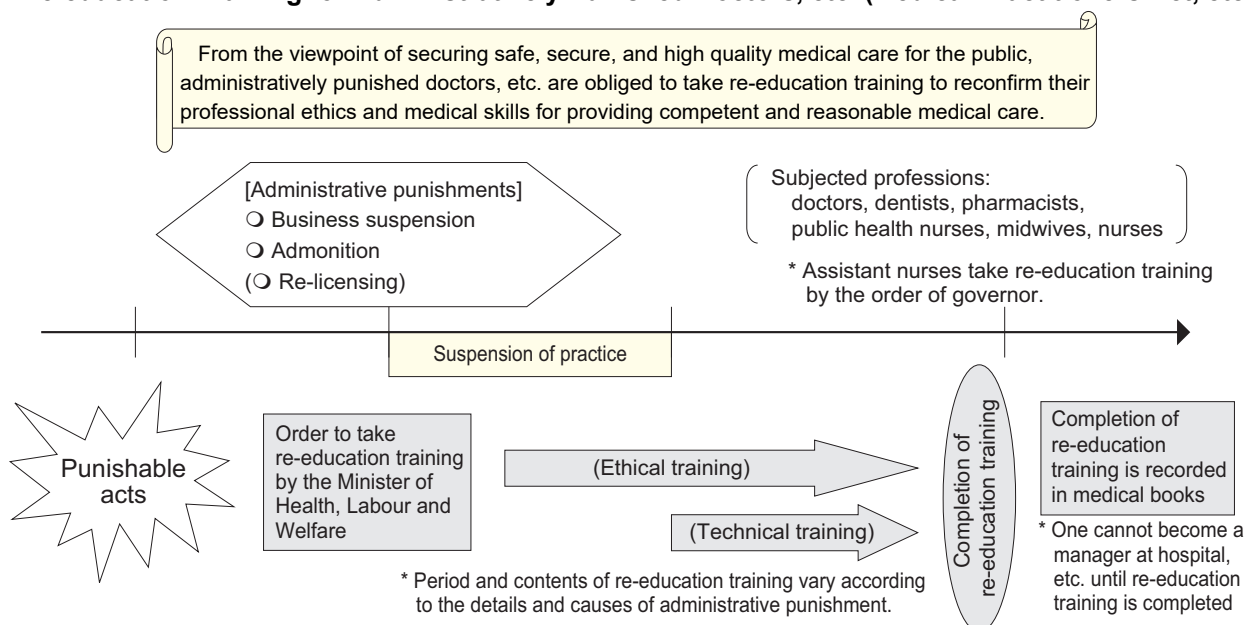
- The Ministerial Ordinance on Clinical Training stipulates that core clinical training hospitals are obligated to make an effort to undergo third-party evaluation of their clinical training and to disclose the results of such evaluations.

(4) Stable provision of regional medical care

- Starting from FY2026, a "wide-area collaborative program" will be established in which some clinical trainees employed at core clinical training hospitals in prefectures with a large number of doctors will undergo training for 24 weeks or more at clinical training hospitals in prefectures with a small number of doctors and other areas.

* Necessary revisions will be carried out within five years after the implementation of this system review.

Re-education Training for Administratively Punished Doctors, etc. (Medical Practitioners Act, etc.)



Medical Corporation System

Outline of Medical Corporation System

1. Purpose of the system

- Corporate bodies based on the Medical Care Act. The system was created by the 1950 revision of the Medical Care Act.
- Enabling administrative bodies of medical care service programs to become corporate bodies without losing the non-profit status of medical practices.

[Around the time of the system establishment]
Reducing the difficulties of administering medical institutions by private persons
(aiming to make fund collection easier)



Granting continuity of administration of medical institutions
→Securing stability of regional medical care

2. Establishment

- Associations or foundations based on the Medical Care Act.
- Prefectural approval
(An organization opening a medical institute in more than 2 prefectures shall obtain approval from a governor at its main address.)
(Number of corporations)
 - Medical corporations 58,902 (as of March 31, 2024)
Of which 58,508 are associations (22,115 without contribution and 36,393 with contribution) and 394 are foundations.
 - * Medical corporation without contribution
 - Medical corporation for which the ownership of residual assets in the event of dissolution is stipulated to be the government, local governments, or other medical corporations without contribution, etc. and exclude individuals (investors).
 - The revised Medical Care Act of 2006 limits newly established medical corporations to be those without contribution. The existing medical corporations, however, shall voluntarily transfer while applying the previous provisions.
 - Social medical corporations 365 (as of April 1, 2024)



3. Operation

- A medical corporation may carry out operations associated with the health/hygiene and social welfare in addition to medical practice (operation of hospitals, clinics, long-term care health facilities)
- Medical corporations certified as social medical corporations may engage in profit-making practices for the purpose of appropriating the profits to the administration of hospitals, etc.
- Dividend of surplus is not allowed.
 - * Social medical corporations
 - Established by the 2006 revision of the Medical Care Act as medical corporations with high public interest that take roles of providing emergency medical care and medical services in remote areas while utilizing high vitality of the private sector.
 - Must meet the requirements such that family corporation members are excluded from being officers, etc. and limiting the ownership of residual assets, in the event of dissolution, to the government and local governments, etc.
 - Exempt from corporation tax on medical and health practices. Exempt from fixed assets tax on hospitals/clinics that engage in practices for securing emergency medical care, etc.

(3) Health Promotion/Disease Measures

Health Centers, etc.

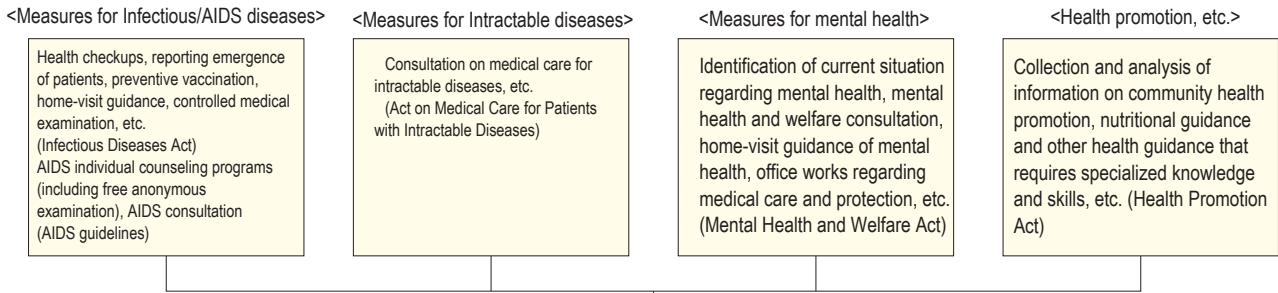
Overview

Activities of Health Centers

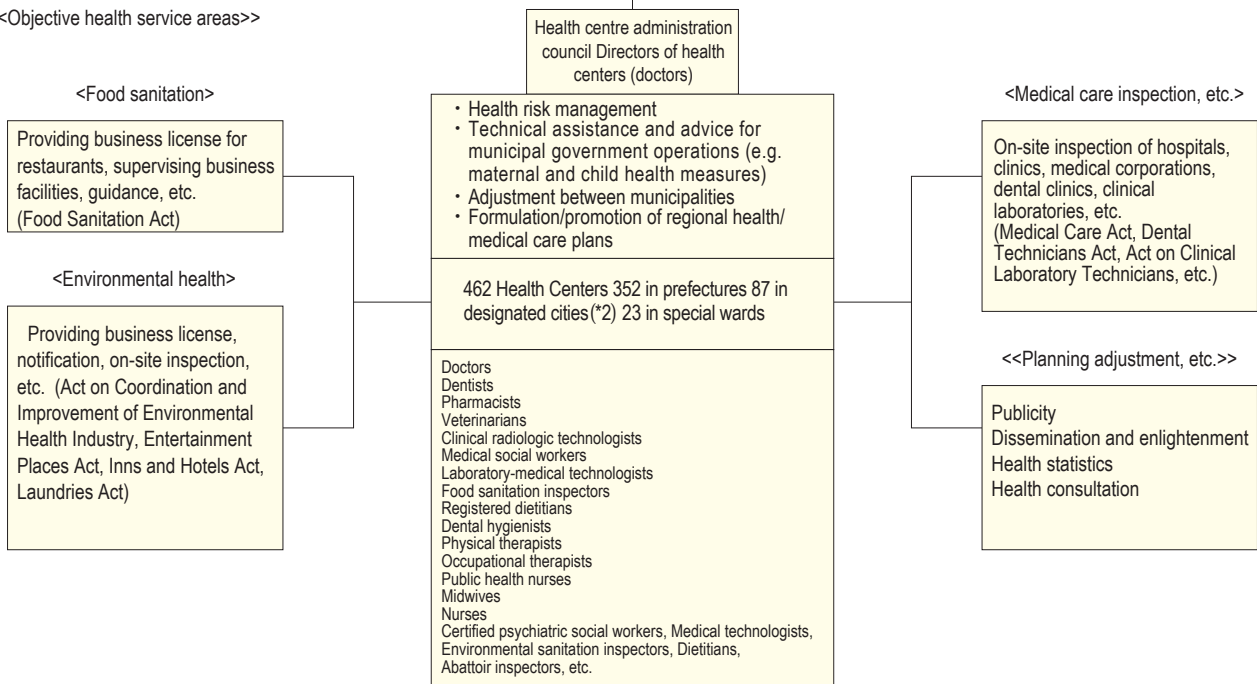
Health centers are front-line comprehensive public health administrative institutions that offer both personal and objective health services. Personal health services include broad-based services, services requiring specialized technologies, and services requiring team work of various health care professionals. In addition, health centers provide required technical assistance for health services provided by municipalities.

Health centers are established in 352 locations in 47 prefectures, 87 locations in 87 designated cities, and 23 locations in 23 special wards under the Community Health Act (As of April 1, 2025).

<<Personal health service areas>>



<<Objective health service areas>>



* In addition to the activities above, health centers provide licenses for opening pharmacies (Pharmaceuticals and Medical Devices Act), take custody of dogs to prevent the spread of rabies (Rabies Prevention Act), and accept applications for opening massage clinics, etc. (Act on Practitioners of Massage, Finger Pressure, Acupuncture and Moxa-cauterization, etc.).

*2 This refers to a city as defined in Article 1 of the Order for Enforcement of the Community Health Act.

Changes in Number of Health Centers

	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025
Total number of health centers	517	510	494	495	495	494	490	486	480	481	469	472	469	470	468	468	468	462
Prefectures	389	380	374	373	372	370	365	364	364	363	360	359	355	354	352	352	352	352
Cities*	105	107	97	99	100	101	102	99	93	95	86	90	91	93	93	93	93	87
Special wards	23	23	23	23	23	23	23	23	23	23	23	23	23	23	23	23	23	23

Source: Health Service Bureau, MHLW

(Note) The number of Health Centers is as of April 1 of each year.

* This refers to a city as defined in Article 1 of the Order for Enforcement of the Community Health Act.

Detailed Data 1 Number of Full-time Medical Personnel at Health Centers by Occupation

Occupation	Number of personnel
	Person
Doctors	716
Dentists	79
Pharmacists	3,081
Veterinarians	2,138
Public health nurses	10,062
Midwives	62
Nurses	178
Assistant nurses	1
Radiology technicians, etc.	357
Medical technologists, etc.	676
Registered dietitians	1,351
Dietitians	60
Dental hygienists	303
Physical/occupational therapists	63
Others	12,445
<Included in the upper column>	
Medical social workers	16
Mental health welfare counselors	471
Nutrition counselors	1,145
Total	31,572

Source: "Report on Regional Public Health Services and Health Promotion Services", Administrative Report Statistics Office to the Councilor, Director-General for Statistics, Information System Management and Industrial Relations, MHLW (Modified by Health Service Bureau) (as of the end of FY2023)

Detailed Data 2 Changes in Number of Public Health Nurses

(Unit: person)

	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023
Municipalities	14,753	14,920	14,850	14,935	15,035	15,227	15,193	15,194	15,338	15,337	15,606	15,721
Designated cities* / special wards	6,256	6,564	6,586	6,829	6,928	7,107	7,512	8,030	8,230	8,737	8,870	9,119
Subtotal	21,009	21,484	21,436	21,764	21,963	22,334	22,705	23,224	23,568	24,074	24,476	24,840
Prefectures	3,659	3,603	3,607	3,613	3,661	3,659	3,637	3,688	3,730	3,905	4,084	4,165
Total	24,668	25,087	25,043	25,377	25,624	25,993	26,342	26,912	27,298	27,979	28,560	29,005

Source: "Report on Regional Public Health Services and Health Promotion Services", Administrative Report Statistics Office to the Councilor, Director-General for Statistics, Information System Management and Industrial Relations, MHLW (Data published as of March 25, 2025)

* This refers to a city as defined in Article 1 of the Order for Enforcement of the Community Health Act.

Health Promotion Measures

Overview

History of National Health Promotion Measures

<p>1st National Health Promotion Measures (from FY1978)</p>	<p>(Basic concept) 1. Lifetime health promotion [Promotion of primary prevention of geriatric diseases] 2. Promotion of health promotion measures through three major elements (diet, exercises, and rest) (special focus on diet)</p>	<p>(Outline of measures) - Lifetime health promotion <ul style="list-style-type: none"> Establishment of health checkups and a complete health guidance system from infants and small children through to the elderly - Establishment of health promotion bases <ul style="list-style-type: none"> Establishment of health promotion centers, municipal health centers, etc. Securing sufficient human resources, including public health nurses and dietitians - Dissemination and enlightenment of health promotion <ul style="list-style-type: none"> Establishment of municipal health promotion councils Promoting the use of recommended dietary allowances Nutritional content labelling for processed food Conducting studies on health promotion, etc. <p style="text-align: right;">etc.</p> </p>	<p>(Guidelines, etc.)</p> <ul style="list-style-type: none"> Dietary guidelines for health promotion (1985) Report on nutritional content labelling for processed food (1986) Announcement of a weight scale diagram and table (1986) Report on smoking and health (1987)
<p>2nd National Health Promotion Measures (from FY1988) (Active 80 Health Plan)</p>	<p>(Basic concept) 1. Lifetime health promotion 2. Promotion of health promotion measures with the focus on exercise habits as they are lagging behind the other two of the three elements (diet, exercise, and rest)</p>	<p>(Outline of measures) - Lifetime health promotion <ul style="list-style-type: none"> Enhanced health checkup and guidance system from infants and small children through to the elderly - Establishment of health promotion bases <ul style="list-style-type: none"> Establishment of health science centers, municipal health centers, health promotion facilities, etc. Securing sufficient manpower such as health fitness instructors, registered dietitians, and public health nurses - Dissemination and enlightenment of health promotion <ul style="list-style-type: none"> Promoting the use of and revising recommended dietary allowances Promoting recommended exercise allowance Promoting the system to approve health promotion facilities Action plan for tobacco control Promoting a system of nutrition information labelling for meals eaten outside home Promoting cities with health oriented cultures and health resorts Conducting studies on health promotion, etc. <p style="text-align: right;">etc.</p> </p>	<p>(Guidelines, etc.)</p> <ul style="list-style-type: none"> Dietary guidelines for health promotion (by individual characteristics: 1990) Guidelines for nutrition information labeling for meals eaten outside home (1990) Report on smoking and health (revised) (1993) Exercise and Physical Activity Guidelines for Health Promotion (1993) Promoting guidelines on rest for health promotion (1994) Committee report on action plan for tobacco control (1995) Committee report on designated smoking areas in public spaces (1996) Physical activity guidelines by age (1997)
<p>3rd National Health Promotion Measures (from FY2000) (National Health Promotion Movement in the 21st Century (Health Japan 21))</p>	<p>(Basic concept) 1. Lifetime health promotion [Focusing on "primary prevention", extension of healthy life expectancy, and enhanced quality of life] 2. Setting specific targets to serve as an indicator for national health/medical standards and promotion of health promotion measures based on assessments 3. Creation of social environments to support individuals' health promotion</p>	<p>(Outline of measures) - National health promotion campaign <ul style="list-style-type: none"> Dissemination and enlightenment of effective programs and tools with regular revision Dissemination and enlightenment of the acquisition of good exercise habits and improved dietary habits with a focus on metabolic syndrome - Implementation of effective medical examinations and health guidance <ul style="list-style-type: none"> Steady implementation of health checkups and health guidance with a focus on metabolic syndrome for insured persons/dependents aged 40 or older by Health Care Insurers (from FY2008) - Cooperation with industry <ul style="list-style-type: none"> Further cooperation in voluntary measures of industries - Human resource development (improving the quality of medical professionals) <ul style="list-style-type: none"> Improved training for human resource development in cooperation between the government, prefectures, relevant medical organizations, and medical insurance organizations - Development of evidence-based measures <ul style="list-style-type: none"> Revision of data identification methods to enable outcome assessments <p style="text-align: right;">etc.</p> </p>	<p>(Guidelines, etc.)</p> <ul style="list-style-type: none"> Dietary guidelines (2000) Committee report on relevance to designated smoking areas (2002) Sleep guidelines for health promotion (2003) Guidelines on implementation of health checkups (2004) Dietary Reference Intakes for Japanese 2005 (2004) Guidelines for well-balanced diet (2005) Manual for smoking cessation support (2006) Exercise and Physical Activity Reference for Health Promotion 2006 (exercise guide 2006) (2006) Exercise guidelines for health promotion 2006 (Exercise Guide 2006) (2006) Dietary Reference Intakes for Japanese 2010 (2009)
<p>4th National Health Promotion Measures (from FY 2013) (The second term of National Health Promotion Movement in the 21st Century (Health Japan 21 (the second term)))</p>	<p>(Basic concept) 1. Lifetime health promotion (with the ultimate goals of extending healthy life expectancy and reducing health disparities) 2. Basic Direction for the National Health Promotion Initiative (1) Focusing on extension of healthy life expectancy and reduction of health disparity (2) Prevention of onset and progression of lifestyle diseases (Prevention of NCD (Non-Communicable Diseases)) (3) Maintenance and improvement of necessary functions for healthy social life (4) Development of social environment for supporting and protecting health (5) Improvement of lifestyle and social environment relating to nutrition and dietary habits, physical activity and exercise, rest, alcohol drinking, tobacco smoking, and oral health.</p> <p style="text-align: right;">etc.</p>	<p>(Outline of measures) - Measures in line with the basic direction (1) Focusing on extension of healthy life expectancy and reduction of health disparity <ul style="list-style-type: none"> Comprehensive promotion for lifestyle diseases and promotion of efforts supporting areas such as medical and long-term care. (2) Prevention of onset and progression of lifestyle diseases (Prevention of NCD(Non-Communicable Diseases)) <ul style="list-style-type: none"> Measures focused on primary prevention and prevention of severe illness Promoting behavior change and social environment improvements that are beneficial to health, such as appropriate diet, moderate exercise, and smoking cessation, as well as promoting medical collaboration systems and implementing specific health examinations and specific health guidance (3) Maintenance and improvement of necessary functions for healthy social life <ul style="list-style-type: none"> Promotion of initiatives related to "mental health", "health of the next generation" and "health of the elderly" according to life stages (4) Development of social environment for supporting and protecting health <ul style="list-style-type: none"> Developing an environment where society as a whole can support each other to protect health Providing information on the activities of companies working voluntarily on promoting health and evaluating these activities. (5) Improvement of lifestyle and social environment relating to nutrition and dietary habits, physical activity and exercise, rest, alcohol drinking, tobacco smoking, and oral health.</p> - Further promotion of the Smart Life Project - Initiatives by various entities such as insurers, collaboration between different sectors, and human resource development - Data health reform and promotion of PHR <p style="text-align: right;">etc.</p>	<p>(Guidelines, etc.)</p> <ul style="list-style-type: none"> Physical Activity Reference 2013 for health Promotion (2013) Physical Activity Guideline(Active Guide) (2013) Sleep Guidelines for Health Promotion 2014 (2014) A report on effects of smoking on health by a study group (FY2016) Standard physical examination and health guidance program (FY 2018 edition) (2018) Manual for smoking cessation support (2nd edition) (2018) Manual for smoking cessation support (2nd edition) (Supplemental Revision) (2018) Dietary Reference Intakes for Japanese 2020 (2020)
<p>5th National Health Promotion Measures (from FY 2024) (The third term of National Health Promotion Movement in the 21st Century (Health Japan 21 (the third term)))</p>	<p>(Basic concept) 1. Towards the realization of a sustainable society in which all citizens can live healthy and fulfilling lives, promoting the development of health initiatives that do not leave anyone behind (inclusion), as well as more effective initiatives (Implementation) 2. Basic direction regarding the promotion of the health of citizens (1) Focusing on extension of healthy life expectancy and reduction of health disparity (2) Improving personal behavior and health conditions (3) Improving the quality of the social environment (4) Health promotion based on a life course approach</p>	<p>(Outline of measures) - Measures in line with the basic direction (1) Focusing on extension of healthy life expectancy and reduction of health disparity <ul style="list-style-type: none"> Improving individual behavior and health conditions, as well as developing and enhancing the quality of the social environment surrounding individuals (2) Improving personal behavior and health conditions <ul style="list-style-type: none"> Improvement of lifestyle and social environment related to nutrition and dietary habits, physical activity and exercise, rest and sleep, alcohol drinking, tobacco smoking, and oral health Promoting initiatives concerning prevention of the outbreak and progression of lifestyle-related diseases (NCDs) Promoting initiatives from the perspective of maintaining and improving living functions (3) Improving the quality of the social environment <ul style="list-style-type: none"> Developing an environment that allows people to connect with society and protects their mental health Creating an environment that allows people to become healthy naturally Developing a foundation for health promotion that anyone can access (including infrastructure development such as PHR) (4) Health promotion based on a life course approach <ul style="list-style-type: none"> Promoting initiatives for health promotion and life course approaches that are specific to each life stage <p style="text-align: right;">etc.</p> </p>	<p>(Guidelines, etc.)</p> <ul style="list-style-type: none"> Physical Activity Guide for Health Promotion 2023 (2024) Physical Activity Guide for Health Promotion 2023 (Active Guide) (2024) Sleep Guidelines for Health Promotion 2023 (2024) Standard physical examination and health guidance program (2024 edition) (2024) Dietary Reference Intakes for Japanese 2025 (2024)

* Partially revised final evaluation of Health Japan 21 (the second term), Figures and Tables, p.484 - 485 "Overview of National Health Promotion Measures"

Outline of the Health Promotion Act

Chapter 1. General Provisions

- (1) Purpose
Provide basic matters regarding comprehensive promotion of people's health and make the effort to improve public health through implementation of measures for health promotion.
- (2) Responsibilities
 1. People: Improved interest and understanding of the importance of healthy lifestyle habits in being aware of one's own health status and make the effort to stay healthy throughout life.
 2. The government and local governments: Make efforts to disseminate the appropriate knowledge on health promotion, collect/organize/analyze/make available information, promote researches, develop and improve the quality of human resources, and provide the required technical support.
 3. Health promotion service providers (insurers, business operators, municipalities, schools, etc.): Make an active effort to promote health promotion programs for people including health consultations.
- (3) Cooperation between the government, local governments, health promotion service providers, and other related entities.

Chapter 2. Basic Policies (legally establish "Health Japan 21")

- (1) Basic policies
Basic policies for comprehensive promotion of people's health are formulated by the Minister of Health, Labour and Welfare.
 1. Basic direction with promoting people's health
 2. Matters regarding goals in promoting people's health
 3. Basic matters regarding formulation of health promotion plans of prefectures and municipalities
 4. Basic matters regarding national health and nutrition surveys in Japan and other surveillance and researches
 5. Basic matters regarding cooperation between health promotion service providers
 6. Matters regarding dissemination of the appropriate knowledge on dietary habits, exercise, rest, smoking, alcohol drinking, dental health, and other lifestyle habits
 7. Other important matters regarding promotion of people's health
- (2) Formulation of health promotion plans for prefectures and municipalities (plans for health promotion measure to the people)
- (3) Guidelines on implementation of health checkups
Guidelines on implementation of health checkups by health promotion service providers, notification of the results, a health handbook being issued, and other measures are formulated by the Minister of Health, Labour and Welfare in supporting people's lifelong self management of health.

Outline of Results of National Health and Nutrition Survey 2023

National Health and Nutrition Survey

- Objective: Amassing basic information for comprehensive promotion of national health in accordance with the Health Promotion (Act No.103 of 2002)
- Subjects: Household in 300 unit areas randomly selected from unit areas established in comprehensive Survey of Living Conditions 2023 (approximately 6,014 households)
- Survey items: [Survey on physical condition] Height, weight, abdominal circumference, blood pressure, blood tests, number of steps taken when walking, interview (medication status, exercise)
[Survey on nutritional intake] Food intake, nutrient intake, etc., dietary situation (skipping meals, eating out, etc.)
[Survey on lifestyle] General lifestyle encompassing dietary habits, physical activities, exercise, rest (sleep), alcohol usage, smoking, dental health, etc.

Key points of the results of the survey

● Physical condition

- The proportion of overweight (BMI ≥ 25 kg/m²) was 31.5% in men aged 20 years and over in 2023. It had increased significantly between 2013 and 2019 but had no significant change thereafter.

● Nutrition/dietary habits

- The mean vegetable intake was 256.0 g/day among all survey participants aged 20 years and over. By sex, it has significantly decreased over the past 10 years among men, while there has been a significant decline since 2015 among women.

● Physical activity and exercise

- The mean daily step counts were 6,628 in men and 5,659 in women (both aged 20 years and over). They have significantly decreased over the past 10 years in both sexes.

● Smoking status and second-hand smoking

- The proportion of regular smokers was 15.7% in all survey participants : 25.6% in men, and 6.9% in women. It has significantly declined over the past decade among both men and women.
- The proportion of people in the survey who are exposed to secondhand smoke has decreased significantly since 2008.

Detailed Data 1
Status of Formulating Health Promotion Plans in Regional Governments Nationwide
[Status of formulating health promotion plans in prefectures]

Already formulated in every prefecture (at the end of March 2002)

[Status of formulating health promotion plans in municipalities and special wards]

	Total	Formulated	Plan to formulate in FY 2023	Plan to formulate in FY 2024	Plan to formulate in FY 2025	No plan
Health center-designated cities	87	86	0	0	0	1
Special wards in Tokyo	23	23	0	0	0	0
Other municipalities	1,631	1,549	6	9	32	35

(As of January 1, 2024)

[Status of formulating health promotion plans in municipalities by prefectures]

Prefecture	No. of municipalities	Formulated	Formulation rate	FY 2023	FY 2024	FY 2025 or later	No plan
Hokkaido	175	138	78.9%	2	1	19	15
Aomori	38	38	100.0%	0	0	0	0
Iwate	32	32	100.0%	0	0	0	0
Miyagi	34	34	100.0%	0	0	0	0
Akita	24	24	100.0%	0	0	0	0
Yamagata	34	34	100.0%	0	0	0	0
Fukushima	56	51	91.1%	2	0	2	1
Ibaraki	43	43	100.0%	0	0	0	0
Tochigi	24	24	100.0%	0	0	0	0
Gunma	33	33	100.0%	0	0	0	0
Saitama	59	59	100.0%	0	0	0	0
Chiba	51	51	100.0%	0	0	0	0
Tokyo	37	33	89.2%	0	0	0	4
Kanagawa	27	26	96.3%	0	0	0	1
Niigata	29	29	100.0%	0	0	0	0
Toyama	14	14	100.0%	0	0	0	0
Ishikawa	18	18	100.0%	0	0	0	0
Fukui	16	16	100.0%	0	0	0	0
Yamanashi	26	26	100.0%	0	0	0	0
Nagano	75	67	89.3%	0	2	2	4
Gifu	41	41	100.0%	0	0	0	0
Shizuoka	33	33	100.0%	0	0	0	0
Aichi	49	49	100.0%	0	0	0	0
Mie	28	28	100.0%	0	0	0	0
Shiga	18	18	100.0%	0	0	0	0
Kyoto	25	20	80.0%	0	1	1	3
Osaka	34	31	91.2%	0	0	0	3
Hyogo	36	36	100.0%	0	0	0	0
Nara	38	38	100.0%	0	0	0	0
Wakayama	29	25	86.2%	0	1	2	1
Tottori	18	18	100.0%	0	0	0	0
Shimane	18	18	100.0%	0	0	0	0
Okayama	25	25	100.0%	0	0	0	0
Hiroshima	20	20	100.0%	0	0	0	0
Yamaguchi	18	18	100.0%	0	0	0	0
Tokushima	24	24	100.0%	0	0	0	0
Kagawa	16	16	100.0%	0	0	0	0
Ehime	19	19	100.0%	0	0	0	0
Kochi	33	33	100.0%	0	0	0	0
Fukuoka	57	54	94.7%	1	2	0	0
Saga	20	18	90.0%	0	0	1	1
Nagasaki	19	19	100.0%	0	0	0	0
Kumamoto	44	39	88.6%	1	0	3	1
Oita	17	17	100.0%	0	0	0	0
Miyazaki	25	23	92.0%	0	1	0	1
Kagoshima	42	42	100.0%	0	0	0	0
Okinawa	40	37	92.5%	0	1	2	0
	1,631	1,549	95.0%	6	9	32	35

(Note) Excluding health center-designated cities and special wards.

Detailed Data 2 Number of Patients and Deaths Related to Lifestyle Diseases

	Estimated number of patients receiving medical treatment (1,000 persons)	Number of deaths (Person)	Death rate (Per 100,000 persons)
Malignant neoplasms	3,939	384,099	319.3
Diabetes mellitus	5,523	14,945	12.4
Hypertensive diseases	16,173	11,791	9.8
Heart diseases (excluding hypertensive)	3,578	226,277	188.1
Cerebrovascular diseases	1,886	102,808	85.5

Source:

<The estimated number of patients receiving medical treatment>

<Number of deaths, Death rate>

“Patient Survey 2023”, Health Statistics Office to the Councilor, Director-General for Statistics, Information System Management and Industrial Relations, MHLW
 “Vital Statistics”, Vital, Health and Social Statistics Office to the Councilor, Director-General for Statistics, Information System Management and Industrial Relations, MHLW (2024 preliminary data)

Detailed Data 3 Prevalence Related to Diabetes

Age	Men (survey samples: 945)		Women (survey samples: 1,226)	
	Strongly suspected of having diabetes	With possibilities of having diabetes	Strongly suspected of having diabetes	With possibilities of having diabetes
20-29	0.0%	0.0%	0.0%	1.9%
30-39	3.4%	1.7%	1.0%	0.0%
40-49	6.3%	4.2%	4.6%	0.0%
50-59	11.1%	5.9%	6.2%	5.3%
60-69	15.7%	8.8%	10.1%	8.5%
70 or older	26.2%	9.7%	13.7%	11.3%

Source: "National Health and Nutrition Survey 2023", Public Health Bureau, MHLW

(Note) The analysis included individuals who had a hemoglobin A1c measurement in their physical condition survey and responded validly to the questions on the past diagnosis of diabetes, the current status of treatment for diabetes, and the current status of medication for diabetes.

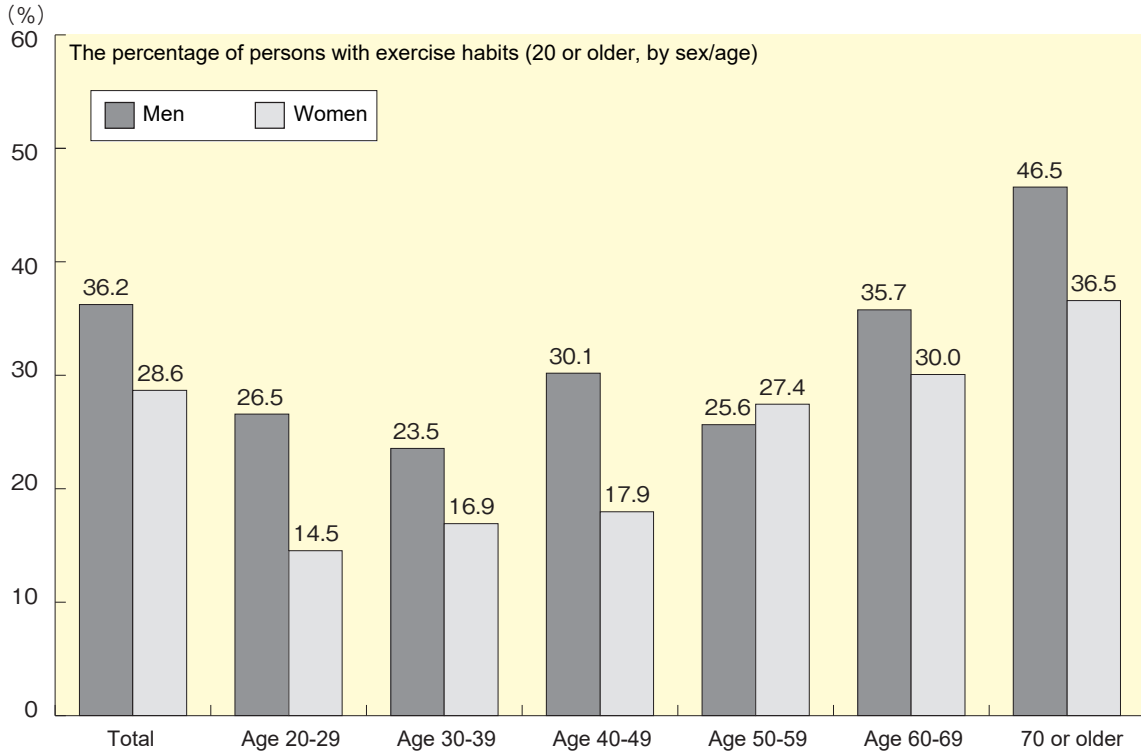
- The definition of "Those strongly suspected of having diabetes"

"Those strongly suspected of having diabetes" are those who had a hemoglobin A1c (NGSP) level of 6.5% or higher or those who responded "yes" to the question "Have you ever received diabetes treatment?" among participants with a hemoglobin A1c measurement and valid responses to the questions on the past diagnosis of diabetes, the current status of treatment for diabetes, and the current status of medication for diabetes.

- The definition of "Those who cannot rule out the possibility of having diabetes"

"Those who cannot rule out the possibility of having diabetes" are those who had a hemoglobin A1c (NGSP) level of 6.0% or more and less than 6.5%, excluding those who are "Those strongly suspected of having diabetes"

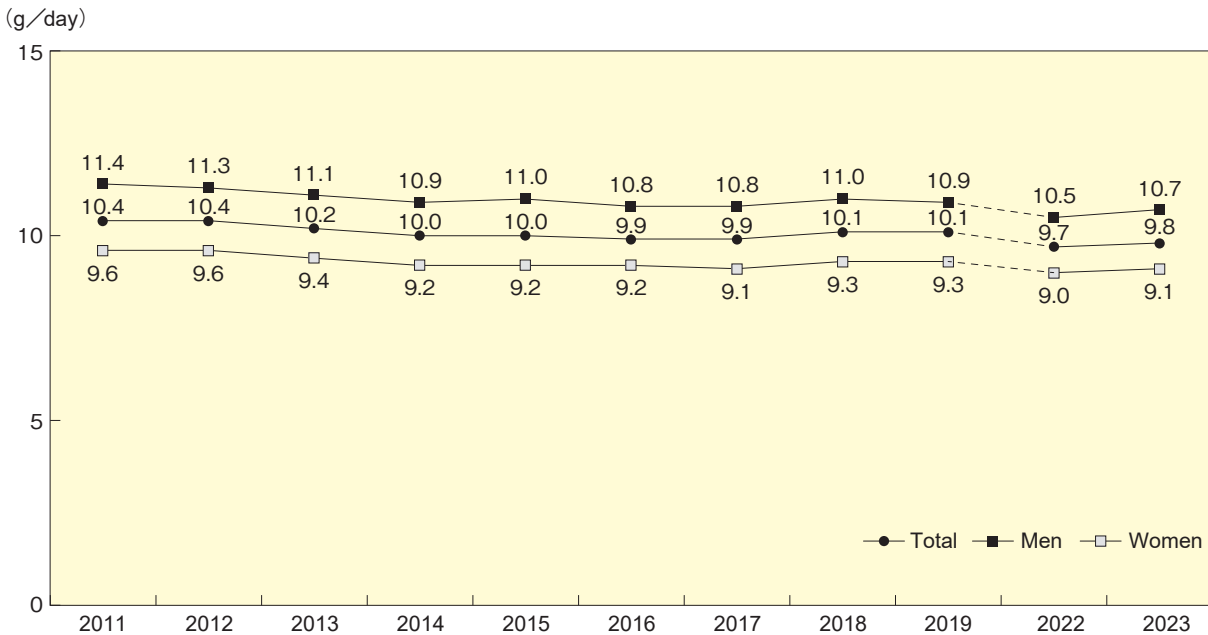
Detailed Data 4 Status of Exercise Habits



Source: "National Health and Nutrition Survey 2023", Public Health Bureau, MHLW

(Note) Persons with exercise habits: Those who have been continuing daily exercise of 30 minutes or longer at least 2 days a week for at least a year.

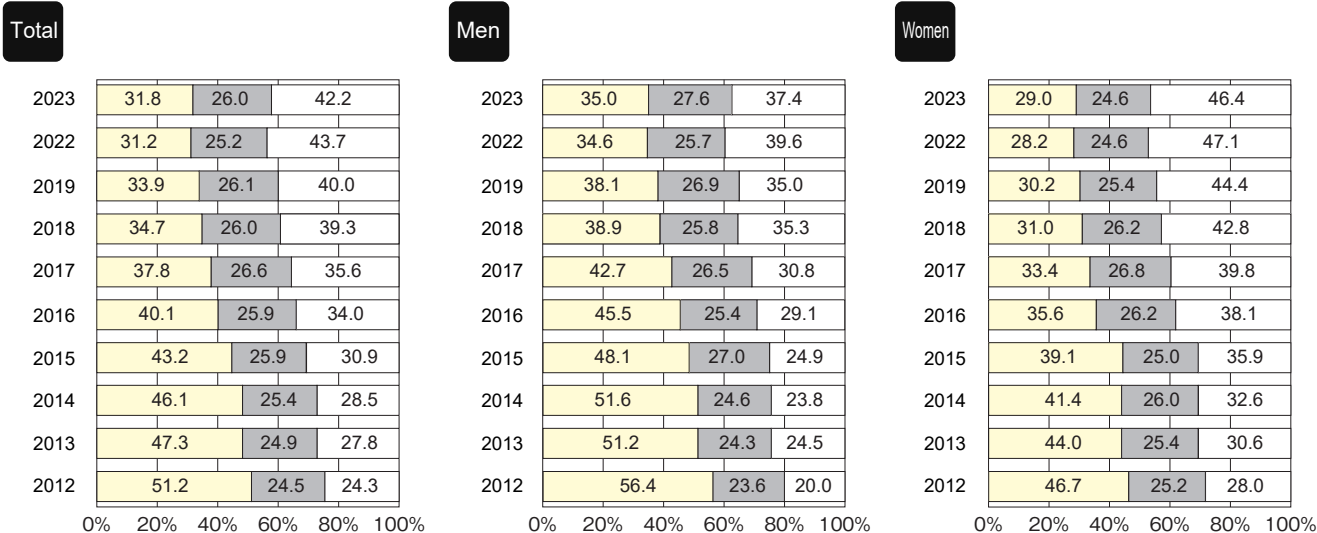
Detailed Data Average of Salt Intake (Aged 20 or Older, by Sex)



"National Health and Nutrition Survey", Public Health Bureau, MHLW

(Note) Surveys were canceled in 2020 and 2021

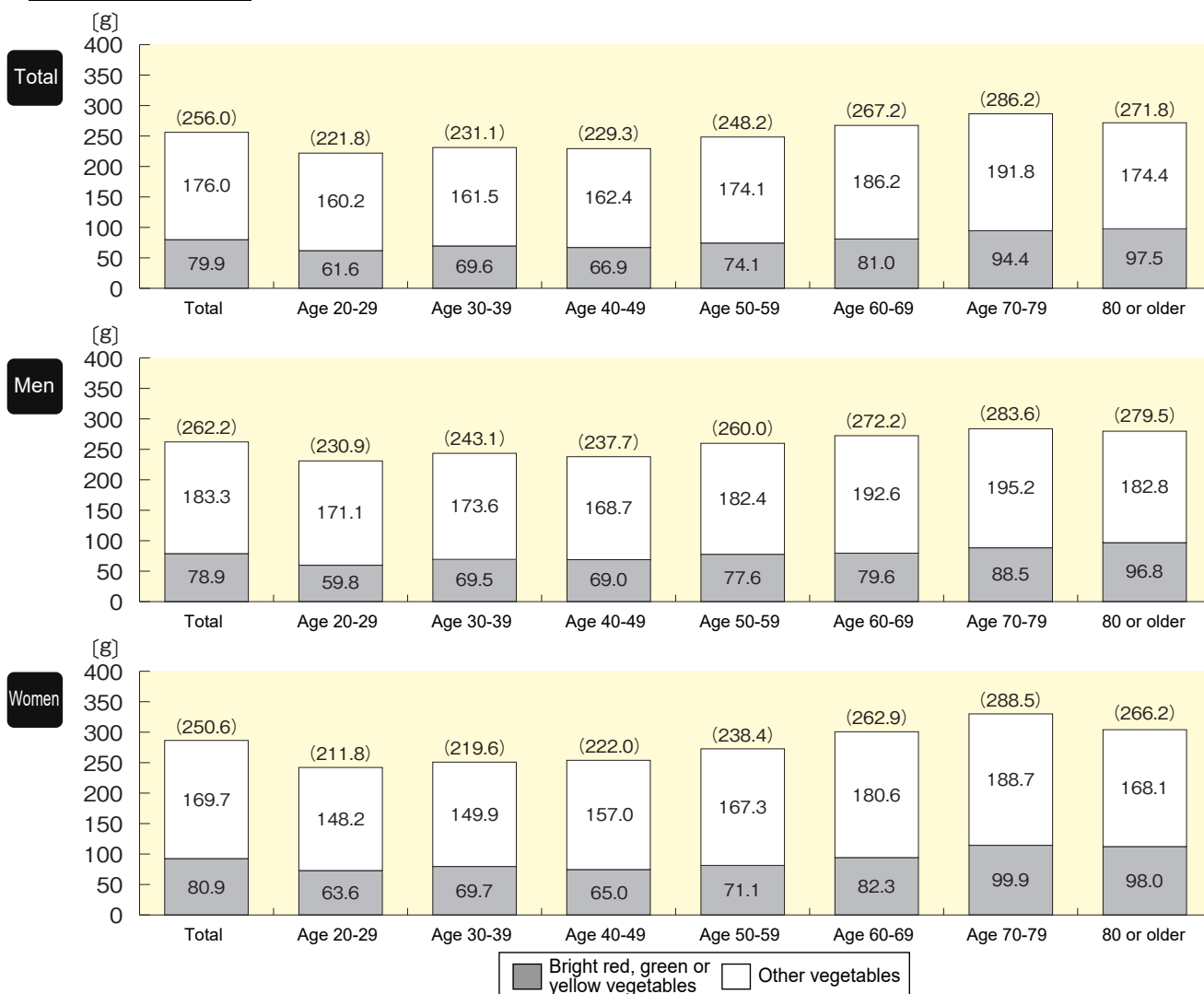
Detailed Data 6 Secular Trend in Distribution of Fat Energy Ratio (Aged 20 or Older)



Source: "National Health and Nutrition Survey",
Public Health Bureau, MHLW
(Note) Surveys were canceled in 2020 and 2021

Less than 25% 25% or more but less than 30% 30% or more

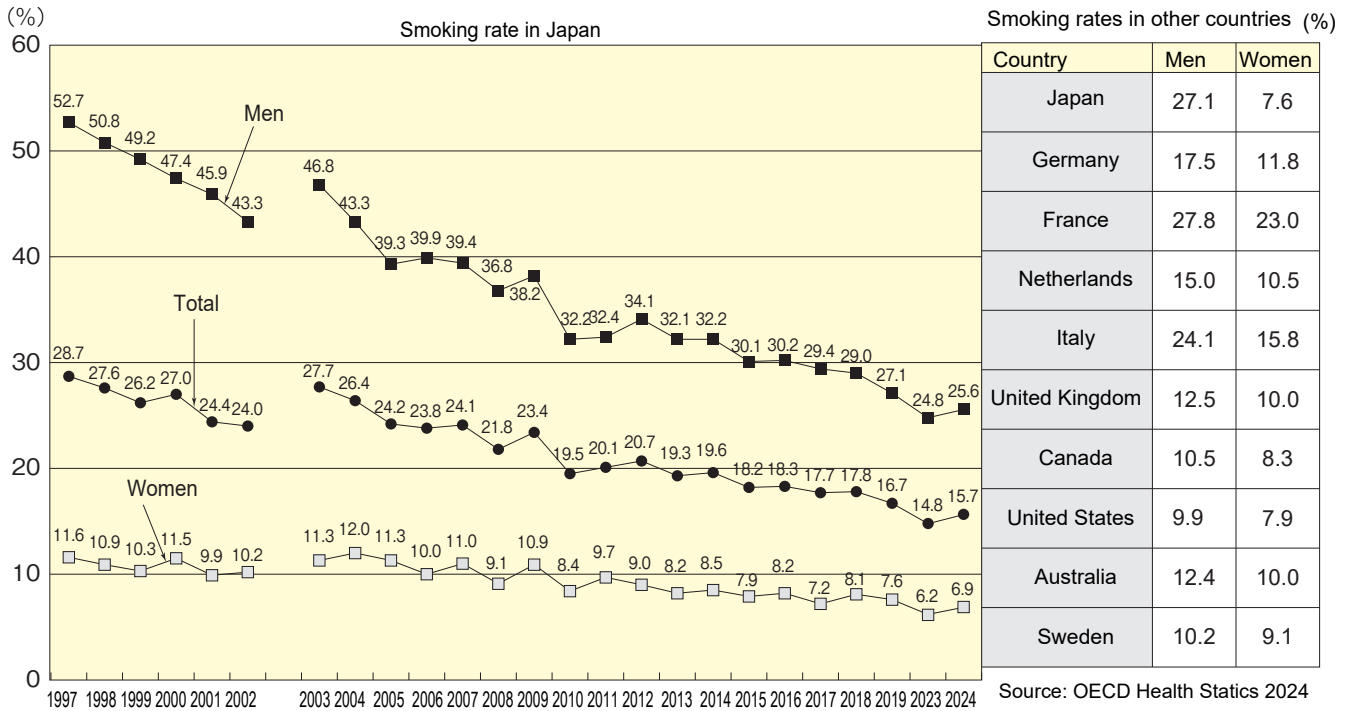
Detailed Data 7 Average Intake of Vegetables, etc. (Aged 20 or Older, by Sex/Age)



Source: "National Health and Nutrition Survey 2023", Public Health Bureau, MHLW

(Note) The figures in parentheses indicate the total intake of "bright red, green or yellow vegetables" and "other vegetables"

Detailed Data 8 Smoking Rate in Japan



Source: "National Nutrition Survey" up to 2002 and "National Health and Nutrition Survey" from 2003 onward

(Note) Definition of smoking and survey methods differ between the National Nutrition Survey and the National Health and Nutrition Survey hence figures cannot simply be compared.

Cardiovascular Measures

Overview

The Basic Plan for Promoting stroke/cerebrovascular and CVD

Overall target

By 2040, increase healthy life expectancy by more than 3 years and reduce age-adjusted mortality from CVD

Each Measure

CVD : stroke/cerebrovascular and CVD

【Foundation】 Collect treatment information on cardiovascular issues and establish a system of provision
 establish official framework to collect and utilize treatment information on CVD

1. Prevention of CVD and creation of awareness and appropriate knowledge

- Prevention of the outbreak and progression of CVD
- Promoting the dissemination and awareness of correct knowledge about CVD (cardiovascular diseases prevention, appropriate response at the early stages of outbreak, prevention of serious illness, after-effects, etc.) to the public from childhood
- Grasping the public's level of awareness, etc. of CVD

3. Promote research on CVD

- Promoting research and development that contributes to methods regarding the clarification of the pathology of CVD, the development of new diagnostic techniques and treatment methods, rehabilitation, etc.
- Formulating policies based on scientific evidence and promoting research to effectively advance measures against CVD

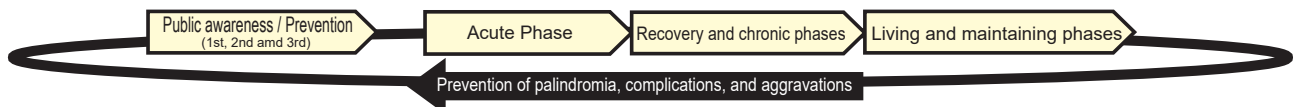
2. Fulfillment of a system for providing healthcare, medical and welfare services

- Widespread medical checkups and promotions to tackle CVD
- Establish an emergency system
- Establish a medical service system for CVD including securing emergency medical services
- Rehabilitation measures
- Support people experiencing delayed effects from CVD
- Palliative care for CVD
- Support cardiovascular measures and patients based on social collaborations
- Support combining treatment with employment assistance for patients
- Implement measures on CVD that require early consideration from childhood and adolescence onwards
- Provide accurate information and consultation support on CVD

Matters necessary to ensure the comprehensive and systematic promotion of CVD measures

- Further strengthening of organic coordination and cooperation between relevant parties
- Coordination with measures for other diseases, etc.
- Measures in anticipation of emergencies such as infectious disease outbreak and spread, or disasters
- Formulating plans by prefecture
- Implementation of necessary financial measures and streamlining and prioritization of the budget
- Evaluation and revision of the basic plan

<Characters and measures of cardiovascular measures>



Overview

The Stroke/Cerebrovascular and CVD Control Act

Purpose

Promulgation date: 14th Dec, 2018, Enforcement date: 1st Dec., 2019

Based on the current situation where CVD such as cerebral apoplexy, hypertension, etc. are major causes of death of citizens, take measures for the prevention, etc. of CVD, extend the life expectancy of citizens, and reduce the burden on healthcare.

Overview

I Basic policy

- Deepen citizens' understanding and interest in the importance of preventing CVD and implement swift and appropriate responses for patients with suspected CVD
- Provide continuous and comprehensive services for healthcare, medical (including rehabilitation), and welfare services for cardiovascular patients irrespective of where they live
- Promote research on CVD provide outcomes of researches, etc. of technical improvement, develop goods utilizing those outcomes and provide them

II Legal measures

- The government will take legal, financial, and other actions required to implement cardiovascular measures

III Formation of a basic plan, etc. for the promotion of cardiovascular measures

- The government will establish a promotion committee for cardiovascular measures and set up a basic plan for the promotion of cardiovascular measures. And after at least every six years, it shall be reviewed. The prefectural governments will establish a prefectural promotion committee for cardiovascular measures and set up a prefectural basic plan for the promotion of cardiovascular measures. And after at least every six years, it shall also be reviewed.

IV Basic implementation

- Promote the prevention of CVD
- Establish systems for the transport and admittance of patients with suspected CVD
- Improve medical institutions
- Maintain and improve the quality of life of patients with CVD
- Establish collaborative systems among related institutions that provide health, medical, and welfare services
- Foster those working in health, medical, and welfare services
- Establish the collection and provision of information systems
- Promote research, etc.

Dental Health Promotion

Overview

8020 (Eighty-Twenty) Campaign

[History of 8020 (Eighty-Twenty) Campaign]

1989	A Study Group on the Dental Health Policy for Adults made public its interim report in which the “8020 (Eighty-Twenty) Campaign” calling for the retention of 20 or more teeth even at age 80 was proposed.
1991	“Promotion of 8020 Campaign” was set to be the major objective for the Dental Hygiene Week (June 4-10).
1992	“8020 Campaign promotion measure projects” were launched for dissemination and enlightenment of the 8020 Campaign (until 1996).
1993	“8020 Campaign promotion support projects” were launched for smooth implementation of 8020 Campaign promotion measure projects (until 1997).
1997	“Dental health promotion projects” were launched.
2000	“8020 Campaign promotion special projects” were launched.
2011	The “Dental Health Promotion Act” was approved.
2012	The “Basic Matters Related to the Promotion of Dental and Oral Health” was announced by the Minister in accordance with the “Dental Health Promotion Act”. The “Health Japan 21 (second term)”, which provides efforts for further advancing 8020 activities, was announced by the Minister.
2013	The results of the “Survey of Dental Diseases (2011)” were published. The title of “Dental Hygiene Week” was changed to “Dental and Oral Health Week” and the priority objective “advancement of dental and oral health that supports the power to live – new development of 8020 Campaign throughout life –”
2017	The results of the “Survey of Dental Diseases (2016)” were published. Those who achieved the 8020 exceeded 50%.
2023	The “Basic Matters Related to the Promotion of Dental and Oral Health (second term)” was announced by the Minister. Results of the “Survey of Dental Diseases (2022)” were published. Those who achieved the 8020 were 51.6%

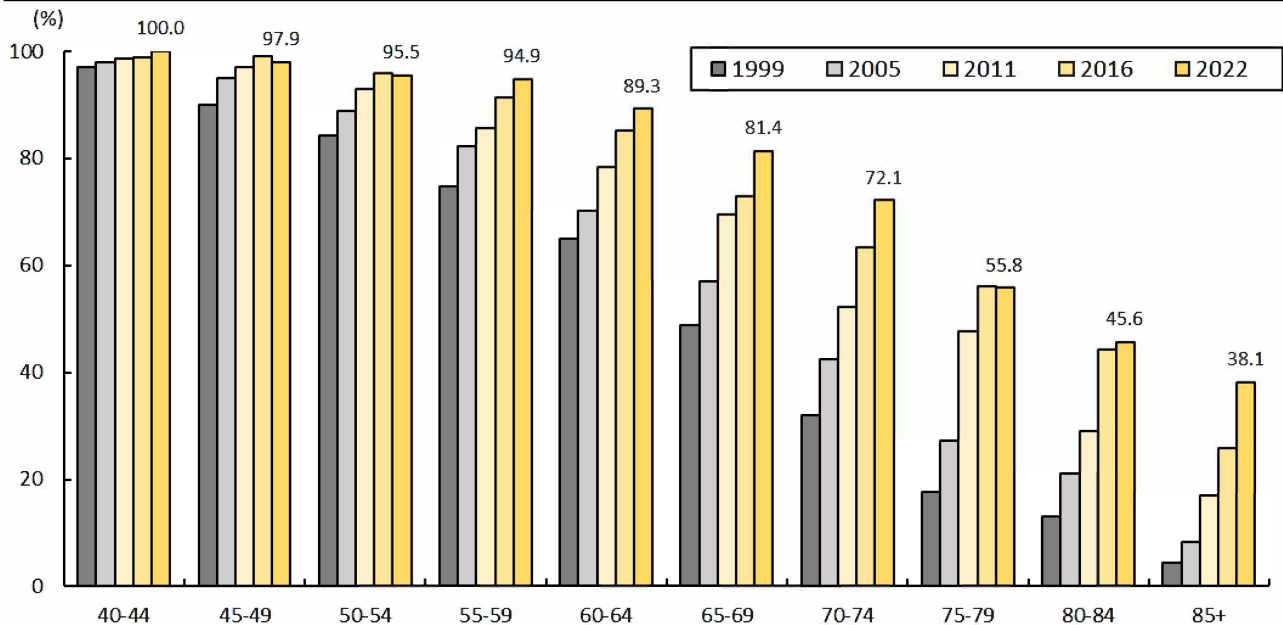
[8020 Campaign and the “Basic Matters Related to the Promotion of Dental and Oral Health (second term)”, the “Health Japan 21 (third term)”]

The “Basic Matters Related to the Promotion of Dental and Oral Health (second term)” and the “Health Japan 21 (third term)” announced in 2023 were mutually harmonized. In the future, it will be important to continue to promote dental and oral health initiatives through lifelong dental health measures (8020 Campaign).

Detailed Data

Changes in Percentage of Persons Having 20 or More Teeth by Age Group

Year \ Age	40-44	45-49	50-54	55-59	60-64	65-69	70-74	75-79	80-84	85+
1999	97.1%	90.0%	84.3%	74.6%	64.9%	48.8%	31.9%	17.5%	13.0%	4.5%
2005	98.0	95.0	88.9	82.3	70.3	57.1	42.3	27.1	21.1	8.3
2011	98.7	97.1	93.0	85.7	78.4	69.6	52.3	47.6	28.9	17.0
2016	98.8	99.0	95.9	91.3	85.2	73.0	63.4	56.1	44.2	25.7
2022	100.0	97.9	95.5	94.9	89.3	81.4	72.1	55.8	45.6	38.1



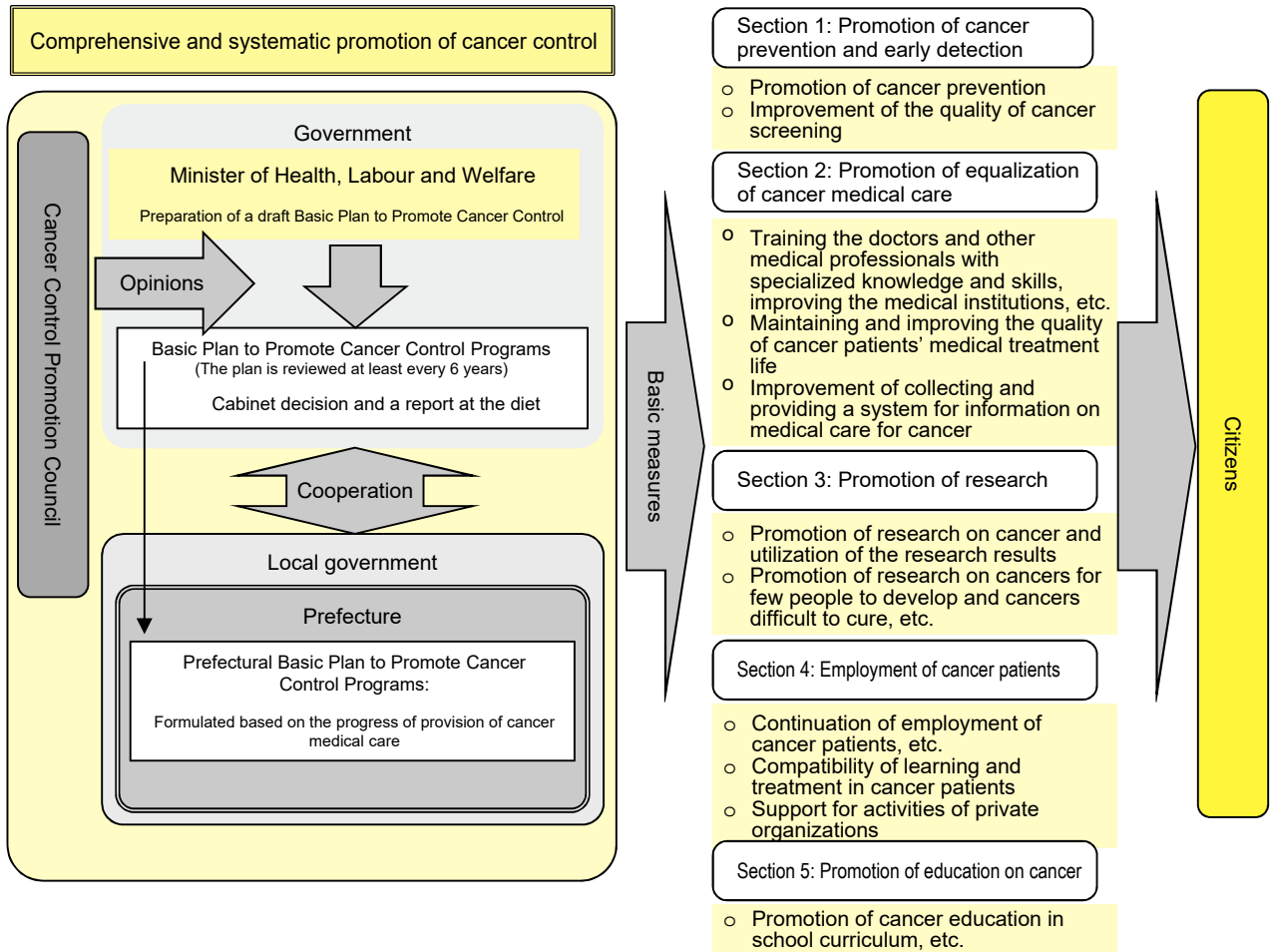
Age

Source: “Survey of Dental Diseases”, Health Policy Bureau, MHLW

Cancer Control Measures

Overview

Cancer Control Act (Act No. 98 of 2006, enforced in April 2007, revised and enforced in December 2016)



**The 4th-term Basic Plan to Promote Cancer Control Programs
(Cabinet decision on March 28, 2023) (Outline)**

Overall goal: "Promoting cancer control measures that do not leave anyone behind, and aiming to overcome cancer with all citizens."

Goal in the Field of "Cancer Prevention"

Aiming to reduce the incidence and mortality rates of cancer by learning about cancer, preventing cancer, and promoting early detection and early treatment through cancer screening.

Goal in the Field of "Cancer Care"

Enriching the system for receiving appropriate medical care, aiming to improve cancer survival rates, reduce cancer mortality rates, and improve the quality of life of all cancer patients and their families

Goal in the Field of "Coexistence with Cancer"

Realizing a community-based society where people with cancer can live with peace of mind and dignity, aiming to improve the quality of life for all cancer patients and their families

1. Cancer prevention

- (1) Primary cancer prevention
 - ① Lifestyle
 - ② Measures for infectious diseases
- (2) Secondary prevention of cancer (cancer screening)
 - ① Measures to improve the rate of medical consultations
 - ② Accuracy management of cancer screening, etc.
 - ③ Implementation of cancer screening based on scientific evidence

2. Cancer care

- (1) Cancer care provision system, etc.
 - ① Equalization and centralization of the medical care provision systems
 - ② Cancer genome medicine
 - ③ Surgery, radiation therapy and drug therapy for cancers
 - ④ Promotion of team medicine
 - ⑤ Cancer rehabilitation
 - ⑥ Promotion of supportive therapy
 - ⑦ Promotion of palliative care from the time of diagnosis of cancers
 - ⑧ Fertility preservation therapy
- (2) Measures for rare and refractory cancers
- (3) Measures for childhood and AYA generation cancers
- (4) Measures for elderly cancer patients
- (5) Prompt implementation of new pharmaceuticals, medical devices, and medical technologies in medical care

3. Coexistence with cancer

- (1) Consultation and support and information provision
 - ① Consultation and support
 - ② Information provision
- (2) Cancer measures and cancer patient support based on social cooperation
- (3) Measures for social problems of cancer patients (survivorship support)
 - ① Employment support
 - ② Appearance care
 - ③ Measures to prevent suicide after a cancer diagnosis
 - ④ Other social problems
- (4) Cancer measures according to life stages
 - ① Childhood and AYA generation
 - ② Elderly

4. Infrastructure to support the above

- (1) Further promoting cancer research, including new technologies such as whole genome analysis
- (2) Strengthening human resource development
- (3) Cancer educating and the dissemination and promoting of knowledge about cancer
- (4) Promoting utilization of cancer registration
- (5) Promoting patient and citizen participation
- (6) Promoting digitalization

3. Comprehensive and systematic promotion of cancer measures

- 1. Further cooperation among persons concerned
- 2. Measures in anticipation of infectious disease outbreak and spread or disasters, etc
- 3. Formulation of local plans by prefectures
- 4. Efforts by citizens
- 5. Necessary financial measures and efficient and prioritized budgets
- 6. Comprehension of goal achievements
- 7. Review of basic plans

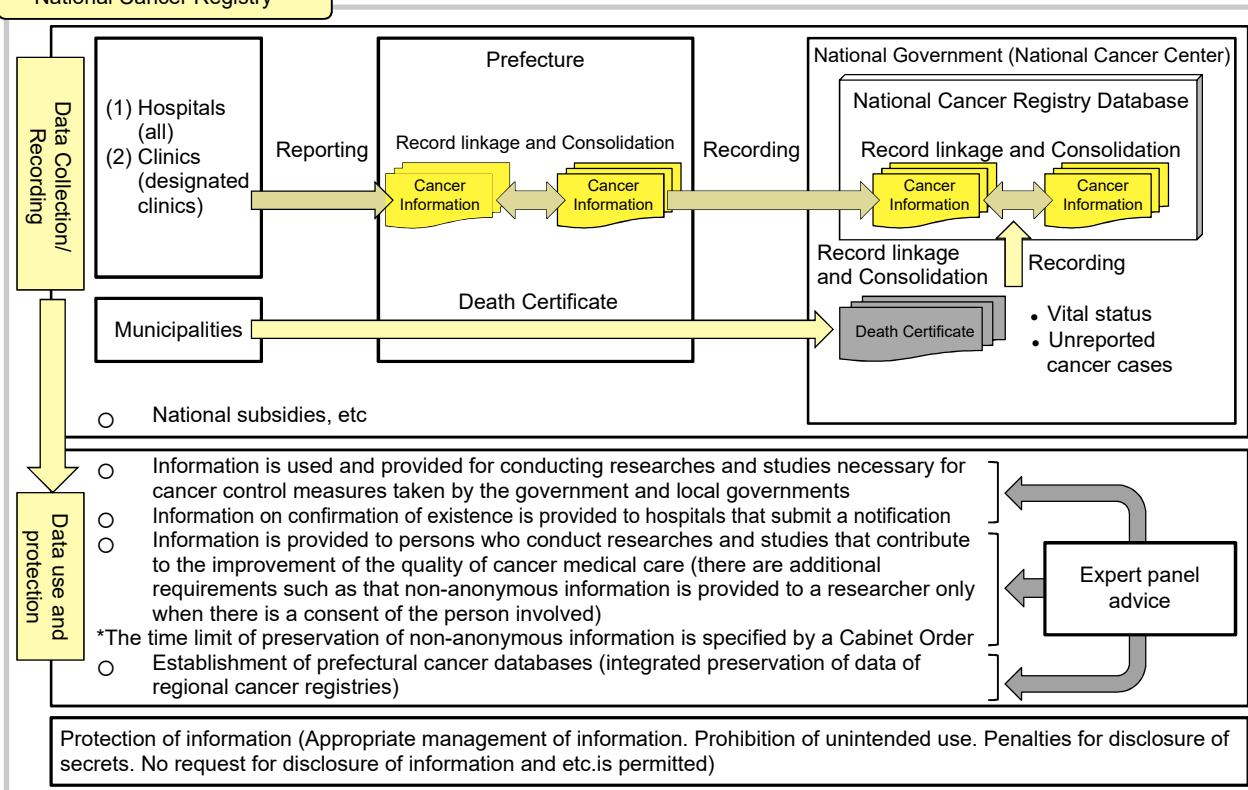
Outline of Cancer Registry Promotion Act

- National cancer registry: The government records and preserves information on cancers, treatment and outcomes in Japan in a database.
 - Hospital-based cancer registry: Hospitals record and preserve detailed information on cancers, treatment and outcomes for the purpose of accurately grasping the status of cancer medical care.
- ➔ The measures for improvement of the quality of cancer medical care (improvement of the quality of cancer medical care and cancer screening and promotion of cancer prevention) and for enhanced provision of information on cancers, cancer medical care and their prevention to citizens and other cancer control measures are implemented based on scientific knowledge.

Basic principles

- The national cancer registry grasps the status of cancers, treatment and outcomes as accurately as possible by means of broad information collection;
- The Hospital-based cancer registry aims to collect necessary information without fail through the national cancer registry and to disseminate and enhance such information;
- The Act aims to collect detailed information on cancer treatment with the aim of enhancing cancer control measures;
- It aims to utilize cancer registries information for researches and studies on cancers including those conducted by the private sector and to use their results for the benefit of society; and
- It aims to strictly protect individual information stored in cancer registries

National Cancer Registry



Promotion of the hospital-based cancer registry (Promotion of the hospital-based cancer registry and system improvement for collection of information on cancer treatment)

Human resource development (Provision of necessary trainings for securing human resources who engage in administrative affairs of the national cancer registry or hospital-based cancer registry)

Utilization of cancer registries information

- Government and prefectures⇒ Enhancement of cancer control measures, provision of information to medical institutions, disclosure of statistics and consultation services for patients
- Medical institutions⇒Provision of appropriate information to patients, analysis and evaluation of cancer medical care, improvement of the quality of cancer medical care
- Researchers who receive cancer registries information⇒Contribution to the improvement of the quality of cancer medical care

Detailed Data Statistics on Cancer

Item	Current status	Source
Number of deaths	<p>Total of 384,099 persons (23.9% of all causes of death) [221,782 males (27.1% of all causes of death)] [162,317 females (20.7% of all causes of death)] → "1 in every 4 Japanese die of cancer"</p>	Vital Statistics of Japan (2024 preliminary data)
Incidence rate	<p>988,900 persons (Malignant neoplasms) [555,918 males] Sites often affected: ① prostate, ② large intestine, ③ lung, ④ stomach, ⑤ liver [432,982 females] Sites often affected: ① breast, ② large intestine, ③ lung, ④ stomach, ⑤ uterus</p>	National Cancer Registration patients number and incidence rate Report 2021 (2021)
Lifetime risk	<p>Male: 62.1%, Female: 48.9% → "1 in every 2 persons will contract cancer in Japan"</p>	Estimates by Center for Cancer Control and Information Services, National Cancer Center (2020)
Patients and persons receiving treatment	<p>The estimated number of patients receiving medical treatment is 3,939,000</p> <ul style="list-style-type: none"> •The estimated number of inpatients on the dates of survey is 106,100 •The estimated number of outpatients on the dates of survey is 186,400 	Patient Survey (2023)
Medical care expenditure for cancer	<p>¥4,366.1 billion * 12.9% of all medical care expenditures for general practice</p>	Estimates of National Medical Care Expenditure (FY 2022)

Measures against allergic diseases

Overview

Basic Act on Allergic Diseases Measures (enacted on December 25, 2015)

Diseases subject to this Act: Bronchial asthma, atopic dermatitis, allergic rhinitis, allergic conjunctivitis, pollinosis, food allergy

*Although the Act provides that any disease other than the six diseases mentioned above may be specified by a Cabinet Order where necessary, there is no plan at this moment to add any disease.

Basic principles

- (1) Improving living conditions by taking comprehensive measures.
- (2) Providing appropriate medical care for allergic diseases regardless of the location of residence.
- (3) Establishing a system by which appropriate information can be obtained and a support system to maintain and improve the quality of life.
- (4) Promoting researches on allergic diseases and disseminating, utilizing and evolving their achievements.

Basic Guidelines for Promotion of Control Measures for Allergic Diseases

- The Minister of Health, Labour and Welfare shall formulate the Basic Guidelines for the purpose of comprehensively promoting measures against allergic diseases
- Basic matters concerning the promotion of measures against allergic diseases
- Matters concerning measures for raising awareness and disseminating knowledge about allergic diseases and for prevention thereof
- Matters concerning the securing of systems to provide medical care for allergic diseases
- Matters concerning researches and studies on allergic diseases
- Other important matters concerning the promotion of measures against allergic diseases

Ministry of Health, Labour and Welfare

Allergic Disease Control Promotion Council

- The Council expresses its opinions when the Basic Guidelines for Measures against Allergic Diseases are formulated or changed
- Its members are appointed by the Minister of Health, Labour and Welfare

(Members)

- Patients and their representatives
- Persons who involve in medical care for allergic diseases
- Persons who have academic experience

*Matters necessary for the organization and operation of the Council are provided for by a Cabinet Order

Measures against Hepatitis

Overview Basic Act on Hepatitis Measures

Basic Act on Hepatitis Measures (Act No.97 of 2009)

Comprehensive formulation/enforcement of measures against hepatitis

- To stipulate basic principles for measures against hepatitis;
- To clarify responsibilities of the government, local governments, medical insurers, citizens, and doctors, etc.;
- To formulate guidelines concerning promotion of measures against hepatitis, and
- To comprehensively promote measures against hepatitis by stipulating basic articles for them

Basic measures

Promotion of prevention and early detection

- Prevention of hepatitis
- Quality improvement of hepatitis examinations, etc.

Research promotion

Promotion of equalization of medical services for hepatitis patients, etc.

- Training of doctors and other medical professionals to acquire the expertise
- Establishment and improvement of medical institutions
- Financial support for medical care expenses on hepatitis patients
- Securing opportunities for hepatitis care
- Establishment and improvement of system for collecting and providing information on hepatitis care, etc.

Measures must be taken with careful consideration given to the human rights of patients and elimination of discrimination against them

Formulation of basic measures against hepatitis

The Council for Promotion of Hepatitis Measures

- Representatives of hepatitis patients, etc. Advice
- The medical professions engaged in hepatitis care
- Persons with relevant knowledge and experience

Relevant administrative organizations

Establish

Advice

Request for documents, etc.

Discussion

Minister of Health, Labour and Welfare

Formulation

Basic measures against hepatitis

- Announcement
- Reviews at least every 5 years
- Revise if necessary

Response to cirrhosis and liver cancer

- Creation of an environment for improved treatment level

- Support for patients with severe cirrhosis and liver cancer

Basic Guidelines for Hepatitis Measures in Brief (formulated on May 16, 2011, revised on March 7, 2022)

1 The basic direction to take in promoting the prevention of hepatitis and hepatitis-related medical care

- Aiming to reduce the number of people who develop liver cirrhosis or liver cancer by achieving “complete elimination of hepatitis”, and setting as a specific indicator of reducing the incidence of liver cancer as much as possible.

2 Matters concerning measures to take in preventing hepatitis

- Necessary to disseminate correct knowledge about hepatitis to prevent new infections.
- Promoting preventive measures for infection of mother-to-child hepatitis B, continuing to promote periodic hepatitis B vaccination, and promoting interferon-free treatment for hepatitis C.

3 Matters concerning improvement of a system to use implementing hepatitis examinations and their capabilities

- To inform all citizens that they need to receive hepatitis virus test at least once
- Continuing to develop a system that allows for examination of the hepatitis virus tests with due consideration to the convenience of the examinee and privacy in the workplace, etc.
- To make such efforts that a hepatitis virus test can be carried out together with a medical examination, while making the concerned parties understand, such as medical insurers and employers.

4 Matters concerning securing of a system to use providing hepatitis-related medical care

- Necessary to further develop the regional hepatitis clinical care network so that all hepatitis patients can receive continuous and appropriate care.
- To make further efforts for increase of hepatitis virus inspection and follow-up after the inspection
- Necessary to enlighten stakeholders such as business operators and get their understanding and cooperation so that the employees can receive medical treatment continuously while continuing to work

5 Matters concerning prevention of hepatitis and human resource development for hepatitis medical care

- It is necessary to develop human resources with knowledge about the prevention of hepatitis infection, such as hepatitis medical coordinators, and those capable of linking appropriate hepatitis care after infection is known, and to promote their activities.

6 Matters concerning surveys and research on hepatitis

- To evaluate and verify research achievements comprehensively, and promote hepatitis research as the basis for comprehensive promotion of measures against hepatitis so that the past achievements can be appropriately reflected on such measures

7 Matters concerning promotion of research and development of medicine for hepatitis-related medical care

- In light of recent trends in hepatitis treatment, it is necessary to proceed with research and development of new medicines related to hepatitis treatment, especially cancer-related medicines including for hepatitis B, cirrhosis and liver cancer, as well as to promote clinical trials and research, and to speed up the review process.

8 Matters concerning public awareness and dissemination of information concerning hepatitis and matters concerning respect for the human rights of hepatitis patients, etc.

- Necessary to disseminate information and enlighten people to promote receipt of hepatitis virus tests, prevent new infections, discontinue unfair discrimination against hepatitis patients, protect their human rights, and create an environment where people can live a secure social life

9 Other important matters concerning the promotion of hepatitis measures

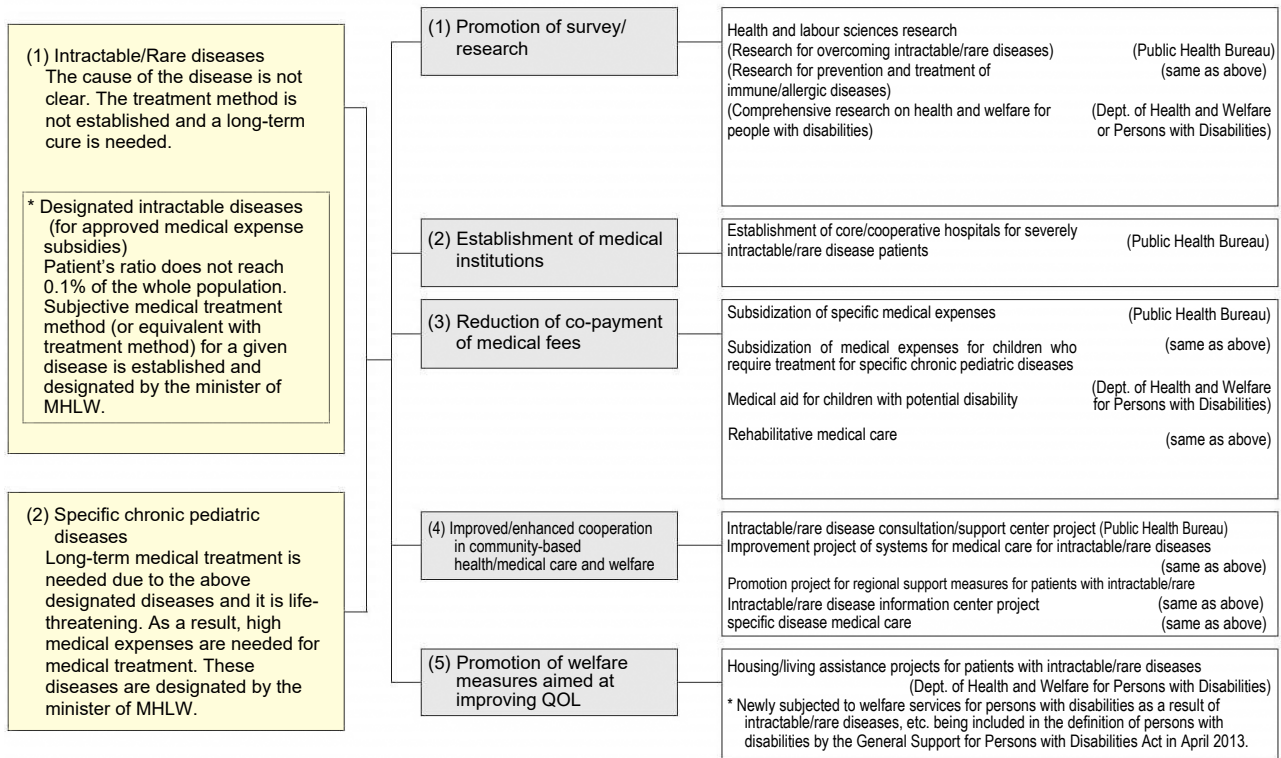
- To strengthen and enhance support for hepatitis patients and their families, etc.
- For the research promotion project for the treatment of liver cancer and severe liver cirrhosis, considering measures to promote effective use, including making it publicly known, while also taking into account the implementation status.
- To require the national government to urge the local governments to make a plan and set a target concerning measures against hepatitis after consultation with the stakeholders based on the actual circumstances in the community
- To request each citizen to confirm his/her own hepatitis virus infection, have proper knowledge about the possibility of infection, act appropriately to prevent new infection, acquire correct knowledge and make efforts for responding appropriately not to cause discrimination against hepatitis patients, etc.

Intractable/Rare Disease Measures

Overview Outline of Intractable/Rare Disease Measures

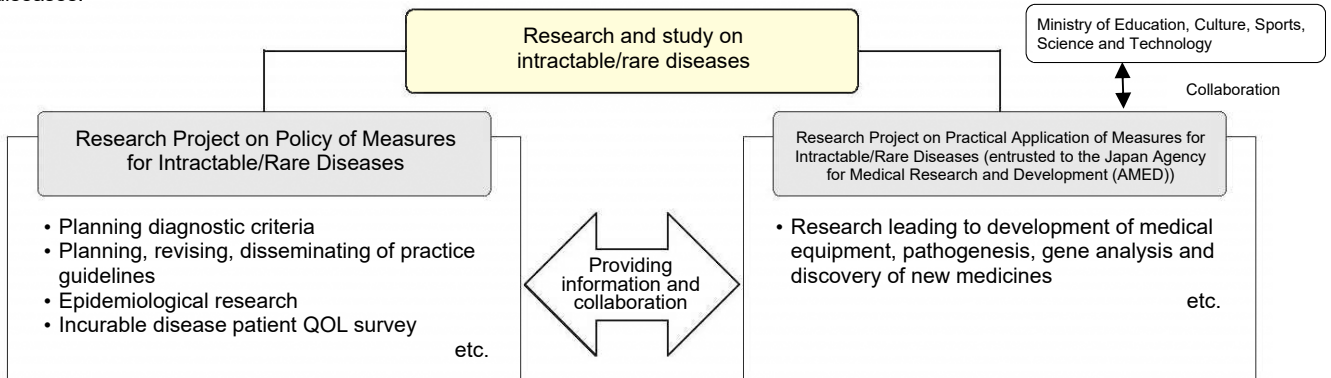
Various projects have been implemented based on Act on Medical Care and Social Supports for Patients with Intractable/Rare Diseases

<Definitions of intractable/rare diseases addressed>



Intractable Diseases Policy Research Program

In order to comprehensively and strategically conduct researches on intractable/rare diseases, the project makes use of the nationwide database to specify epidemiology and pathogenesis, develop new cure methods and conduct researches with the use of regenerative medical techniques as well as promotes researches and studies integrated with the policies for intractable/rare diseases.



Detailed Data Designated Intractable Diseases

No.	Disease Name	No.	Disease Name	No.	Disease Name
1	Spinobulbar muscular atrophy	103	CFC syndrome	205	Fragile X syndrome related disease
2	Amyotrophic lateral sclerosis	104	Costello syndrome	206	Fragile X syndrome
3	Myelopathic muscular atrophy	105	Charge syndrome	207	Tmc/Art.; truncus arteriosus
4	Primary lateral sclerosis	106	Cryopyrin associated periodic fever syndrome	208	Corrected TGA
5	Progressive supranuclear palsy	107	Systemic-onset juvenile idiopathic arthritis	209	TGA
6	Parkinson's disease	108	TNF receptor associated periodic syndrome	210	Single ventricle
7	Corticobasal degeneration	109	Atypical hemolytic uremic syndrome	211	Hypoplastic left heart syndrome
8	Huntington disease	110	Blau syndrome	212	Tricuspid atresia
9	Neuroacanthocytosis	111	Congenital myopathy	213	Pulmonary atresia with intact ventricular septum
10	Charcot-Marie-Tooth disease	112	Marinesco – Sjogren's syndrome	214	Pulmonary atresia with ventricular septal defect
11	Myasthenia gravis	113	Muscular dystrophy	215	Tetralogy of Fallot
12	Congenital myasthenic syndrome	114	Non- dystrophic myotonia syndrome	216	Double outlet right ventricle (DORV)
13	Multiple sclerosis / Optic neuromyelitis	115	Hereditary periodic paralysis	217	Ebstein disease
14	Chronic inflammatory demyelinating polyradiculo neuropathy/Multifocal motor neuropathy	116	Atopic myelitis	218	Alport's syndrome
15	Inclusion body myositis	117	Syringomyelia	219	Galloway-Mowat syndrome
16	Crow-Fukase syndrome	118	Myelomeningocele	220	Rapidly progressive glomerulonephritis
17	Multiple-system atrophy	119	Isaacs syndrome	221	Anti-glomerular basement membrane disease
18	Spinocerebellar degeneration (except multiple-system atrophy)	120	Hereditary dystonia	222	Primary Nephrotic syndrome
19	Lysosomal storage disease	121	Neurodegeneration with brain iron accumulation	223	Primary membranoproliferative glomerulonephritis
20	Adrenoleukodystrophy	122	Brain table hemosiderosis	224	Purpura nephritis
21	Mitochondrial diseases	123	HTRA1-related cerebral small vessel disease	225	Congenital nephrogenic diabetes insipidus
22	Moyamoya disease	124	Autosomal dominant cerebral artery disease with subcortical infarct and leukoencephalopathy	226	Interstitial cystitis
23	Prion disease	125	Autosomal dominant cerebral arteriopathy with subcortical infarction and leukoencephalopathy	227	Osler disease
24	Subacute sclerosing panencephalitis	126	Perry disease	228	Obliterating bronchiolitis
25	Progressive multifocal leukoencephalopathy	127	Frontotemporal lobar degeneration	229	Pulmonary proteinosis (autoimmunity/hereditary)
26	HTLV-1-associated myelopathy	128	Vickers staff brainstem encephalitis	230	Alveolar hypopventilation syndrome
27	Idiopathic basal ganglia calcification diseases	129	Epileptic type (biphasic) acute encephalopathy	231	α1-antitrypsin deficiency
28	Systemic amyloidosis	130	Congenital insensitivity to pain with anhidrosis	232	Camey complex
29	Ulrich disease	131	Alexander disease	233	Wolfram syndrome
30	Distal muscular dystrophy	132	Congenital supranuclear palsy	234	Peroxisomal disease (excluding adrenoleukodystrophy)
31	Beth Rem myopathy	133	Moebius syndrome	235	Accessory thyroid hyperplasia disease
32	Autophagic vacuolar myopathy	134	Nervous system malformation/De Morsier syndrome	236	Pseudohypoparathyroidism
33	Schwarz Yanperu syndrome	135	Aicardi syndrome	237	Adrenocorticotrophic hormone insensitivity
34	Neurofibromatosis	136	Hemimegalencephaly	238	Vitamin D-resistant rickets/osteomalacia
35	Pemphigus	137	Focal cortical dysplasia	239	Vitamin D-dependent rickets/osteomalacia
36	Epidermolysis bullosa	138	Nerve cell migration disorder	240	Phenylketonuria
37	Pustular psoriasis (universal)	139	Congenital cerebral white matter asplasia	241	High tyrosinemia type 1
38	Stevens-Johnson syndrome	140	Dorabe syndrome	242	High tyrosinemia type 2
39	Toxic epidermal necrosis	141	Medial temporal lobe epilepsy with hippocampal sclerosis	243	High tyrosinemia type 3
40	Takayasu's disease	142	Myoclonic epilepsy absences	244	Maple syrup urine disease (MSUD)
41	Giant cell arthritis	143	Epilepsy with myoclonic cataplexy	245	Propionic acidemia
42	Polyarteritis nodosa	144	Lennox-Gastaut syndrome	246	Methylmalonic acidemia
43	Microscopic polyangiitis	145	West syndrome	247	Isovaleric acidemia
44	Multiple vasculitis granulomatous disease	146	Otawara syndrome	248	Glucose transporter 1 deficiency
45	Eosinophilic multiple vasculitis granulomatous disease	147	Early myoclonic encephalopathy	249	Glutaric acidemia type 1
46	Malignant rheumatoid arthritis	148	Infant epilepsy with migratory focus seizure	250	Glutaric acidemia type 2
47	Buerger's disease	149	One side convulsions, hemiplegia – epilepsy syndrome	251	Urea cycle disorders
48	Primary antiphospholipid antibody syndrome	150	Ring chromosome 20 syndrome	252	Lysinuric protein intolerance
49	Systemic lupus erythematosus	151	Rasmussen's encephalitis	253	Congenital malabsorption of folate
50	Dermatomyositis / polymyositis	152	PCDH19 related syndrome	254	Porphyria
51	Systemic scleroderma	153	Refractory frequent partial seizures intussusception acute encephalitis	255	Multiple carboxylase deficiency
52	Mixed connective tissue disease	154	Developmental and/or epileptic encephalopathy with spike-and-wave activation in sleep (DEE-SWAS, EE-SWAS)	256	Muscle type glycocon storage disease
53	Sjogren's syndrome	155	Landau-Kleffner syndrome	257	Glycogen storage disease
54	Adult-onset Still's disease	156	Rett syndrome	258	Galactose- 1 – phosphate uridytransferase deficiency
55	Relapsing polychondritis	157	Sturge-Weber syndrome	259	lecithin-cholesterol acyltransferase deficiency
56	Bechet's disease	158	Tuberous sclerosis	260	Sitosterolemia
57	Idiopathic dilated cardiomyopathy	159	Xeroderma	261	Tangier disease
58	Hypertrophic cardiomyopathy	160	Congenital ichthyosis	262	Primary hyperlipidemia
59	Constrictive cardiomyopathy	161	Familial benign chronic pemphigus	263	Cerebrotendinous xanthomatosis
60	Aplastic anaemia	162	Pemphigoid (including acquired epidermolysis bullosa)	264	Abeta-lipoproteinemia
61	Autoimmune hemolytic anemia	163	Idiopathic acquired systemic anhidrosis	265	Lipodystrophy
62	Paroxysmal nocturnal	164	Oculocutaneous albinism	266	Familial Mediterranean fever
63	Immune thrombocytopenia	165	Pachydermoperiostosis syndrome	267	Hyper-IgD syndrome
64	Thrombotic thrombocytopenic purpura	166	Pseudoxanthoma elasticum	268	Nakajo-nisimura syndrome
65	Primary immunodeficiency syndrome	167	Marfan syndrome / Loey-Dietz syndrome	269	Purulent gonitis • pyoderma gangrenosum • hirsutism syndrome
66	IgA nephropathy	168	Ehlers-Danlos syndrome	270	Chronic nonbacterial osteomyelitis
67	Polycystic kidney	169	Menkes disease	271	Spondylarthritis anklylopoietica
68	Ossification of the ligamentum flavum	170	Okushipitaru horn syndrome	272	Fibrodysplasia ossificans progressive
69	Ossification of the posterior longitudinal ligament	171	Wilson's disease	273	Congenital scoliosis with rib anomaly
70	Extensive spinal canal stenosis	172	Hypophosphatasia	274	Osteogenesis imperfecta
71	Idiopathic femoral head necrosis	173	VATER syndrome	275	Thanatophoric dysplasia
72	Pituitary ADH secretion disorders	174	Nasu-Hakola disease	276	Achondroplasia
73	Pituitary TSH secretion hyperthyroidism	175	Weaver's syndrome	277	Lymphangiomas/gorham's disease
74	Pituitary PRL secretion hyperthyroidism	176	Coffin-Lowry syndrome	278	Huge lymphatic malformation (cervicofacial lesion)
75	Cushing's disease	177	Arima syndrome	279	Huge venouse malformation (neck oropharyngeal diffuse lesion)
76	Pituitary gonadotropin secretion hyperthyroidism	178	Mowat - Wilson syndrome	280	Huge arteriovenouse malformation (cervicofacial or limb lesion)
77	Pituitary growth hormone secretion hyperthyroidism	179	Williams' syndrome	281	Klippel-Trenaury-Weber syndrome
78	Anterior pituitary hypothyroidism	180	ATR-X syndrome	282	Congenital thropoietic anemia
79	Familial hypercholesterolemia (homozygous)	181	Crouzon syndrome	283	Acquired pure red cell aplasia
80	Thyroid hormone insensitivity syndrome	182	Apert syndrome	284	Diamond-blackfan anemia
81	Congenital adrenal cortex enzyme deficiency	183	Pheiffer syndrome	285	Fanconi anemia
82	Congenital adrenal hypoplasia	184	Anley-Bixler syndrome	286	Hereditary sideroblastic anemia
83	Addison's disease	185	Coffin Siris syndrome	287	Epstein-Barr virus
84	Sarcoidosis	186	Trothmund-Thomson syndrome	288	Autoimmune hemorrhaphilia XIII
85	Idiopathic interstitial pneumonia	187	Kabuki syndrome	289	Cronkhite-Canada syndrome
86	Pulmonary arterial hypertension	188	Polysplenia syndrome	290	Chronic nonspecific multiple ulcers of the small intestine
87	Pulmonary venous obstruction/pulmonary capillary hemangiomas	189	Asplenia syndrome	291	Hirschsprung disease (entire colon type or small intestine type)
88	Chronic thromboembolic pulmonary hypertension	190	Branchio-oto-renal syndrome	292	Cloacal exstrophy
89	Lymphangioliomomatosis	191	Werner's syndrome	293	Persistent cloaca
90	Retinitis pigmentosa	192	Cockayne's syndrome	294	Congenial diaphragmatic hernia
91	Bad chian syndrome	193	Prader-Willi syndrome	295	Infant giant liver hemangioma
92	Idiopathic portal hypertension	194	Sotos' syndrome	296	Biliary atresia
93	Primary biliary cirrhosis	195	Noonan's syndrome	297	Alagille syndrome
94	Primary sclerosing cholangitis	196	Young Simpson's syndrome	298	Hereditary pancreatitis syndrome
95	Autoimmune hepatitis	197	1p36 deletion syndrome	299	Cystic fibrosis
96	Crohn's disease	198	4ps syndrome	300	IgG4-related disease
97	Ulcerative colitis	199	5ps syndrome	301	Heredomacular dystrophy
98	Eosinophilic gastrointestinal disease	200	No. 14 chromosome father disomy syndrome	302	Leber's hereditary optic neuropathy
99	Chronic idiopathic pseudo-bowel obstruction	201	Angelman syndrome 303	303	Ascher syndrome
100	Huge bladder short and small colon intestinal peristalsis deficiency	202	Smith-Magenis syndrome	304	Juvenile-onset bilateral sensorineural hearing loss
101	Intestinal ganglion cells insignificant disease	203	22q11.2 deletion syndrome	305	Delayed endolymphatic hydrops
102	Rubinstein - Teibi syndrome	204	Emanuel syndrome	306	eosinophilic sinusitis

Detailed Data Designated Intractable Diseases

No.	Disease Name
307	Canavan disease
308	Progressive leukoencephalopathy
309	Progressive myoclonic epilepsy
310	Congenital syndrome
311	Congenital tricuspid stenosis
312	Congenital mitral valve stenosis
313	Congenital pulmonary vein stenosis
314	Left pulmonary artery right pulmonary artery initiation
315	Nail Patera syndrome/LMX 1 B-related nephropathy
316	Carnitine circuit disorder
317	Triple enzyme deficiency
318	Citrin deficiency
319	Sepiapterin reductase (SR) deficiency
320	Congenital glycosylphosphatidylinositol (GPI) deficiency
321	Nonketotic hyperglycinemia
322	β -ketothiolase deficiency
323	Aromatic L-amino acid decarboxylase deficiency
324	Methyl glutamic nuria
325	Hereditary autoinflammatory disease
326	Marble bone disease
327	Idiopathic thrombosis (limited to those due to hereditary thrombophilia)
328	Anomalous anterior segment formation
329	Aniridia
330	Congenital tracheal stenosis / Congenital subglottic stenosis
331	Idiopathic multicentric Castleman disease
332	Gelatinous drop-like corneal dystrophy
333	Hutchinson - Gilford syndrome
334	Cerebral Creatine Deficiency Syndromes
335	Nephronophthisis
336	Familial Hypobetalipoproteinemia Type 1 (homozygote)
337	Homocystinuria
338	Progressive Familial Intrahepatic Cholestasis
339	MECP2 Duplication Syndrome
340	Primary Ciliary Dyskinesia (including Kartagener Syndrome)
341	TRPV4 Channelopathies
342	Lamin B1 related adult-onset autosomal dominant leukodystrophy
343	PURA-related neurodevelopmental disorders
344	Very long-chain acyl-CoA dehydrogenase deficiency
345	STING-associated vasculopathy with onset in infancy
346	Primary extrahepatic portal obstruction
347	Bleeding disorders caused by hyperfibrinolysis
348	Lowe syndrome

Infectious Disease Measures

Overview

Outline of the Act on Prevention of Infectious Diseases and Medical Care for Patients with Infectious Diseases

(Approved on September 28, 1998 and enforced on April 1, 1999)

Preventive administrative measures against outbreak and spread of infectious diseases

- Development and establishment of the surveillance system for infectious diseases
- Promotion of comprehensive nationwide and prefectural measures (in order to facilitate cooperation of related parties, basic guidelines to prevent infectious diseases are formulated and announced by the government, and the prevention plans by the prefectural governments)
- Formulation of guidelines to prevent specific infectious diseases, including influenza, sexually transmitted diseases, AIDS, tuberculosis, measles rubella and mosquito-borne infectious diseases (the government formulates and announces guidelines to investigate causes, prevent outbreak and spread, provide medical care services, promote research and development, and obtain international cooperation for the diseases that particularly require comprehensive preventive measures)

Types of infectious diseases and medical care system

Type of infectious disease	Key measures	Medical care system	Medical fee payment
New infectious diseases	Hospitalization, medical stay program, home convalescence	Type 1 Agreement Designated Medical Institution [The prefectural governor concludes an agreement with a designated medical institution] (enacted in April 2024)	Publicly funded in full (no insurance applied)
		Type 2 Agreement Designated Medical Institution [The prefectural governor concludes an agreement with a designated medical institution that covers outpatient care, etc.] (enacted in April 2024)	
		Designated medical institutions for specific infectious diseases (several nationwide designated by the government)	
Type 1 (Plague, Ebola hemorrhagic fever, South American hemorrhagic fever, etc.)	Hospitalization	Designated medical institutions for Type 1 infectious disease [1 hospital in each prefecture designated by prefectural governors]	Medical insurance applied with public funds (for hospitalization)
Type 2 (Avian influenza (H5N1, H7N9), Tuberculosis, MERS, etc.)		Designated medical institutions for Type 2 infectious disease [1 hospital in each secondary medical service area designated by prefectural governors]	
Type 3 (Cholera, Enterohemorrhagic Escherichia coli infection, etc.)	Work restriction in certain jobs	General medical institutions	Medical insurance applied (partial cost sharing)
Type 4 (Avian influenza (excluding H5N1, H7N9), Zika virus infection, etc.)	Sterilization and other objective measures	General medical institutions	Medical insurance applied (partial cost sharing)
Type 5 (Influenza (excluding avian influenza and novel influenza infection, etc.), AIDS, viral hepatitis (excluding hepatitis E and hepatitis A), new coronavirus infection (COVID-19) etc.)	Identification of the situation with infection and information provision	General medical institutions	Medical insurance applied (partial cost sharing)
Infectious diseases such as novel influenza, etc. (novel influenza, novel coronavirus infections, etc. (excluding COVID-19))	Hospitalization, medical stay program, home convalescence	Designated medical institutions for specific/Type 1/Type 2 infectious disease, designated medical institutions for Type 1/ Type 2 agreements	Medical insurance applied with public funds

* Infectious diseases other than Type 1, 2, or 3 infectious diseases requiring emergency measures are designated as "designated infectious diseases" in Cabinet Order and are treated the same as Type 1, 2, and 3 infectious diseases for a limited period of 1 year in principle.

Development of hospitalization procedures respecting patients' human rights

- Work restriction and hospitalization according to the type of infectious disease
- Introduction of a system to recommend hospitalization based on patients' decisions
- Hospitalization up to 72 hours by orders of prefectural governors (directors of health centers)
- Hospitalization for every 10 days (30 days for tuberculosis) with hearing opinions from the council for infectious disease examination established in health centers
- Reporting of complaints on conditions of hospitalization to prefectural governors
- Provision of special cases to make decisions within 5 days against the request for administrative appeal from the patients who are hospitalized for more than 30 days
- In the event of emergency, the government should be responsible for providing necessary guidance to prefectural governments on hospitalization of patients.

Development of measures, including sufficient sterilization to prevent infectious diseases from spreading

- Sterilization to prevent Type 1, 2, 3, and 4 infectious diseases and pandemic influenza from spreading
- Restricting entry to buildings to prevent Type 1 infectious diseases from spreading
- In the event of emergency, the government should be responsible for providing necessary guidance to prefectural governments on sterilization and other measures.

Development of countermeasures against zoonoses



- Prohibition of the import of monkeys and the import quarantine system for monkeys
- Prohibition of the import of masked palm civets, bats, African soft-furred rats, prairie dogs, etc.
- Designation of 11 diseases, including Ebola hemorrhagic fever, etc., as subjects of notification obligation for veterinarians
- "Notification System for the Importation of Animals" to require importers of living mammals and birds, and carcasses of rodents and Lagomorpha to report necessary information to the Minister of Health, Labour and Welfare (quarantine station) along with a health certificate issued by government authorities of the exporting countries

Development of regulation on possession of pathogens, etc.



- Regulation through enforcement of standards of prohibition, permission, notification, and facilities according to the classification of Type 1, 2, 3, and 4 pathogens, etc.
- Establishment of standards on facilities according to the types of pathogens, etc.
- Development of regulations on prevention of infectious disease outbreaks, selection of persons in charge of handling pathogens, and obligation for the owners to notify the transportation of pathogens, etc.
- Supervision by the Minister of Health, Labour and Welfare on facilities handling pathogens, including on-site inspection of the facilities and orders of corrective measures for sterilization/transfer methods, etc.

Development of countermeasures for infectious disease such as novel influenza with considering countermeasures against the COVID-19



- Implementation of measures, including hospitalization, etc. and enabling measures equivalent to those for Type 1 infectious diseases to be taken by Cabinet Order
- Request for persons possibly infected to report health status and abstain from going out
- Disclosure of information regarding outbreak and measures to be taken, etc.
- Report on progress from prefectural governors
- Enhancement of cooperation between prefectural governors and directors of Quarantine Stations
- Strengthen information collaboration among countries and local authorities
- Consultations at prefectural cooperation councils, development of information infrastructure, cooperation with general municipalities (enacted in April 2024, partially enacted in April 2023)
- Comprehensive coordination and instructions regarding hospitalization, etc. by the prefectural governor
- Agreements were concluded between prefectures and medical institutions, testing institutions, and accommodation facilities regarding medical care, testing, accommodation, etc. (enacted in April 2024)
- Mandatory provision of medical care by government-run and public medical institutions in the event of an infectious disease outbreak or spread (enacted April 2024)
- Securing medical care and support for patients of medical stay program or home convalescence (enacted in April 2024)
- Ensuring the supply of materials to deal with infectious diseases by allowing the government in an emergency to request and instruct businesses to produce such materials, and to provide the businesses with the necessary support (enacted in April 2024)

Immunization

Overview

Diseases and Persons Subjected to Routine Vaccination

Diseases	Persons subjected to vaccination
Diphtheria	1. Those aged 2 to 90 months (the first/initial dose should be administered before the first day of 90 month) 2. Those aged 11 years or older but younger than 13 years
Pertussis	Those aged 2 to 90 months (the first/initial dose should be administered before the first day of 90 month)
Polio (acute myelitis)	Those aged 2 to 90 months (the first/initial dose should be administered before the first day of 90 month)
Measles	1. Those aged 12 to 24 months (the first/initial dose should be administered before the first day of 24 month) 2. Those aged 5 years or older but younger than 7 years who are in the period between the day 1 year before the start of elementary school and the day before the start of school
Rubella	1. Those aged 12 to 24 months (the first/initial dose should be administered before the first day of 24 month) 2. Those aged 5 years or older but younger than 7 years who are in the period between the day 1 year before the start of elementary school and the day before the start of school
Japanese encephalitis	1. Those aged 6 to 90 months (the first/initial dose should be administered before the first day of 90 month) 2. Those aged 9 years or older but younger than 13 years
Tetanus	1. Those aged 3 to 90 months (the first/initial dose should be administered before the first day of 90 month) 2. Those aged 11 years or older but younger than 13 years
Tuberculosis	Those younger than 1 year old
Hib infection (Haemophilus influenzae type B)	Hib vaccine: Those aged 2 to 60 months Five-in-one vaccine: Those aged 2 to 90 months
Pneumococcal infectious disease (limited to one that is of infants)	Those aged 2 to 60 months (the first/initial dose should be administered before the first day of 60 month)
Varicella	Those aged 12 to 36 months (the first/initial dose should be administered before the first day of 36 month)
Hepatitis B	Those younger than 1 year old
Human papillomavirus infection	Females who are in the period between the first day of the fiscal year in which they turn 12 years old and the last day of the fiscal year in which they turn 16 years old
Rotavirus infection disease	1 titer: From the day after reaching 6 weeks after birth until the day after reaching 24 weeks after birth 5 titer: From the day after reaching 6 weeks after birth until the day after reaching 32 weeks after birth
Influenza	1. Those aged 65 years or older 2. Those aged 60 years or older but younger than 65 years suffering from cardiac, renal, or respiratory disorders, etc.
COVID-19	1. Those aged 65 years or older 2. Those aged 60 years or older but younger than 65 years suffering from cardiac, renal, or respiratory disorders, etc.
Pneumococcal infectious disease (limited to one that is of the elderly)	1. Those aged 65 years 2. Those aged 60 years or older but younger than 65 years suffering from cardiac, renal, or respiratory disorders, etc.
Shingles	1. Those aged 65 years 2. Those aged 60 to under 65 who have immune dysfunction caused by human immunodeficiency virus

*1 Persons born between April 2, 1995 and April 1, 2007 are eligible for routine Japanese Encephalitis vaccinations until the day before they reach 20 years old.

*2. Women born between April 2, 1997 and April 1, 2009 who have received at least one dose of the HPV vaccine between April 1, 2022 and March 31, 2025 can receive routine HPV vaccinations until March 31, 2026.

*3. For the five years from FY2025 to FY2029, those who will turn 70, 75, 80, 85, 90, 95, or 100 years old within those fiscal years are eligible for routine shingles vaccination. (Those over 100 years old are eligible only in FY2025.)

Detailed Data

Benefits Type and Amount of Relief System for Injury to Health with Vaccination (As of April,1, 2025)

Regular vaccinations against Category A diseases/extra vaccinations * Excluding extra vaccinations against Category B diseases			Regular vaccinations against Category B diseases		
Benefit type	Qualification	Details and amount of benefit	Benefit type	Qualification	Details and amount of benefit
Subsidy for medical care expenses	Recipients of medical services due to illness caused by vaccination	Amount equivalent to co-payment calculated based on the case of health insurance	Subsidy for medical care expenses	Recipients of medical services due to illness caused by vaccination	Amount equivalent to co-payment calculated based on the case of health insurance
Medical allowance	Same as above	Inpatient: 8 days or more per month: (month) ¥39,900 Inpatient: less than 8 days per month: (month) ¥37,900 Outpatient: 3 days or more per month: (month) ¥39,900 Outpatient: less than 3 days per month: (month) ¥37,900 Inpatient and outpatient treatment within the same month: (month) ¥39,900	Medical allowance	Same as above	Inpatient: 8 days or more per month: (month) ¥39,900 Inpatient: less than 8 days per month: (month) ¥37,900 Outpatient: 3 days or more per month: (month) ¥39,900 Outpatient: less than 3 days per month: (month) ¥37,900 Inpatient and outpatient treatment within the same month: (month) ¥39,900
Pension for rearing children with disabilities	Fosterers of children younger than 18 with certain disabilities caused by vaccination	Class 1: (annual) ¥1,714,800 (additional amount for long-term care):(annual) ¥878,400 Class 2: (annual) ¥1,371,600 (additional amount for long-term care):(annual) ¥585,600	Disability Pension	Those aged 18 or older with certain disabilities caused by vaccination	Class 1: (annual) ¥3,045,600 Class 2: (annual) ¥2,436,000
Disability Pension	Those aged 18 or older with certain disabilities caused by vaccination	Class 1: (annual) ¥5,481,600 (additional amount for long-term care):(annual) ¥878,400 Class 2: (annual) ¥4,384,800 (additional amount for long-term care):(annual) ¥585,600 Class 3: (annual) ¥3,289,200	Survivors' Pension	The bereaved will be beneficiary in case the deceased who died from vaccination was the main wage earner of the family (Pension shall be paid up to 10 years)	(annual) ¥2,664,000
Lump-sum death benefit	The bereaved of the person who died of diseases caused by vaccination	¥48,000,000	Lump-sum benefit for survivors	The bereaved will be beneficiary in case the deceased who died from vaccination was not the main wage earner of the family	¥7,992,000
Funeral allowance	Hosts of funerals for those who died of diseases caused by vaccination	¥219,000	Funeral allowance	Hosts of funerals for those who died of illness caused by vaccination	¥219,000

* The medical care covered by the benefits of the medical expenses and medical allowances for Category B disease shall be the medical care required when it is deemed necessary to be admitted to a hospital or clinic.

* Deadline for claiming a health problem in category B diseases

(Note) 1. The term of claims for subsidy for medical care expenses shall be within 5 years after the payment of the expenses eligible for the benefits.

2. The deadline for claiming medical allowance shall be five years from the first day of the month following the month in which the medical treatment date for such claim belongs.

3. The term of claims for Survivors' Pension, lump-sum benefit for survivors, and funeral expenses shall be within 2 years from the death of the deceased who died from vaccination for the cases where the deceased was paid with subsidy for medical care expenses, medical allowance, or Disability Pension for his/her complications or disabilities while he/she was alive, or within 5 years from the death for other cases.

Tuberculosis Measures

Overview

Outline of Tuberculosis Prevention Measures

- A. Regular health checkups (X-ray test, etc.) — Elderly (age 65 and over), (high school) students, employees working at school and hospitals, and facility residents
- B. Regular preventive vaccination (BCG) — Infants younger than 1 year old
- C. Patient management
 - Notification — At the time of diagnosis and admission/discharge from hospital.
 - Registration — Tuberculosis registration cards, identification of the current situation of patients
 - Medication advice — Home-visit, health education, etc.
 - Screening for proper disease management — Persons requiring follow-ups, patients who have suspended treatment, etc.
- D. Infection prevention
 - Contact health examination — Health examination to contact person with tuberculosis patients
 - Work restriction, etc. — Restriction on attendance of tuberculosis patients at work
 - Admission recommendation — Recommendation for hospitalization to tuberculosis patients
- E. Medical care (public fund)
 - Hospitalization care — Medical care expenses for tuberculosis patients subject to a recommendation or requirement for hospitalization
 - Ambulatory care — Medical fees for ambulatory care for tuberculosis patients

Detailed Data 1

Changes in Number of Newly Notified Tuberculosis Patients, Incidence, and Number of Deaths

Year	Number of newly notified patients (Person)	Incidence (Per 100,000 persons)	Number of deaths (Person)	Death rate (Per 100,000 population)
1960	489,715	524.2	31,959	34.2
1965	304,556	309.9	22,366	22.8
1970	178,940	172.3	15,899	15.4
1975	108,088	96.6	10,567	9.5
1980	70,916	60.7	6,439	5.5
1985	58,567	48.4	4,692	3.9
1990	51,821	41.9	3,664	3.0
1995	43,078	34.3	3,178	2.6
1999	43,818	34.6	2,935	2.3
2000	39,384	31.0	2,656	2.1
2001	35,489	27.9	2,491	2.0
2002	32,828	25.8	2,317	1.8
2003	31,638	24.8	2,337	1.9
2004	29,736	23.3	2,330	1.8
2005	28,319	22.2	2,296	1.8
2006	26,384	20.6	2,269	1.8
2007	25,311	19.8	2,194	1.7
2008	24,760	19.4	2,220	1.8
2009	24,170	19.0	2,159	1.7
2010	23,261	18.2	2,129	1.7
2011	22,681	17.7	2,166	1.7
2012	21,283	16.7	2,110	1.7
2013	20,495	16.1	2,087	1.7
2014	19,615	15.4	2,100	1.7
2015	18,280	14.4	1,956	1.6
2016	17,625	13.9	1,893	1.5
2017	16,789	13.3	2,306	1.9
2018	15,590	12.3	2,204	1.8
2019	14,460	11.5	2,087	1.7
2020	12,739	10.1	1,909	1.5
2021	11,519	9.2	1,845	1.5
2022	10,235	8.2	1,664	1.4
2023	10,096	8.1	1,587	1.3
2024			* 1,461	* 1.2

Source: <Number of newly registered patients / prevalence rate>

"Aggregate Result of the Annual Reports of Surveillance of Tuberculosis", Health Service Bureau, MHLW

<Number of deaths / Death rates>

"Vital Statistics", Vital, Health and Social Statistics Office to the Councilor, Director-General for Statistics, Information System Management and Industrial Relations, MHLW

(Note) 1. The figures for 1998 and later do not include those of atypical mycobacteria positive.

2. The increase in the number of deaths and the mortality rate after 2017 includes the impact of revisions to the cause of death classification, etc.

3. The figures indicated by "*" are preliminary data.

Detailed Data 2**Tuberculosis Incidence by Prefecture (as of the end of 2023)**

	Prefecture or City	Incidence
Prefectures with the lowest incidence	Iwate	3.6
	Yamanashi	4.0
	Yamagata	4.4
	Nagano	5.2
	Akita, Fukushima	5.3
Prefectures with the highest incidence	Oita	12.2
	Nara	10.8
	Osaka	10.3
	Hyogo, Kagoshima, Nagasaki	9.8
	Gifu	9.1

Detailed Data 3**International Comparison of Tuberculosis Incidence**

Country	Incidence
United States	2.7
Canada	5.6
Sweden	3.2
Australia	5.4
Netherlands	3.9
Denmark	2.9
France	6.9
United Kingdom	7.7
Japan	8.1

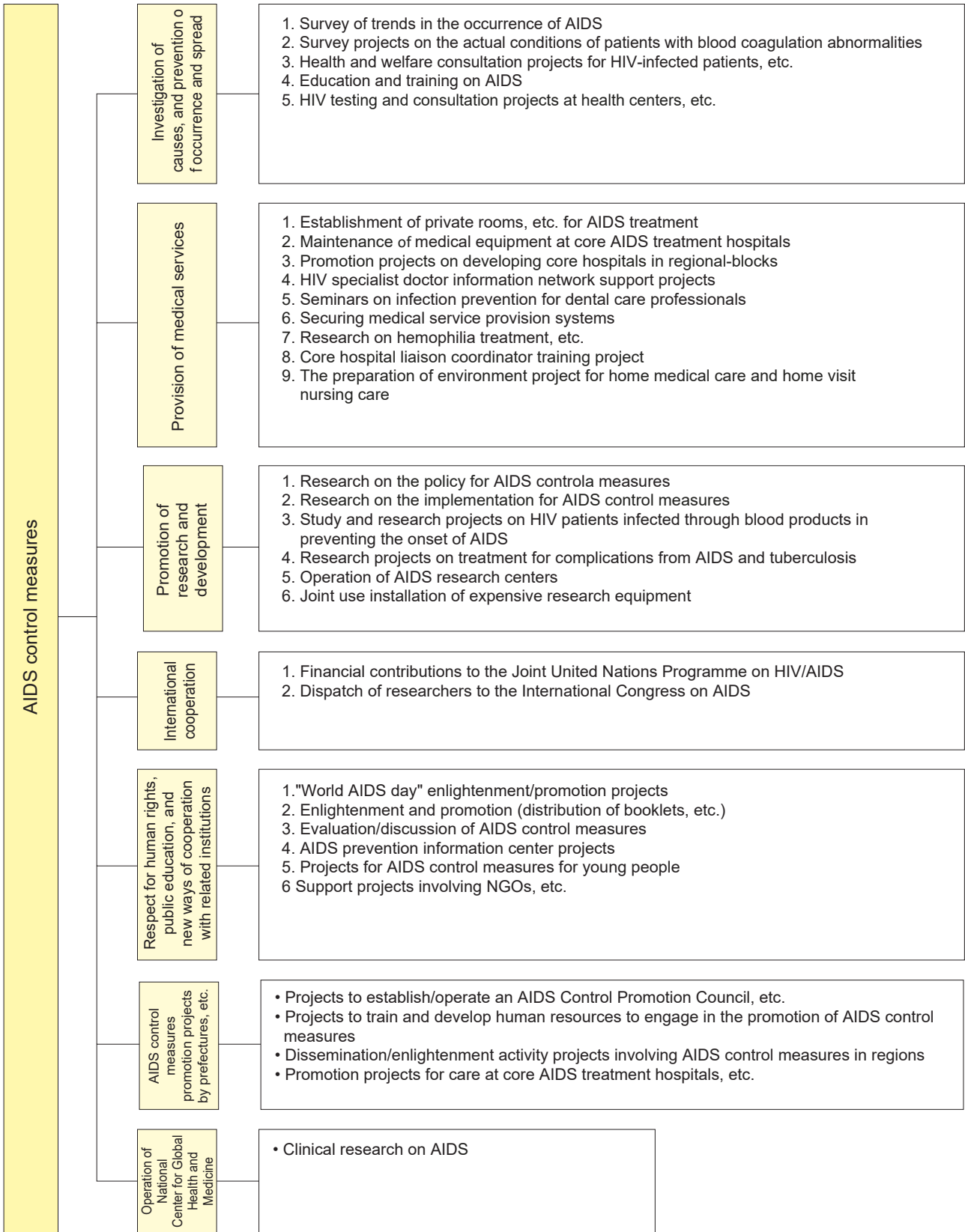
Source: WHO's global tuberculosis database

* Data is referred to one at 2023.

AIDS Control Measures

Overview

Outline of AIDS Control Measures



Detailed Data 1

Changes in Number of HIV Carriers and AIDS Patients by Nationality and Gender

Category	Nationality	Gender	1985	1986	1987	1988	1989	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005
HIV	Japan	Male	0	0	34	15	35	27	52	108	102	134	147	189	234	261	379	336	475	481	525	636	709
		Female	0	0	11	4	18	10	17	16	22	32	19	41	34	36	45	32	50	40	32	44	32
		Total	0	0	45	19	53	37	69	124	124	166	166	230	268	297	424	368	525	521	557	680	741
	Foreign national	Male	0	0	10	4	21	11	26	45	33	37	47	65	49	58	39	53	59	55	48	62	60
		Female	0	0	0	0	6	18	105	273	120	95	64	81	80	67	67	41	37	38	35	38	31
		total	0	0	10	4	27	29	131	318	153	132	111	146	129	125	106	94	96	93	83	100	91
Total		0	0	55	23	80	66	200	442	277	298	277	376	397	422	530	462	621	614	640	780	832	
AIDS	Japan	Male	5	3	6	9	15	18	24	36	53	91	108	156	170	158	212	239	221	232	252	290	291
		Female	0	0	3	2	2	3	0	1	5	9	11	15	12	10	12	21	24	20	19	19	11
		Total	5	3	9	11	17	21	24	37	58	100	119	171	182	168	224	260	245	252	271	309	302
	Foreign national	Male	1	2	3	3	4	10	14	13	19	28	33	45	39	42	46	41	61	36	39	54	49
		Female	0	0	2	0	0	0	0	1	9	8	17	18	29	21	31	28	26	20	26	22	16
		total	1	2	5	3	4	10	14	14	28	36	50	63	68	63	77	69	87	56	65	76	65
Total		6	5	14	14	21	31	38	51	86	136	169	234	250	231	301	329	332	308	336	385	367	
Category	Nationality	Gender	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	Total	Total % of		
HIV	Japan	Male	787	931	999	894	956	923	889	963	959	860	857	802	768	741	598	614	515	511	19,446	79.3	
		Female	49	38	34	38	41	42	31	33	35	38	28	22	32	29	21	10	12	12	1,080	4.4	
		Total	836	969	1,033	932	997	965	920	996	994	898	885	824	800	770	619	624	527	523	20,526	83.7	
	Foreign national	Male	76	76	60	71	59	71	65	97	82	88	108	136	121	116	114	98	94	138	2,452	10.0	
		Female	40	37	33	18	19	20	17	13	15	20	18	16	19	17	17	20	11	8	1,554	6.3	
		total	116	113	93	89	78	91	82	110	97	108	126	152	140	133	131	118	105	146	4,006	16.3	
Total		952	1,082	1,126	1,021	1,075	1,056	1,002	1,106	1,091	1,006	1,011	976	940	903	750	742	632	669	24,532	100.0		
AIDS	Japan	Male	335	343	359	386	421	419	387	438	409	379	376	348	328	281	282	260	202	247	8,789	81.0	
		Female	20	22	19	15	15	16	18	11	13	11	18	21	15	9	10	3	6	5	446	4.1	
		Total	355	365	378	401	436	435	405	449	422	390	394	369	343	290	292	263	208	252	9,235	85.1	
	Foreign national	Male	33	34	32	21	29	21	31	28	26	30	39	27	25	37	46	40	35	35	1,151	10.6	
		Female	18	19	21	9	4	17	11	7	7	8	4	17	9	6	7	12	9	4	463	4.3	
		total	51	53	53	30	33	38	42	35	33	38	43	44	34	43	53	52	44	39	1,614	14.9	
Total		406	418	431	431	469	473	447	484	455	428	437	413	377	333	345	315	252	291	10,849	100.0		

Source: "AIDS Surveillance Report 2023", National AIDS Surveillance Committee, MHLW

(Note) The figures do not include HIV carriers and AIDS patients who have been infected through blood-coagulation-factor preparations.

Detailed Data 2

Status of AIDS Patients in the World (as of the end of 2022, UNAIDS Report)

Region		Number of HIV infected patients (adults/children)	Number of newly infected HIV patients (adults/children)	Percentage of HIV-positive adults (%)	Number of persons died from AIDS (adults/children)
Asia Pacific	2023	6.7 million [4,900,000-7,200,000]	300 thousand [190,000-360,000]	0.2 [0.2-0.2]	150 thousand [99,000-210,000]
	2010	4.9 million [3,900,000-6,400,000]	320 thousand [240,000-450,000]	0.2 [0.2-0.3]	280 thousand [170,000-460,000]
East/South Africa	2023	20.8 million [18,900,000-23,000,000]	450 thousand [530,000-900,000]	5.7 [5.5-6.9]	260 thousand [230,000-360,000]
	2010	16.8 million [15,000,000-18,900,000]	1.2 million [940,000-1,400,000]	7.5 [6.5-8.5]	660 thousand [510,000-870,000]
Eastern Europe, Central Asia	2023	2.1 million [1,700,000-2,000,000]	140 thousand [130,000-180,000]	1.2 [1-1.2]	44,000 [36,000-53,000]
	2010	890 thousand [810,000-970,000]	100 thousand [94,000-110,000]	0.5 [0.5-0.5]	34,000 [25,000-41,000]
Latin America	2023	2.3 million [1,500,000-2,800,000]	120 thousand [68,000-150,000]	0.5 [0.3-0.6]	30,000 [18,000-42,000]
	2010	1.5 million [1,100,000-1,800,000]	100 thousand [78,000-130,000]	0.4 [0.3-0.5]	42,000 [29,000-58,000]
Caribbean Coast	2023	340 thousand [290,000-380,000]	15,000 [9,500-18,000]	1.2 [1-1.3]	5,100 [4,200-7,600]
	2010	300 thousand [250,000-390,000]	19,000 [14,000-31,000]	1.2 [1.0-1.7]	13,000 [9,300-22,000]
Middle East / North Africa	2023	210 thousand [150,000-210,000]	23,000 [11,000-18,000]	<0.1 [<0.1-<0.1]	6,200 [3,900-6,900]
	2010	180 thousand [120,000-250,000]	16,000 [9,000-27,000]	<0.1 [<0.1-0.1]	8,800 [5,800-13,000]
Western/Central Africa	2023	5.1 million [4,500,000-5,600,000]	190 thousand [140,000-270,000]	1.2 [1.1-1.4]	130 thousand [110,000-170,000]
	2010	6 million [4,400,000-8,000,000]	410 thousand [240,000-620,000]	2.4 [1.7-3.2]	370 thousand [240,000-540,000]
Western Europe / Central Europe / North America	2023	2.3 million [1,900,000-2,600,000]	56,000 [51,000-76,000]	0.2 [0.2-0.3]	13,000 [9,400-16,000]
	2010	1.8 million [1,600,000-2,000,000]	75,000 [62,000-90,000]	0.3 [0.3-0.3]	21,000 [15,000-28,000]
Total	2023	39.9 million [33,900,000-43,800,000]	1.3 million [1,100,000-2,000,000]	0.7 [0.6-0.8]	630 thousand [510,000-860,000]
	2010	32.4 million [27,400,000-38,500,000]	2.2 million [1,700,000-2,900,000]	0.7 [0.6-0.9]	1.4 million [1,000,000-2,000,000]

*Actual figures fall within the range of the figures in parentheses. The estimated numbers and ranges are calculated based on the best data available to date.

Source:UNAIDS 2024 estimates

Pandemic Influenza Preparedness

Overview Pandemic Influenza Preparedness

Pandemic Influenza

Pandemic influenza occurs when a new type of influenza virus, which has never spread among humans, gains a new ability for human-to-human transmission. In contrast to seasonal influenza, which can cause outbreak annually, humans have little or no immunity to pandemic influenza. This allows pandemic influenza an ability to efficiently transmit from one human to another, possibly resulting in global pandemic. In recent years, highly pathogenic avian influenza A (H5N1) that can be transmitted from birds to humans has sporadically emerged, mainly in Southeast Asia and North America. If the viruses mutate into a form that can spread among humans, it could have a significant impact on people's well-being, health, lives and the national economy. The government is therefore implementing the following pandemic preparedness and response measures.

Major events

Dec. 2005	Formulation of the "National Action Plan for Novel Influenza" (Meeting of Relevant Ministries and Agencies on Countermeasures against Avian Influenza, etc.)
May 2008	Amendment of the Act on Infectious Disease Control and the Act on Quarantine (Legislative preparation by categorizing new or re-emerging influenza as "pandemic influenza" to legally conduct hospitalization and quarantine at the ports of entry. In addition, influenza H5N1 transmitted from birds to humans was categorized as the infectious disease category 2 "avian influenza (H5N1)" in the Act on Infectious Diseases Control)
Feb. 2009	Fundamental amendment of the "National Action Plan for Novel Influenza" (Meeting of Relevant Ministries and Agencies on Countermeasures against Novel Influenza Diseases, Avian Influenza) followed by the amendment of the Act on Infectious Diseases Control
Apr. 2009	Emergence of Influenza A(H1N1)pdm09
Jul. 2009	Establishment of the Office for Pandemic Influenza and New Infectious Diseases Preparedness and Response in the Cabinet Secretariat
Mar. 2011	After the announcement was made that the influenza A (H1N1)pdm09 would no longer be recognized as a pandemic influenza provided for in the Infectious Diseases Control Law on and after March 31, measures against pandemic influenza were shifted to conventional preparedness against seasonal flu.
July 2011	Amendment of the Act on Preventive Vaccinations (providing new temporary vaccinations framework based on the assumption of pandemic influenza that had the same level of high transmissibility as the influenza A(H1N1)pdm09 but not highly pathogenic)
Sep. 2011	Revision of the "National Action Plan for Novel Influenza" (Ministerial Meeting on Countermeasures against Novel Influenza) based on the experiences of influenza A(H1N1) pdm09
Apr. 2012	Approval of the Act on Special Measures Against Novel Influenza (Adopting the law concerning special countermeasures at the time of an outbreak of a novel influenza, etc.)
Jun. 2013	Formulation of the "Guidelines for National Action Plan for Novel Influenza, etc." (Cabinet decision) Formulation of the "Guidelines for National Action Plan for Novel Influenza, etc." (Meeting of Relevant Ministries and Agencies on Countermeasures against Novel Influenza and New Infectious Diseases, Avian Influenza, etc.)
Mar. 2016	Partial revisions to the "Guidelines for National Action Plan for Novel Influenza, etc." in response to the review of the policies for stockpiles of influenza antiviral drugs
Sep. 2017	Partial amendments to the "National Action Plan for Novel Influenza, etc." (cabinet decision) and partial revisions to the "Guidelines for National Action Plan for Novel Influenza, etc." in response to the review of the stockpiles of influenza antiviral drugs
Mar. 2019	•Cell culture method vaccine actual production facility maintenance promotion project" completed.
Feb. 2021	Partial amendments of the Act on Special Measures Against Novel Influenza
Apr. 2023	Partial amendments of the Act on Special Measures Against Novel Influenza
Sep. 2023	Abolishment of the Office for Pandemic Influenza and New Infectious Diseases Preparedness and Response and establishment of the Cabinet Agency for Infectious Diseases Crisis Management
Jul. 2024	Fundamental revision of the National Action Plan for Novel Influenza, etc. (Cabinet decision)
Aug. 2024	Fundamental revision of the Guidelines for National Action Plan for Novel Influenza, etc. (Approved by the Secretary General for Infectious Disease Crisis Management, Cabinet Secretariat)

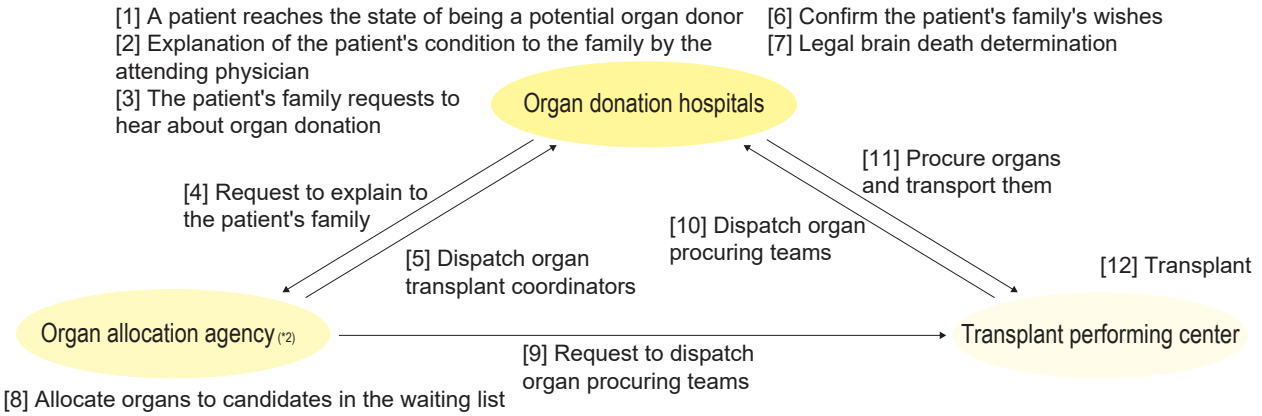
Major budgetary projects

Stockpiles of influenza antiviral drugs	Stockpile targeting approximately 45 million people, including national, prefectural, and distribution
Stockpiles of pre-pandemic vaccine	Priority is given to stockpiling of vaccine stocks with a high "importance in crisis management". The target is to stockpile enough for up to 10 million people.
Promotion of technical development on Pandemic Influenza vaccine	Promotion of technical development of Cell culture method vaccine for Pandemic Influenza

Organ Transplantation and Hematopoietic Stem Cell Transplantation

Overview

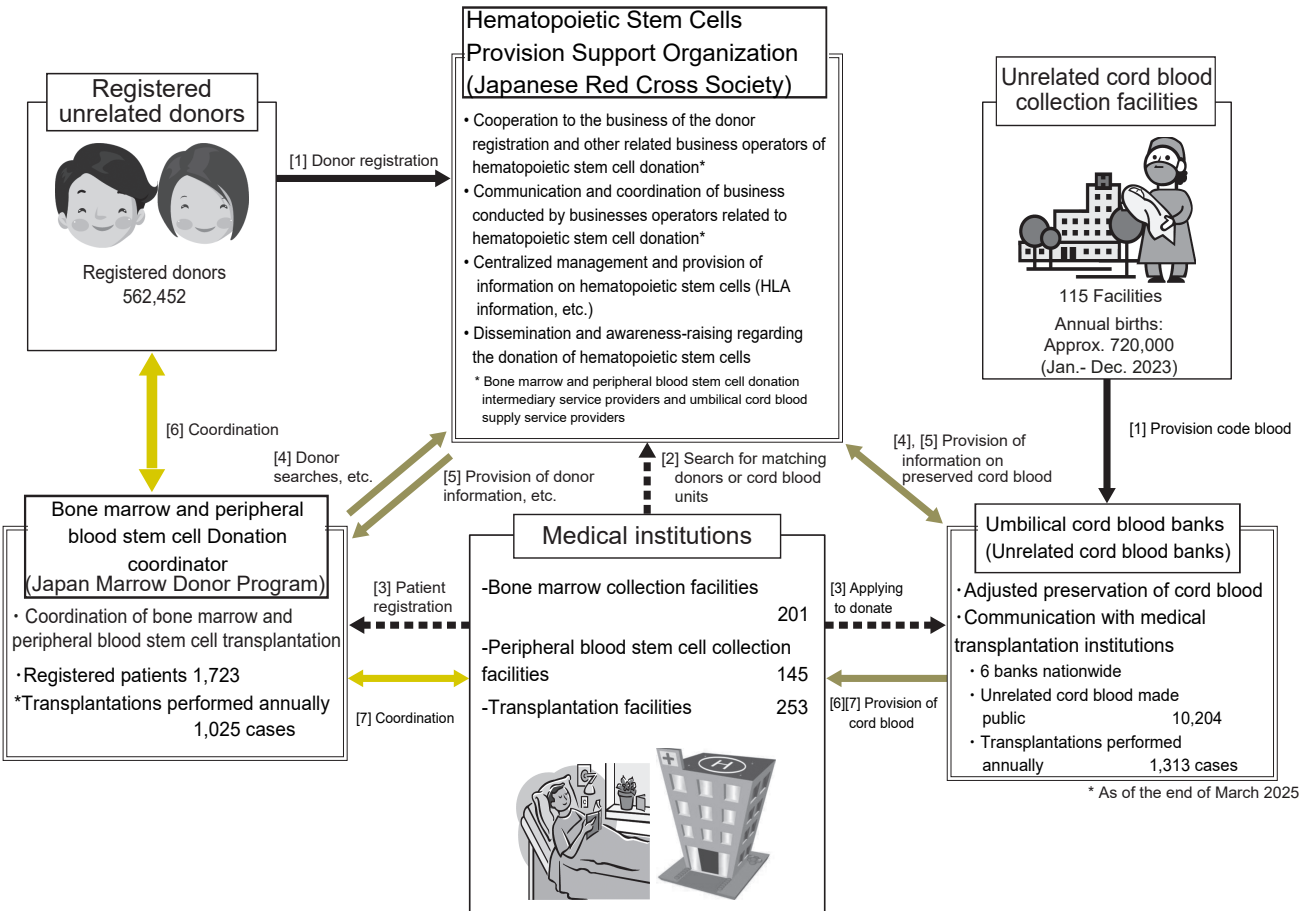
Organ Transplant System (*1)



(*1) This is just one example, and there may be cases that do not follow it.

(*2) As of April 1, 2025, all organs other than the eyeballs are allocated by the Japan Organ Transplant Network, a public interest incorporated association, while eyeballs are allocated by 54 eye banks across the country, which also handle promotion activities related to organ donation.

Unrelated Hematopoietic Stem Cell Transplantation System



* As of the end of March 2025

Detailed Data 1
Accumulated Number of Organ Transplantations based on the Act on Organ Transplantation

	Number of donors		Number of transplantations performed		Registered transplant applicants
		Under brain death		Under brain death	
Heart	957 person	957 person	956 person	956 person	813 person
Lung	837 person	837 person	1,031 person	1,031 person	631 person
Liver	1,002 person	1,002 person	1,063 person	1,063 person	514 person
Kidney	2,587 person	1,066 person	4,861 person	2,083 person	14,883 person
Pancreas	584 person	579 person	580 person	576 person	141 person
Small intestine	34 person	34 person	34 person	34 person	8 person
Eyeball (cornea)	23,472 person	484 person	37,748 person	896 person	2,117 person

Source: Japan Organ Transplant Network, Japan Eye Bank Association

- (Note)
1. The number of donors and the number of transplantations performed indicate the cumulative total from October 16, 1997 (the day of the enforcement of the Act on Organ Transplantation) to March 31, 2025. The number of registered transplant applicants is as of March 31, 2025.
 2. There have been 1,181 persons of brain death tests conducted nationwide under the Act on Organ Transplantation since the enforcement of the law until March 31, 2025. In the eight cases, the donor was determined legally brain dead, but the organ was not procured for medical reasons. The case is therefore not included in the number of donors.
 3. The number of pancreas and kidneys includes the number of pancreatic kidney simultaneous transplants (504 cases) and the number of registered pancreatic kidney simultaneous transplant applicants (118 persons).
 4. The number of heart and lung cases includes the number of the heart lung simultaneous transplants (3 cases) and the number of registered heart lung simultaneous transplant applicants (4 persons).
 5. The number of liver and kidney cases includes the number of cases of liver kidney simultaneous transplants (66 cases) and the number of registered liver kidney simultaneous transplant applicants (44 persons).
 6. The number of cases of liver and small intestine transplants includes the number of liver-small intestine simultaneous transplants (3 cases).

Detailed Data 2
Changes in Numbers of Hematopoietic Stem Cell Transplantations Performed

	Unrelated donors		Number of unrelated transplantations		
	Number of registered donors	Number of registered cord blood	Bone marrow	Peripheral blood stem cell	Cord blood
1991	3,176	-	-	-	-
1992	19,829	-	8	-	-
1993	46,224	-	112	-	-
1994	62,482	-	231	-	-
1995	71,174	-	358	-	-
1996	81,922	-	363	-	1
1997	94,822	-	405	-	19
1998	114,354	-	482	-	77
1999	127,556	-	588	-	117
2000	135,873	4,343	716	-	165
2001	152,339	8,384	749	-	221
2002	168,413	13,431	739	-	296
2003	186,153	18,424	737	-	697
2004	204,710	21,335	851	-	674
2005	242,858	24,309	908	-	658
2006	276,847	26,816	963	-	732
2007	306,397	29,197	1,027	-	762
2008	335,052	31,149	1,118	-	859
2009	357,378	32,793	1,232	-	895
2010	380,457	32,994	1,191	1	1,075
2011	407,871	29,560	1,269	3	1,107
2012	429,677	25,385	1,323	15	1,199
2013	444,143	13,281	1,324	19	1,134
2014	450,597	11,595	1,269	62	1,165
2015	458,352	11,185	1,176	58	1,311
2016	470,270	11,287	1,127	123	1,347
2017	483,879	9,991	1,059	182	1,334
2018	509,263	9,516	992	222	1,355
2019	529,965	9,162	992	240	1,430
2020	530,953	9,316	838	258	1,431
2021	537,820	9,617	869	304	1,316
2022	544,305	9,674	744	311	1,360
2023	554,123	9,854	773	319	1,367
2024	562,452	10,204	684	341	1,313
Total	-	-	27,217	2,458	25,417

Source: Japan Marrow Donor Program, Japanese Red Cross Society

* The figures for cord blood stem from FY1996 to FY1998 indicate the number of transplantations coordinated by cord blood banks before the establishment of the Japan Cord Blood Bank Network.

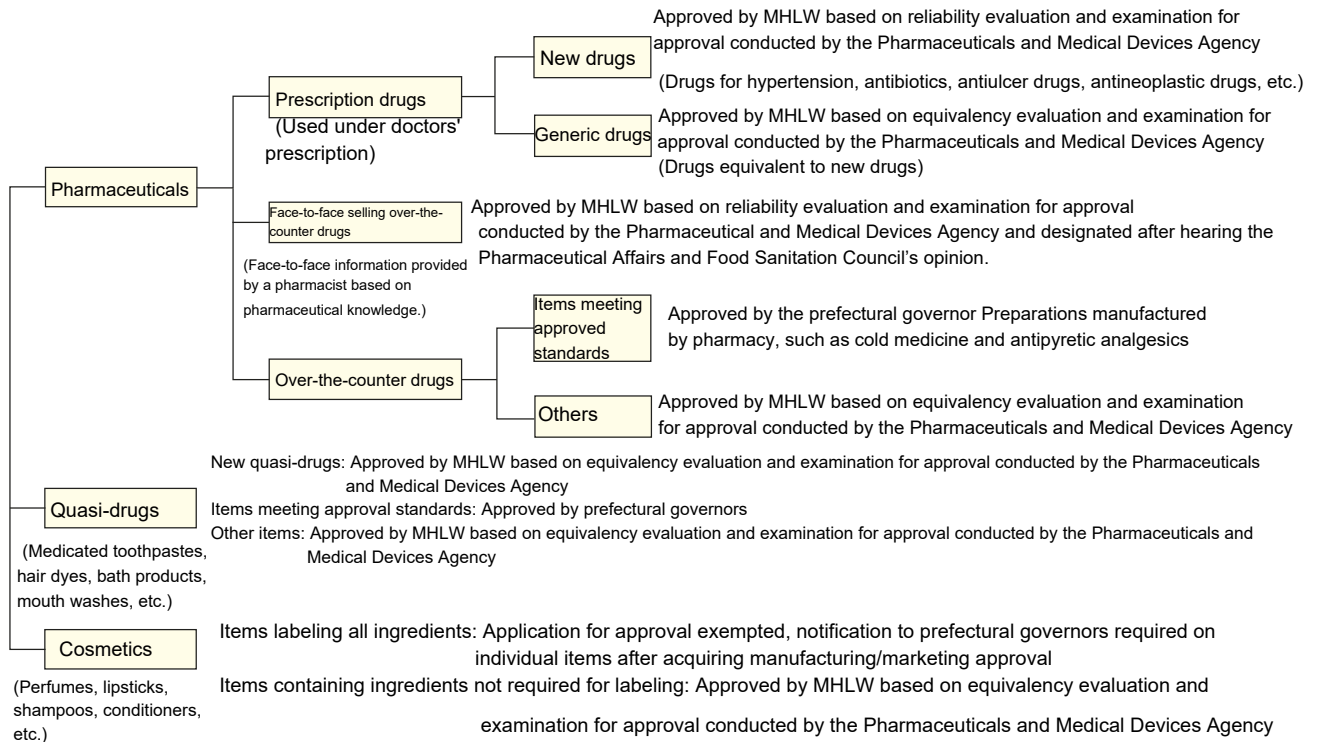
* Number of donors is as of the end of the respective years.

(4) Pharmaceuticals, etc.

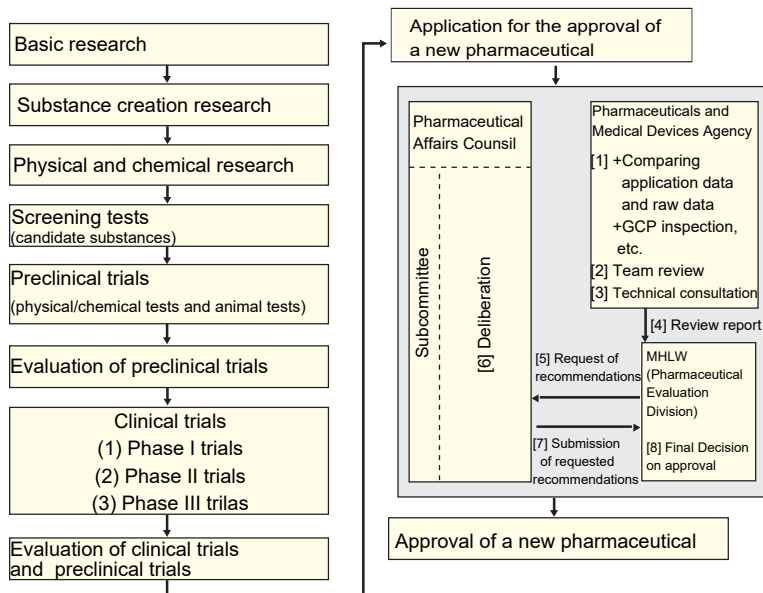
Approval/Licensing System for Pharmaceuticals, Quasi-Drugs, and Cosmetic

Overview

Classification of Examinations for the Approval of Pharmaceuticals, etc.



Flow of Examination for the Approval of a New Pharmaceutical



[Examination for the approval of a new pharmaceutical]

The quality, efficacy, and safety of a new drugs require an especially careful review. Therefore, a mechanism is in place in which the Pharmaceutical Affairs Council (an advisory organ to the Minister of Health, Labour and Welfare) composed of experts in the fields of medical science, pharmaceutical science, veterinary science, and statistical science deliberates on these subjects based on a number of data derived from basic and clinical studies. This mechanism also includes the decision-making process in which the Minister of Health, Labour and Welfare makes decisions on the approvals of a new drug based on the results of the deliberations of the Council.

Good Laboratory Practices (GLP) for the implementation of animal testing (against toxicity) among non-clinical tests and Good Clinical Practices (GCP) for the implementation of clinical tests are set forth by ministerial ordinances. Each test is regulated by GLP and GCP to assure appropriate testing.

[License for marketing and manufacturing pharmaceuticals, etc.]

The approval and licensing system for pharmaceuticals, etc. was revised. Since April 2005, the system has been applied separately to a marketing authorization holder that ships products to markets and to a manufacturer of the products.

To obtain a license, a marketing authorization holder will be reviewed whether it complies with the standards on quality control procedures, as well as post-marketing safety control procedures. A manufacturer will be reviewed whether it complies with the standards on structure and facilities of manufacturing sites and on quality control procedures.

Prefectural governors issue the license for marketing and that for manufacturing, except for manufacturing of some pharmaceuticals that require sophisticated manufacturing technology.

(Note) The trials that are deemed necessary for application for the approval of a new drug can be roughly divided into two categories: preclinical (physical/chemical tests and animal tests) and clinical trials. Clinical trials are conducted on a phased basis from phase I trial (a small number of healthy volunteers), the phase II trial (a small number of patients), and the phase III trial (a large number of patients), as indicated in the chart above.

Detailed Data 1 Number of Licenses for Marketing Authorization Holder of Drugs, etc.

(As of the end of 2024)

Category	Pharmaceuticals		Quasi-drugs	Cosmetics	Total	
	Class 1 pharmaceuticals	Class 2 pharmaceuticals				
Marketing	1,032	290	742	1,564	4,403	6,999

Source: Survey by the Pharmaceutical Safety and Environmental Health Bureau of MHLW

(Note) Licenses are granted by prefectural governors (from April 1, 2005).

Detailed Data 2 Number of Approvals for Manufacturing and Marketing Drugs, etc. (2024)

		Prescription pharmaceuticals	Face-to-face selling / OTC pharmaceuticals	Quasi-drugs	Cosmetics
Manufacturing	Approval	317	279	1,401	0
Marketing	Approval with partial revision	1,810	186	251	0
Approval	Total	2,127	465	1,652	0

Source: Survey by the Pharmaceutical Safety and Environmental Health Bureau of MHLW

(Note) The figures exclude in vitro diagnostics.

Detailed Data 3 Number of Approvals and Registrations for Manufacturing Pharmaceuticals, etc.

(As of the end of 2024)

Category	Pharmaceuticals	Quasi-drugs	Cosmetics	Total
Manufacturing	2,072	2,190	4,367	8,629

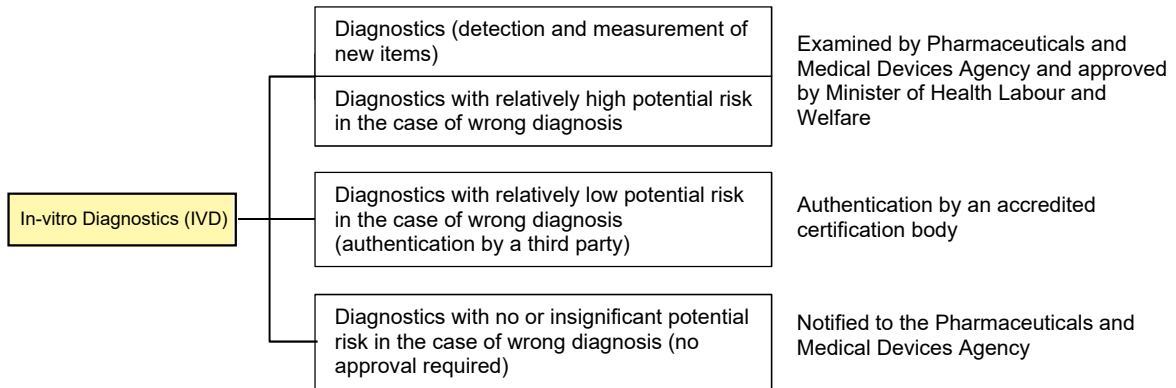
Source: Survey by the Pharmaceutical Safety and Environmental Health Bureau of MHLW

(Note1) Licenses are granted by prefectural governors from April 1, 1995 (excluding some drugs).

(Note2) On August 1, 2021, a new registration system was established for manufacturing facilities that only store products.

Review for the Approval of In-vitro Diagnostics (IVD)

Overview Review for the Approval of IVD



Detailed Data 1 Number of Licenses for Marketing IVD

(As of the end of 2024)

	IVD
Marketing	202

Source: Survey by the Pharmaceutical Safety and Environmental Health Bureau of MHLW
(Note) Licenses are granted by prefectural governors.

Detailed Data 2 Number of Approvals for Marketing (2024)

	Medicines for in-vitro diagnosis
Approval	43
Approval with partial change	79
Total	122

Source: Survey by the Pharmaceutical Safety and Environmental Health Bureau of MHLW

Detailed Data 3 Number of Registrations for Manufacturing IVD

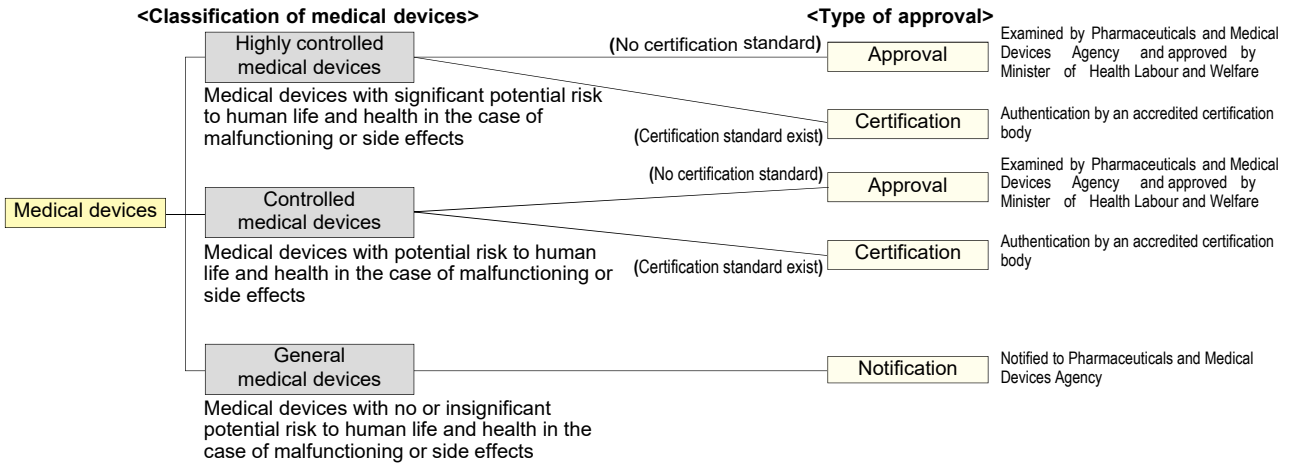
(as of the end of 2024)

	IVD
Manufacturing	253

Source: Survey by the Pharmaceutical Safety and Environmental Health Bureau of MHLW
(Note) Licenses are granted by prefectural governors.

Medical Device Approval/Licensing System

Overview Review for the Approval of Medical Devices



Detailed Data 1 Number of Licenses for Marketing Authorization Holder of Medical Devices

(As of the end of 2024)

Category	Class 1 medical devices	Class 2 medical devices	Class 3 medical devices	Total
Marketing	827	1,264	922	3,013

Source: Survey by the Pharmaceutical Safety and Environmental Health Bureau of MHLW
 (Note) Licenses are granted by prefectural governors (from April 1, 2005).

Detailed Data 2 Number of Approvals for Manufacturing and Marketing Medical Equipment, etc. (2024)

		Medical devices
Marketing	Approval	399(2)
	Approval with partial change	552(0)

Source: Survey by the Pharmaceutical Safety and Environmental Health Bureau of MHLW
 (Note) Number of cases of the confirmation for the change plan is entered in the "Approval" column, and number of cases of the confirmation for the change in the change plan is entered in the "Partial Change Approval" column, respectively as their included number of cases with using ().

Detailed Data 3 Number of Licenses and Registrations for Manufacturing Medical Devices, etc.

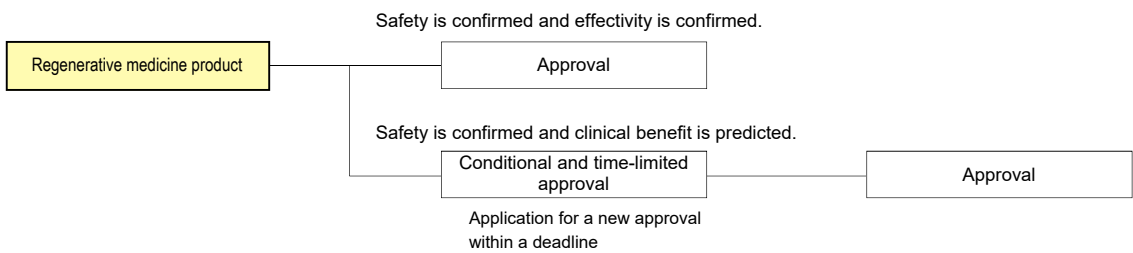
(As of the end of 2024)

		Medical devices
Manufacturing		4,703
Repairs		6,697

Source: Survey conducted by Pharmaceutical safety and Environmental Health Bureau, MHLW
 (Note) Manufacturing licenses are granted by prefectural governors.
 Repairing licenses are granted by prefectural governors.

Overview

Review for the Approval of Regenerative Medicine Products



Detailed Data 1

Number of Licenses for Marketing Authorization Holder of Regenerative Medicine Products

(As of the end of 2024)

	Regenerative medicine product
Marketing	27

Source: Survey by the Pharmaceutical Safety and Environmental Health Bureau of MHLW
 (Note) Licenses are granted by prefectural governors.

Detailed Data 2

Number of Approvals for Marketing Regenerative Medicine Products (2024)

	Regenerative medicine product
Approval	1 (0)
Approval with partial change regarding manufacture and sales	18 (0)

Source: Survey conducted by Pharmaceutical safety and Environmental Health Bureau, MHLW
 (Note) Number of cases of the confirmation for the change plan is entered in the "Approval" column, and number of cases of the confirmation for the change in the change plan is entered in the "Partial Change Approval" column, respectively as their included number of cases with using ().

Detailed Data 3

Number of Licenses for Manufacturing Regenerative Medicine Products

(As of the end of 2024)

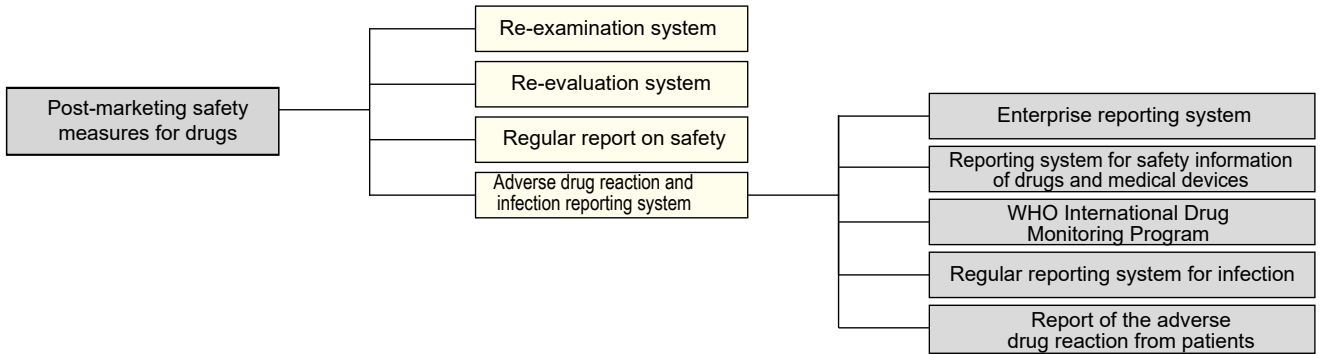
	Regenerative medicine product
Manufacturing	34

Source: Survey by the Pharmaceutical Safety and Environmental Health Bureau of MHLW

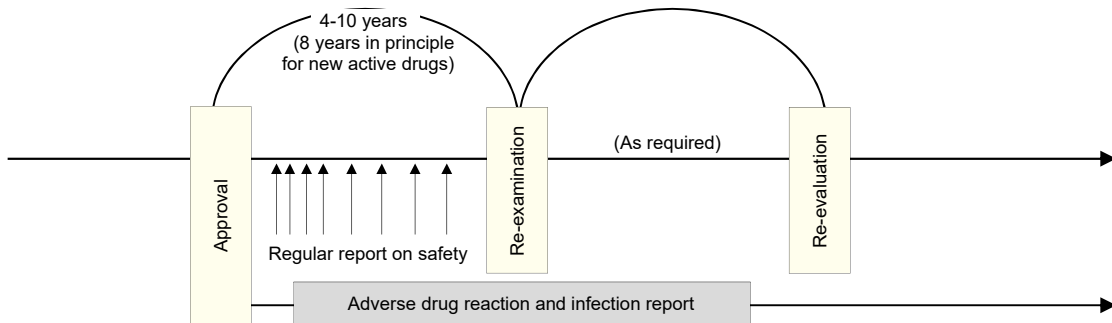
Post-manufacturing and Marketing Safety Measures for Drugs/Medical Equipment

Overview

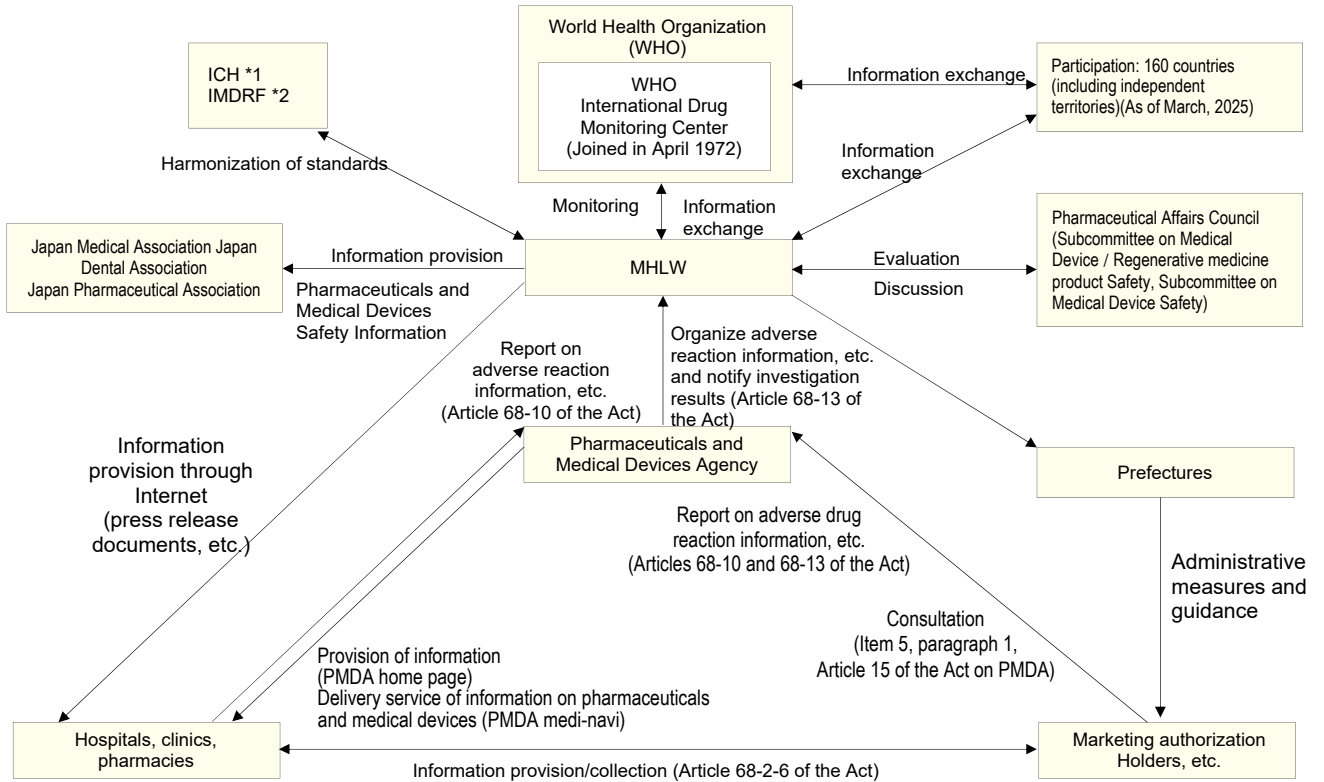
Post-Marketing Safety Measures for Drugs



Flow of Post-Marketing Surveillance and Re-examination/Re-evaluation of Drugs



Outline of the Adverse Drug Reaction, etc. Reporting System



*1: International Conference on Harmonisation of Technical Requirements for Registration of Pharmaceuticals for Human Use

*2: International Medical Device Regulators Forum

Detailed Data 1 Results of Prescription Drug Re-examination

(As of the end of FY2024)

No. of reexamination results (no. of items)		
Drugs that can be approved for effectiveness	Drugs that are approved for effectiveness with partial revision of matters to be approved	Drugs that are not approved for effectiveness
4,730	153	0

* In case that the same items are reexamined more than once, calculated figures are based on actual reexamination.

Source: Survey by the Pharmaceutical Safety and Environmental Health Bureau of MHLW

Detailed Data 2 Results of Prescription Drug Re-evaluation

(As of the end of FY2024)

(1) Phase 1 re-evaluation

	No. of finished ingredients or no. of subscriptions	No. of finished items
Total	1,819	19,612
Only one ingredient contained in medicine	1,159	18,169
Mixed ingredients for medicine	660	1,443

(2) Phase 2 re-evaluation

	No. of finished ingredients or no. of subscriptions	No. of finished items
Total	131	1,860
Only one ingredient contained in medicine	108	1,668
Mixed ingredients for medicine	23	192

(3) New reevaluation

	No. of ingredients	No. of finished items
Total	1,115	9,225
Re-evaluation for medicine effect	477	4,635
Re-evaluation of quality	638	4,590

Source: Survey by the Pharmaceutical Safety and Environmental Health Bureau of MHLW

(Note) 1. Phase 1 re-evaluation (between November 1973 and September 1995): Ingredients approved before September 30, 1967)

2. Phase 2 re-evaluation: covers ingredients approved between January 1988 and March 1996) : covers ingredients approved between October 1, 1967 and March 31, 1980.

3. New re-evaluation (between December 1990 and March 2016): covers all the ingredients.

Detailed Data 3 Changes in the Number of Reports on Adverse Drug Reaction, etc. in the Past 5 Years

(Unit: case)

FY	Reports from marketing authorization holders ^{Note 1)}					Reports on adverse drug reactions from medical professionals ^{Note 3)}
	Reports on adverse drug reactions ^{Note 2)}	Reports on infectious diseases ^{Note 2)}	Reports on research results	Reports on overseas measures	Regular reports on infectious diseases	
2020	51,359	70	874	1,652	1,070	10,985
2021	82,257	51	989	1,730	1,060	40,374
2022	71,176	55	1,024	1,611	1,064	11,819
2023	65,107	49	803	1,589	1,093	9,701
2024	65,214	51	902	1,714	1,137	9,474

Note 1) Including a report once accepted but withdrawn later by the manufacturer/seller (such as one found to have not taken the medicine after reporting, etc.), and a report accepted as a non-target report (such as one for which the causal relation was denied due to additional information after the reporting).

Note 2) Reports on domestic cases.

Note 3) The sum consists of the number of adverse reaction reports based on the safety information reporting system and the number of post-vaccination side reaction reports.

Source: Survey by the Pharmaceutical Safety and Environmental Health Bureau of MHLW

Detailed Data 4 Changes in the Number of Fault Reports on Combination Drugs^(Note1) Medical Devices

FY	Fault cases of combination(domestic)	Fault cases of combination drugs(Overseas)
2020	1,429	2,622
2021	1,480	2,929
2022	1,894	3,069
2023	1,712	2,627
2024	1,756	3,010

Note 1) A medicinal combination product refers to a medicine that has been approved for sale as an integrated unit with mechanical device such as insulin pen injector. Subject to the enforcement of the Pharmaceuticals and Medical Devices Law on November 25, 2014, reporting was mandated from November 25, 2016 after the transitional measure period from November 25, 2014 to November 24, 2016.

Source: Survey by the Pharmaceutical Safety and Environmental Health Bureau of MHLW

Detailed data 5 **Reported Number of Adverse Reactions, etc. of Quasi-drugs/Cosmetics** ^{Note 1)}

FY	Quasi-drugs (domestic)	Cosmetics (domestic)
2020	97	58
2021	78	63
2022	104	142
2023	136	158
2024	124	128

Note 1) Reporting has been required since the enforcement of the ministerial ordinance on April 1, 2014 that revised part of Ordinance for Enforcement of the Pharmaceutical Affairs Act and the ministerial ordinance concerning the standards for post-marketing safety management of the pharmaceuticals, quasi-drugs, cosmetics and medical equipment.

Source: Survey by the Pharmaceutical Safety and Environmental Health Bureau of MHLW

Detailed Data 6 **Changes in Number of Reports on Adverse Event Related to Medical Devices, etc. in the Past 5 Years**

FY	Reports from marketing authorization holders					Reports on adverse drug reactions from medical professionals (Unit: case)
	Reports on adverse event ^{Note 1)}	Reports on infectious event ^{Note 2)}	Reports on research results	Reports on overseas measures	Regular reports on infectious diseases	
2020	129,159	0	3,068	883	75	427
2021	144,492	0	3,883	1,184	73	354
2022	255,318	0	3,685	777	65	292
2023	230,880	0	4,104	1,453	71	326
2024	322,539	0	4,150	968	71	372

Note 1) Reports on adverse event include overseas cases.

Note 2) Reports on domestic cases.

Source: Survey conducted by Pharmaceutical safety and Environmental Health Bureau, MHLW

Detailed Data 7 **Changes in Number of Reports on Adverse Events including Drugs Produced by Utilizing Regenerative Medicine**

FY	Reports from manufacturers (Unit: case)					Reports on adverse drug reactions from medical professionals (unit: case)
	Reports on adverse event ^{Note 1)}	Reports on infectious diseases ^{Note 2)}	Research reports	Reports on overseas measures	Regular reports on infectious diseases	
2020	1,951	0	1	6	74	6
2021	2,390	0	2	7	100	5
2022	3,063	0	0	8	155	2
2023	4,422	0	1	17	170	0
2024	5,531	0	0	24	169	5

Note 1) Reports on adverse event of drugs produced by utilizing regenerative medicine, etc. including overseas cases.

Note 2) Reports on domestic cases

Source: Survey by the Pharmaceutical Safety and Environmental Health Bureau of MHLW

Relief Systems for Adverse Drug Reactions and Infections Acquired through Biological Products

Overview

[Relief System for Adverse Drug Reactions]

The purpose of this system is to provide various relief benefits and prompt relief to patients and their families, apart from civil liability, in relation to injury caused by adverse reactions despite the proper use of drugs.

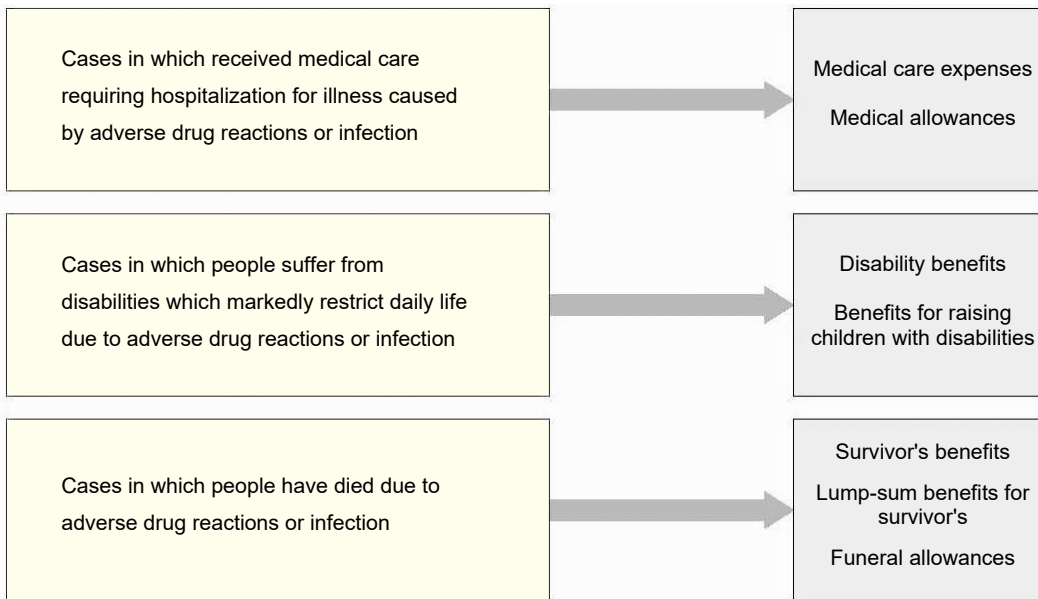
[Relief System for Infections Acquired through Biological Products]

The purpose of this system is to provide various relief benefits and prompt relief to patients and their families, apart from civil liability, in relation to injury caused by infections despite the proper use of biological products.

[Responsible organization]

Pharmaceuticals and Medical Devices Agency

[Types of Relief Benefits]



[Activities on the Relief for Caused Damages]

Since 1968, the Agency has been entrusted by the pharmaceutical enterprises and the government to pay health management allowances, etc. to patients who have been settled by SMON (subacute myelo-optico-neuropathy) of the lawsuit out of court.

[Relief Program for AIDS patients, etc. caused by Blood Products]

A survey and research project has been conducted since FY 1993 for helping HIV carriers infected through the use of contaminated blood products to prevent them from developing symptoms. For the prevention of the onset of AIDS and for health management in daily life, the government provides health management expenses and in turn requests the carriers report their health status.

Since FY 1996, assistance on health management expenses has been provided for the health management of those who developed AIDS and accepted the court settlement.

Detailed Data Changes in Status of Adverse Drug Reaction Relief Payments (as of the end of each FY)

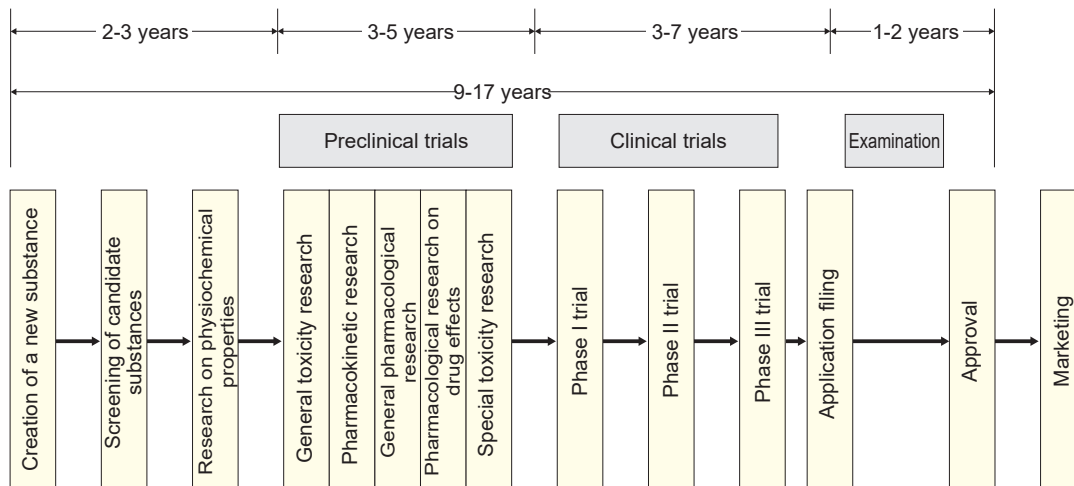
	1980-1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011
Amount (¥1,000)	8,705,179	935,148	1,022,185	1,055,985	1,204,243	1,262,647	1,587,567	1,582,956	1,696,525	1,798,706	1,783,783	1,867,190	2,058,389
Number of claims (case)	3,814	480	483	629	793	769	760	788	908	926	1,052	1,018	1,075
Number of payments (case)	2,965	343	352	352	465	513	836	676	718	782	861	897	959
	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024
Amount (¥1,000)	1,920,771	1,959,184	2,113,286	2,086,902	2,267,542	2,351,545	2,353,225	2,461,090	2,420,942	2,375,568	2,382,272	2,316,984	2,334,832
Number of claims (case)	1,280	1,371	1,412	1,566	1,843	1,491	1,419	1,590	1,431	1,379	1,230	1,355	1,419
Number of payments (case)	997	1,007	1,204	1,279	1,340	1,305	1,263	1,285	1,342	1,213	1,152	1,016	1,020

Source: Pharmaceutical and Medical Devices Agency

Research/Development of Drugs and Pharmaceutical Industry

Overview Process and Period of New Drug Development

Developing a new drug is considered to take 9-17 years and require nearly ¥100 billion per product including the costs of abandoned cases.



Detailed Data Breakdown of Marketing Authorization Holders of Drugs, etc. by Scale

Category	Number of enterprises		Drug sales (¥100 million)		Prescription drug sales (included) (¥100 million)	
		Percentage		Percentage		Percentage
Capital of less than ¥100 million	158	49.3%	5,779	3.0%	3,775	2.4%
¥100 million - 5 billion	105	32.8%	46,098	23.4%	35,563	22.4%
¥5 billion or more	58	18.1%	145,024	73.7%	119,071	75.2%
Total	321	100.0%	196,901	100.0%	158,409	100.0%

Source: "Survey of the Prescription Pharmaceuticals Industry of Japan FY 2023", Health Policy Bureau, MHLW

(Note 1) Survey targets were enterprises marketing drugs with approval of marketing authorization under the Law on Securing Quality, Efficacy and Safety of Products Including Pharmaceuticals and Medical devices as of March 31, 2024, that were members of categorized organizations (15 organizations) of the Federation of Pharmaceutical Manufacturers' Association of Japan.

(Note 2) As for the numerical values in the table, it may not agree with the total due to the rounding of figures.

Medical Devices

Overview Production of Medical Devices, etc.

(Unit: ¥100 million, %)

Year	Production	Percent change from the previous year	Export	Import	Total domestic production
1979	5,669	23.1	—	—	—
1989	12,195	9.9	2,266	2,972	12,819
1999	15,075	-0.4	3,273	8,345	19,298
2005	15,724	2.5	4,739	10,120	20,695
2006	16,883	7.4	5,275	10,979	24,170
2007	16,845	-0.2	5,750	10,220	21,727
2008	16,924	0.5	5,592	10,907	22,001
2009	15,762	-6.9	4,752	10,750	21,829
2010	17,134	8.7	4,534	10,554	22,856
2011	18,085	5.5	4,809	10,584	23,525
2012	18,952	4.8	4,901	11,884	25,894
2013	19,055	0.5	5,305	13,008	26,722
2014	19,895	4.4	5,723	13,685	27,655
2015	19,456	-2.2	6,226	14,249	27,173
2016	19,146	-1.6	5,840	15,564	28,455
2017	19,904	4.0	6,190	16,492	29,314
2018	19,490	-2.1	6,676	16,204	28,672
2019	24,942	28.0	9,535	25,790	38,843
2020	24,036	-3.6	9,748	25,268	38,309
2021	26,043	8.4	10,042	27,412	41,449
2022	25,829	-0.8	10,941	29,180	41,858
2023	26,748	3.6	11,255	33,217	45,491

Source: "Annual Report on the Survey of Pharmaceutical Industry Productions, Health Policy Bureau, MHLW

Detailed Data Production by Medical Device Type

(Unit: ¥100 million, %)

Category	Production	Percentage
1 Medical mirror	3,217	12.0
2 Visceral function substitute	2,367	8.9
3 Cannulae/catheters of assorted tip configurations	2,319	8.7
4 Medical X-ray device and X-ray tube for medical X-ray device	2,226	8.3
5 Blood test device	2,201	8.2
6 Visceral function test device	1,431	5.3
7 Physiotherapy device	1,360	5.1
8 Orthopedic goods	1,234	4.6
9 Dental metals	952	3.6
10 Eyeglasses for sight correction	900	3.4
11 Pump for drugs	857	3.2
12 Vision tester	775	2.9
13 X - ray film	603	2.3
14 Others	575	2.1
15 Needles and puncture needle	527	2.0
16 Medical gap-filling adhesive	457	1.7
17 Medical materials generator	350	1.3
18 Blood collecting or transfusion device	321	1.2
19 Orthopedic instruments and apparatus (note)	274	1.0
20 Tooth crown materials	236	0.9
21 Dental unit	235	0.9
22 Syringe barrel	195	0.7
23 Hearing aid	190	0.7
24 Blood pressure test or pulse wave velocity test device	184	0.7
25 Medical puncture device and rotating instrument (note)	167	0.6
26 Dental hand piece	165	0.6
27 Operating table and treatment table	155	0.6
28 Respiratory equipment	150	0.6
29 Condom	136	0.5
30 Medical disinfection apparatus	117	0.4
31 Electrical therapy apparatus for household use	107	0.4
32 Magnetic therapy apparatus	106	0.4
33 Electrosurgical unit	100	0.4
34 Urine test or stercus test device	89	0.3
35 Medical knife	86	0.3
36 Suture	85	0.3
37 Medical cauter	77	0.3
38 Medical evacuator	74	0.3
39 Medical microtome	71	0.3

Category	Production	Percentage
40 Acus or moxibustion device	66	0.2
41 Dental ground materials	62	0.2
42 Ligation device and Suturing devices	62	0.2
43 Dental cutting machine	59	0.2
44 Dental impression material	57	0.2
45 Diagnosis program.	50	0.2
46 Medical washer	46	0.2
47 Vibrator	43	0.2
48 Dental engine	41	0.2
49 Radiological material diagnosis device	38	0.1
50 Tampon for menstruation treatment	38	0.1
51 Medical light	35	0.1
52 Incubator	32	0.1
53 Plate materials	31	0.1
54 Dental calcium sulfate and calcium sulfates' goods	30	0.1
55 Thermometer	28	0.1
56 Perception test or physical function test device	26	0.1
57 Medical inhalant	26	0.1
58 Vision corrective glass	25	0.1
59 Opening or stoma device	24	0.1
60 Visual acuity chart and color anomaly test table	24	0.1
61 Dental materials for root canal filling	18	0.1
62 Medical forceps	17	0.1
63 Hearing test device	17	0.1
64 Medical rolled cotton	17	0.1
65 Accessories designated due to the MHLW Act	13	0.1
66 Protection kit from radiation hazard	12	0.0
67 Dental casting apparatus	10	0.0
68 Medical pincette	9	0.0
69 Dental steamer and polymerization vessel	9	0.0
70 Medical elevator	8	0.0
71 Medical scissors	8	0.0
72 Medical centrifugal separator	7	0.0
73 Splint	7	0.0
74 Medical incubator	7	0.0
75 Pneumothorax and pneumoperitoneum apparatus	6	0.0
76 Anesthesia apparatus and Rebreathing bags for anesthesia apparatus and gas canister	6	0.0
77 Medical sew	6	0.0
78 Medical dilator	5	0.0

Category	Production	Percentage
79 Medical uncal	5	0.0
80 Dental filling instruments	5	0.0
81 Impression taking or maxillomandibular registration device	5	0.0
82 Dental wax	4	0.0
83 Stethoscope	4	0.0
84 Dental filling instrument	4	0.0
85 Dental broach	3	0.0
86 Surgical gloves and finger cot	3	0.0
87 Dental desiccator	3	0.0
88 Biological fluid test device	3	0.0
89 Medical lever	2	0.0
90 Dental probe	1	0.0
91 Hernia supporters (note)	1	0.0
92 Medical treatment program	1	0.0

Category	Production	Percentage
93 Medical snare	1	0.0
94 For medical use only	1	0.0
95 Spatula	1	0.0
96 Contact lenses (excluding for sight correction.)	1	0.0
97 Medical bougie	1	0.0
98 Medical spoon	1	0.0
99 Medical Water sterilizers	1	0.0
100 Plexor	0	0.0
101 Medical hammer	0	0.0
102 Contraceptive device	0	0.0
103 Smallpox vaccination device	0	0.0
104 Medical raspatory	0	0.0
105 Finger pressure substitute	0	0.0
Total	26,748	100.0

Source: "Annual Report on the Survey of Pharmaceutical Industry Productions 2023", Health Policy Bureau, MHLW

Pharmacies

Overview

Separation of dispensing and prescribing functions in improving the quality of national medical care by dividing the roles of doctors and pharmacists based on their specialized field in that doctors will issue prescriptions to patients and the pharmacists of pharmacies then dispense according to those prescriptions.

[Advantages of separation of dispensing and prescribing functions]

- 1) By centrally and continuously grasping the patient's condition and medications taken by the pharmacy pharmacist and checking the prescription contents, it is possible to confirm whether the multiple medications and interactions caused by visiting multiple clinical departments exist, and to improve the effectiveness and safety of drug therapy.
- 2) Pharmacists, in cooperation with prescribing physicians and dentists, will explain effects, side effects, directions for use, etc. of drugs to patients (patient compliance instruction) so that patients improve their understanding on drugs and are expected to take dispensed drugs as directed leading to improved efficacy and safety of drug therapies.
- 3) Doctors and dentists can freely prescribe drugs necessary for patients even when the particular drugs are not stocked in their own hospitals or clinics.
- 4) Issuing prescriptions to patients allows them to know which drugs they are taking.
- 5) Reduced outpatient dispensing work of hospital pharmacists allows them to engage in hospital activities for inpatients which they should essentially perform.

Detailed Data Changes in Number of Pharmacies and Prescriptions

FY	Number of pharmacies	Number of prescriptions (10,000/year)	Number of prescriptions per 1,000 persons (per month)	Nationwide average rate of separation of dispensing and prescribing functions (%)
FY1989	36,670	13,542	95.2	11.3
FY1990	36,981	14,573	105.4	12.0
FY1991	36,979	15,957	111.7	12.8
FY1992	37,532	17,897	125.8	14.1
FY1993	38,077	20,149	140.6	15.8
FY1994	38,773	23,501	161.0	18.1
FY1995	39,433	26,508	182.5	20.3
FY1996	40,310	29,643	210.0	22.5
FY1997	42,412	33,782	238.1	26.0
FY1998	44,085	40,006	278.8	30.5
FY1999	45,171	45,537	307.3	34.8
FY2000	46,763	50,620	348.6	39.5
FY2001	48,252	55,960	393.7	44.5
FY2002	49,332	58,462	393.0	48.8
FY2003	49,956	59,812	418.8	51.6
FY2004	50,600	61,889	368.7	53.8
FY2005	51,233	64,508	425.2	54.1
FY2006	51,952	66,083	442.5	55.8
FY2007	52,539	68,375	481.0	57.2
FY2008	53,304	69,436	483.0	59.1
FY2009	53,642	70,222	494.1	60.7
FY2010	53,067 *	72,939	486.6	63.1
FY2011	54,780	74,689	498.3	65.1
FY2012	55,797	75,888	533.3	66.1
FY2013	57,071	76,303	510.2	67.0
FY2014	57,784	77,558	509.3	68.7
FY2015	58,326	78,818	513.1	70.0
FY2016	58,678	79,929	533.1	71.7
FY2017	59,138	80,386	529.8	72.8
FY2018	59,613	81,229	568.9	74.0
FY2019	60,171	81,803	547.6	74.9
FY2020	60,951	73,116	533.1	75.7
FY2021	61,791	77,143	525.7	75.3
FY2022	62,375	79,987	539.2	76.4
FY2023	62,828	85,630	588.9	80.3

Source: The number of pharmacies as of December 31 of each year until 1996 and of the end of each fiscal year from 1997 on by the Pharmaceutical safety and Environmental Health Bureau, MHLW. The total number of prescriptions, the number of prescriptions per 1,000 persons, and prescription receiving rates surveyed by Japan Pharmaceutical Association.

(Note) How to calculate the rate of prescription receipt are as follows:

$$\text{Prescription receipt rate (\%)} = \frac{\text{Number of prescriptions to pharmacies}}{\text{Number of prescriptions issued to outpatients (total)}} \times 100$$

* Miyagi Prefecture is not included due to the effect of the Great East Japan Earthquake.

Blood Programme

Overview

[Blood Products]

Blood products refer to all pharmaceutical products which are derived from human blood and are roughly classified into blood transfusion products and plasma derivatives. All of the blood transfusion products are supplied through blood donations in Japan.

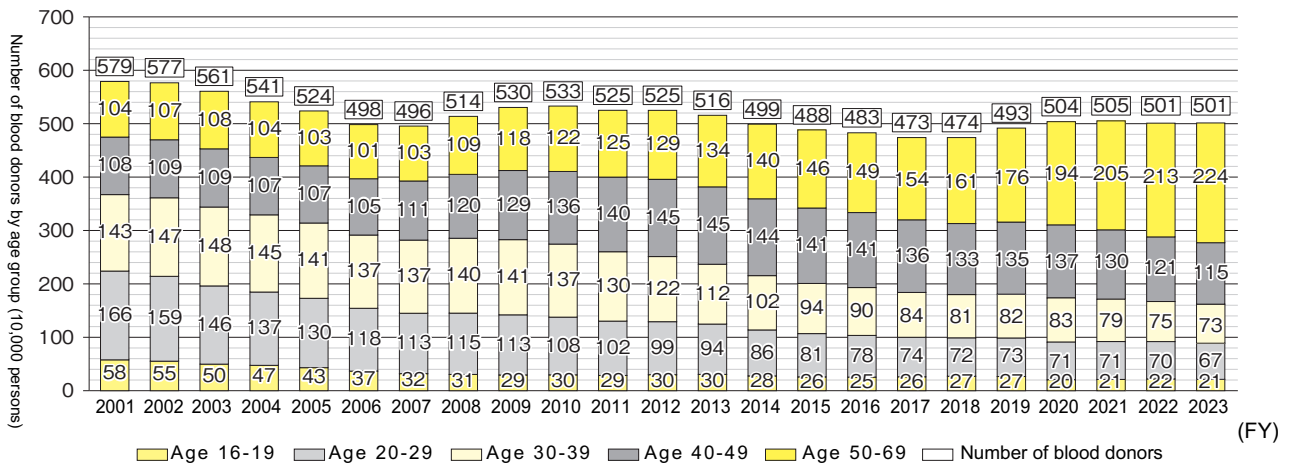
Regarding plasma derivatives, the domestic self-sufficiency has been achieved for blood coagulation factor products. On the other hand, for some albumin products and anti-HBs human immunoglobulin products, the products and raw materials are still imported from overseas. From the viewpoint of ethics and international fairness, efforts are being made to achieve domestic self-sufficiency for these plasma products.

Category	Type	Application
Blood transfusion products	Red blood cell products	Anemia due to hematopoietic organ diseases and chronic bleeding, etc.
	Plasma products	Liver damage, disseminated intravascular coagulation (DIC), thrombotic thrombocytopenic purpura (TTP), hemolytic-uremic syndrome (HUS), etc.
	Platelet products	Active bleeding, preoperative conditions of surgical operation, large volume blood transfusion, disseminated intravascular coagulation (DIC), blood disorders, etc.
Plasma derivatives	Albumin products	Hemorrhagic shock, nephrotic syndrome, hepatic cirrhosis accompanying intractable ascites, etc.
	Immunoglobulin products	Aglobulinemia or hypoglobulinemia, severe infection, chronic inflammatory demyelinating polyneuropathy(CIDP), Kawasaki disease, etc.
	Blood coagulation factor products	Supplementing blood coagulation factor to patients with blood coagulation factor deficiency

[Status of Blood Donation]

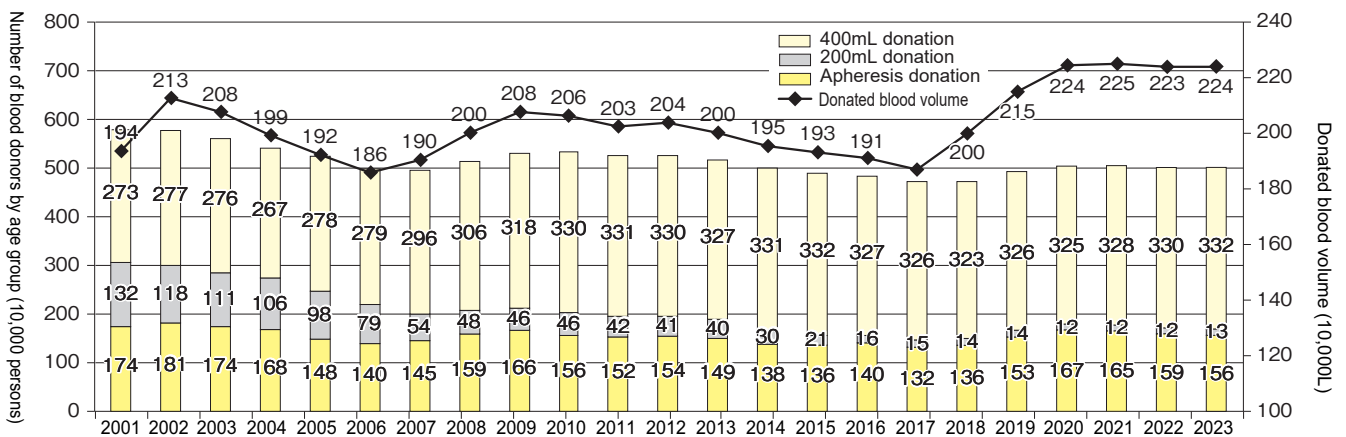
In recent years, the amount of blood donated per person has increased, and so the amount of blood needed can be secured with fewer donors than before. On the other hand, looking at the trend in the number of blood donors, the proportion of young people in their teens to 30s among all blood donors has decreased significantly compared to 10 years ago, and so activities to promote blood donation among young people have become important.

Detailed Data 1 Change in Number of Blood Donors



Source: Survey by Japanese Red Cross Society, and Created by the Pharmaceutical Safety Bureau of MHLW

Detailed Data 2 Changes in Number of Blood Donors by Donation Type and Donated Blood Volume



* From FY 2018, the amount of blood donated by component blood donation is calculated based on the total volume at the manufacturing stage (including the amount of blood storage solution).

(5) Health Risk Management System

Health Risk Management System

