



<https://doi.org/10.66534/hp.2026.0011>

Healthcare Politics in Japan: Differentiated Policy Dynamics across Multiple Arenas

Ryozo Matsuda ^{1,*} 

¹ College of Social Sciences, Ritsumeikan University, Kyoto, Japan

* Corresponding author: Ryozo Matsuda, College of Social Sciences, Ritsumeikan University, Kyoto, Japan (r.matsuda7425@chpjp.org)

Published: 30 June 2026

CC BY 4.0 · Open Access

ABSTRACT

Background: Japan's postwar welfare state developed around the universal Statutory Health Insurance System (SHIS), a complex public-private arrangement involving diverse insurers, providers, and government actors. Because most healthcare providers operate outside direct government control, the regulation of healthcare organizations and the setting of SHIS payment rates have remained central concerns in Japanese healthcare politics. However, the diversity of institutional arrangements and policymaking processes across different healthcare policy arenas has received limited systematic attention.

Methods: This paper conducts an institutional analysis of policy documents, media reports, and scholarly literature to examine Japanese healthcare politics over the past three decades.

Results: The paper begins by outlining the institutional structure of the SHIS and the key actors involved. It then examines four major arenas of healthcare policymaking: consensus-building in national councils, biennial revisions of medical fees and drug prices, system-wide health insurance reforms, and healthcare delivery reforms involving complex central-local relations. The analysis further considers how these arenas are affected by recent political transformations. These transformations include stronger political leadership, shifts in party competition, and intensifying conflicts over cost containment and cost-sharing. The analysis also highlights the emerging but uneven influence of patient voices and public opinion; while these forces remain structurally limited overall, they can occasionally prove decisive.

Conclusion: Rather than constituting a single unified process, contemporary healthcare politics in Japan is best understood as a differentiated system in which multiple policy processes coexist across distinct arenas. At the same time, changing political structures are reshaping distributive conflicts—increasingly centered on patient cost-sharing—within a healthcare system historically committed to universal coverage.

KEYWORDS: Japan; health politics; health policy; statutory health insurance; healthcare reform; cost-sharing

Introduction

After World War II, Japan developed its welfare state around pensions and healthcare as pillars. This development, achieved under a loose cross-party consensus, took shape under the long-term rule of the Liberal Democratic Party (LDP) in the latter half of the twentieth century (Campbell et al., 2014). At the core of the healthcare system stands the Statutory Health Insurance System (SHIS), formed in the 1960s. This system combines employment-based health insurance with residence-based health insurance to create a framework under which all residents are compulsorily enrolled in health insurance (R. Matsuda,

2019; Sakamoto et al., 2018). Within this framework, both public and private actors supply healthcare services, giving rise to a complex policymaking process (Health and Global Policy Institute, 2019).

Research on Japanese healthcare politics has traditionally focused on the SHIS. For example, the scope of SHIS benefits and the setting of payment methods—both of which shape the economic incentives facing healthcare organizations—have remained central subjects of healthcare politics (Campbell & Ikegami, 1998; Ikegami & Anderson, 2012; Ikegami & Campbell, 2004; Yamagishi, 2022). The framework under which municipalities administer residence-based health insurance has also been identified as a

distinctive feature of the Japanese welfare state (Kitayama, 2011, 2024).

However, as gradual healthcare reform proceeds against a backdrop of changing healthcare needs driven by population aging and pressure to contain spending, it has become increasingly important to attend to the diverse arenas in which healthcare politics unfolds. For instance, although a variety of public and private organizations supply healthcare services under the SHIS, each operating under distinct organizational constraints (R. Matsuda, 2016), reform within this mixed economy of healthcare requires attention to region-specific politics.

This paper focuses on Japanese healthcare politics across major policy arenas, analyzing it with attention to the diversity of institutional arrangements and policy processes. It first organizes the institutional structure and policy actors, and then examines the distinct political dynamics that characterize each policy arena. It further considers recent shifts toward stronger political leadership and changes surrounding patient cost-sharing, describing the composite character of healthcare politics. The paper's focus is on the politics of healthcare services; matters relating to pharmaceuticals are addressed only insofar as they intersect with this focus.

Methodologically, this paper offers an interpretive institutional analysis rather than a systematic review. It draws selectively on publicly available documentary sources on Japanese healthcare policymaking since the 1990s—including Cabinet decisions, ministerial policy documents, advisory council reports, official notices issued to prefectures, party policy platforms, and press coverage—read alongside the Japanese- and English-language scholarly literature on Japanese health politics. The analysis covers the past three decades, with particular attention to the period since the mid-2010s. Rather than testing a causal hypothesis, the paper proceeds by tracing how particular policy issues are sorted into distinct institutional venues, and by comparing the configuration of actors, decision rules, and characteristic conflicts that each venue generates.

Institutions and Actors in Healthcare Politics

Healthcare Financing

The SHIS is composed of various forms of compulsory insurance involving large firms, small and medium-sized enterprises (SMEs), and local governments, respectively—an arrangement that formed part of the Japanese-style welfare state of the latter twentieth century, with its emphasis on employment-based welfare (Estévez-Abe, 2008; Shizume et al., 2021). Through the administration of these insurers, the following political actors come to participate.

First, Health Insurance Societies (Kenpo Kumiai)—established by large firms and covering their managers and employees—have formed a national organization, the National Federation of Health Insurance Societies (Kenporen), which is actively engaged in the policymaking process. The Japan Health Insurance Association (Kyokai

Kenpo), which covers employers and employees of SMEs and is the largest single insurer, participates in policymaking at the national level, while its prefectural branches represent an influential local voice in healthcare politics that cannot be ignored. In addition, municipalities—which jointly operate the Health Insurance System for the Advanced Elderly covering residents aged 75 and over (in practice, through a single federation established by the municipalities within each prefecture)—and prefectures and municipalities, which share responsibility for administering National Health Insurance (NHI) covering other residents (the self-employed, agricultural and forestry workers, part-time workers, retirees, and others), each put forward policy proposals through their respective national organizations. These insurers do not simply represent their enrollees in the abstract: each is bound to a distinct financial position. Kenporen speaks for societies whose reserves are drained by cross-subsidies to the elderly, Kyokai Kenpo for a scheme dependent on statutory tax subsidy, and the municipal and prefectural organizations for insurers carrying the enrollees with the lowest average incomes and the highest per-capita costs. Their positions in the policy process track these balance sheets closely.

Organizations representing these insurers become members of the Central Social Insurance Medical Council (Chui-kyo), which determines payment methods under the statutory health insurance system, and thereby hold authority to participate directly in policymaking. The Council is composed of three types of members: representatives of the payer side, representatives of the provider side, and representatives of the public interest; among payer-side representatives, in addition to representatives of these insurers, a representative of the Japanese Trade Union Confederation (Rengo) is also appointed.

In realizing universal enrollment under the SHIS, the government made a bold commitment to subsidize the system from general tax revenue. These subsidy rates are set separately for each insurance scheme, and although they have changed over time, they have continued to add up to a broadly similar overall share of the burden (OECD, 2025).

Under this arrangement, substantial expenditure flows annually from the national general budget into the SHIS, making the revision of payment methods to healthcare institutions—normally conducted once every two years—inevitably a major political concern. In particular, the question of how much to raise overall prices is directly linked to the government's budget formulation for the subsidies to statutory insurers mandated by law, making it a political event that involves not only insurers and healthcare-related organizations but also politicians (Ikegami, 2019). One distinctive feature of Japanese healthcare politics is a somewhat ritualized process in this budget negotiation, in which cabinet ministers visibly represent opposing positions: the Minister of Health, Labour and Welfare acts as an advocate for healthcare institutions facing rising prices and wage demands, negotiating with the Minister of Finance, who holds the budget-control function. It should also be noted that the Japanese healthcare system includes, as a complement to the SHIS, a tax-funded Public Assis-

tance Program that fully covers the medical expenses of low-income individuals, which carries its own distinct political controversies involving stigma (Estévez-Abe, 2008).

Although numerous organizations are involved in healthcare provision, the Japan Medical Association (JMA) stands out for its political influence (Steslicke, 1973). The JMA is a network-type organization based on voluntary membership among physicians; while it was traditionally associated with LDP-dependent clientelistic politics, as constraints on healthcare spending have become a political issue, the JMA has, since the 2000s, shifted its strategy toward emphasizing public interests such as universal coverage and the maintenance of regional healthcare, engaging in policymaking across party lines (Yamaguchi, 2016). Its representatives not only sit on many national advisory councils related to healthcare but also serve on the healthcare policy councils established by each prefecture. This reorientation toward public-interest arguments should not be read as a departure from material interest. The JMA's membership base remains weighted toward proprietor-physicians operating clinics, whose incomes depend directly on the fee schedule for outpatient and primary care, and its defense of "regional healthcare" has in practice aligned with resistance to the functional consolidation that would concentrate resources in large hospitals.

The JMA is generally regarded as the body that aggregates the views of physicians primarily operating clinics; beyond this, the views of hospital-related organizations tend to be expressed through the representatives of various other organizations. Under the non-binding proportional representation system introduced for House of Councilors elections in 2001, in addition to the traditionally influential healthcare professions of physicians, dentists, pharmacists, and nurses, other co-medical professional organizations have increasingly put forward their own organizationally endorsed candidates (Tanaka, 2025).

Healthcare Delivery

Traditionally, government intervention in healthcare delivery was limited. Although the establishment of hospitals required prefectural approval, the review criteria were confined largely to structural aspects such as minimum facility and staffing standards, while decisions regarding bed increases and equipment installation were generally left to the autonomy of individual healthcare institutions; as a result, the healthcare sector continued to expand through the end of the twentieth century.

However, from the 1980s onward, prefectures have gradually strengthened their authority to regulate hospitals, and mechanisms for doing so have been progressively developed (Sakamoto et al., 2018). Prefectural Healthcare Councils, which deliberate on the healthcare delivery system within each prefecture, were established, and prefectures were granted authority to deny the opening of new hospitals or increases in hospital beds where these would exceed the number of beds deemed necessary for the region—calculated on the basis of standards set by the central government. Prefectures were further obligated to formulate and

publish a Health Care Delivery Plan, describing, with the cooperation of relevant stakeholders, the healthcare functions to be enhanced in the future. Although prefectures lack the authority to compel healthcare institutions to implement this blueprint, they can encourage its realization through subsidies. The central government's guidelines for formulating these plans initially concerned mainly hospital services; over the thirty years since their introduction, they have come to include increasingly detailed content—descriptions organized by disease (such as cancer) and by function (such as emergency care)—and, more recently, have come to specify the names of individual healthcare institutions (OECD, 2015; Taneda et al., 2023).

Initially, emphasis was placed on enhancing and coordinating healthcare functions; however, as pressure for greater efficiency in healthcare services has intensified, the pursuit of downsizing and functional reorganization of healthcare institutions—discussed further below—has become more prominent. At the same time, while continuing to respect the autonomous management of healthcare institutions, the government has strengthened its authority to collect information concerning them. For example, hospitals are now required to classify the beds they operate into four categories—Advanced Acute Phase Function, Acute Phase Function, Convalescence Phase Function, and Chronic Phase Function—and to report this classification to the government to inform the formulation of a reorganization vision (Taneda et al., 2023). In addition, penalties for non-cooperation have been introduced, including the public disclosure of the names of healthcare institutions that fail to provide information necessary for formulating this vision or fail to participate in relevant councils (Director of the Regional Healthcare Planning Division, Health Policy Bureau, Ministry of Health, Labour and Welfare, 2018), advancing a form of mandated collaboration (Sullivan et al., 2024).

Different Policy Processes across Healthcare Policy Arenas

The institutional arrangement of healthcare politics gives rise to distinct policy arenas for different policy issues, within which distinct policy processes unfold—an arena-differentiated structure that extends Lowi's (1964) classic argument that policy type determines the politics it generates. The Japanese case suggests a further specification: what differentiates these arenas is not only the substantive type of policy at stake, but the institutional venue in which it is decided, each venue carrying its own constellation of actors, forms of conflict, and decision rules. Nonetheless, across these arenas, the agendas and draft proposals considered by policy advisory councils prior to legislation or government regulation are, for the most part, prepared by the bureaucracy, giving the bureaucracy substantial influence over national healthcare policymaking (Campbell, 1992; Morita, 2016; Schwartz, 1998). At the same time, in some cases—such as the revision of the medical fee schedule—deliberation by an advisory council is mandated by law, and some scholars regard these councils as

instruments of political control (Ikeda, 2020). Moreover, in recent years, the statements and views of non-bureaucratic council members have carried increasing weight (Tanaka, 2024).

Setting Direction: Consensus-Building

First, the strategic direction of healthcare policy is typically deliberated by the government's standing advisory councils, where consensus is formed or confirmed. In Japan, healthcare policy has historically been treated as a branch of social security policy, and the Social Security Council of the Ministry of Health, Labour and Welfare (MHLW) plays a foundational role in shaping the strategic direction of healthcare policy. Healthcare-related organizations, including the JMA, as well as health insurance organizations, participate in this Council, where the formation of consensus is emphasized.

Overall social security matters—particularly the comprehensive design of tax and social insurance contributions and benefits—are also debated in the Council on Economic and Fiscal Policy within the Cabinet Office, which determines the government's basic policies on economic and fiscal matters. The discussions there are incorporated into the “Basic Policy on Economic and Fiscal Management and Reform,” decided annually by the Cabinet. The Council does not merely authorize the discussions of the Social Security Council; it sometimes proposes its own policies. For example, the Basic Policy decided in June 2021 included the introduction of repeat prescriptions; because this new prescription format did not require legislative amendment, it was introduced from fiscal year 2022 (Cabinet Office, Government of Japan, 2021). Japanese ministries are each permitted to express their own views, and on efficiency-related issues such as the scope of SHIS benefits and the introduction of repeat prescriptions, the Ministry of Finance's Fiscal System Council and related divisions have at times put forward a more aggressive reform agenda than the MHLW (Fiscal System Council, 2021). The divergence is institutionally grounded: the Ministry of Finance's standing interest lies in restraining the statutory subsidy that healthcare draws from the general account, while the MHLW's authority and budget are tied to the programs it administers and to its relations with the provider organizations it regulates. This divergence of views between the Ministry of Finance and the MHLW—a form of bureaucratic dualism—is ultimately resolved through a policy process that also involves the ruling party (Campbell, 1992; Löer, 2026).

Normal Business: Price Negotiations

What unifies Japan's multi-insurer healthcare system is the medical fee schedule and the drug price list, which respectively determine the scope and prices of the healthcare services and pharmaceuticals covered by insurance (Campbell & Ikegami, 1998; Ikegami, 2019). These have generally been revised once every two years since 1988, constituting a periodically recurring political process. Because these payment decisions have a direct impact on the expenditure of health insurers and on the revenue

of healthcare institutions and pharmaceutical companies, decisions concerning changes in the overall price level involve relevant organizations, including the JMA, and are typically made by the Prime Minister after taking their views into account. For example, for fiscal year 2026, Prime Minister Takaichi decided to raise the price level of medical fees by 3.09% while lowering drug prices by 0.87% (Yomiuri Shimbun, 2025).

Although a diagnosis-group-based, per-diem lump-sum payment system (DPC-based payment) has been introduced for major acute-care hospitals, fee-for-service payment remains the basic method of payment for healthcare services in Japan (Ikegami, 2019). The medical fee schedule therefore incorporates a range of incentives for healthcare institutions regarding the supply of healthcare services, including hospital admission and discharge. These incentives are determined in detail by the Chu-i-kyo, in line with the direction of healthcare policy on which consensus has been reached in the Social Security Council. Bureaucrats primarily take the lead in formulating and consolidating these proposals.

System Reform

Japan's statutory health insurance has remained essentially unchanged since the 1960s in the sense that it covers nearly the entire population. However, practical matters—such as the organization of insurers under the multi-insurer model and the rules governing contributions and user cost-sharing—have been subject to cumulative reform (Sakamoto et al., 2018).

Among the major recent reorganizations of insurers are the creation of the Health Insurance System for the Advanced Elderly and the reorganization of the National Health Insurance system. In 2008, a reform of insurance enrollment was implemented, under which residents aged 75 and over—who had previously been enrolled in various residence- or employment-based insurers—were uniformly enrolled in the newly established prefectural-level Health Insurance System for the Advanced Elderly (R. Matsuda, 2010). In addition, National Health Insurance, a region-based statutory insurance scheme previously administered by municipality-level insurers, was restructured from 2018 so that prefectures assumed financial responsibility while municipalities retained responsibility for day-to-day administration (Health, Labour and Welfare Statistics Association, 2025).

Under the statutory health insurance system, divided between residence-based and employment-based insurance, differences in cost-sharing between the two had generated institutional complexity; however, a legislative amendment in the early 2000s established a uniform cost-sharing rate across insurers, generally set at 30% (with certain mitigations for catastrophic burdens) (Ikegami et al., 2011). At the same time, reduced rates were applied to children and the elderly. Over the subsequent two decades, as measures to counter the declining birthrate expanded, the scope of the reduced cost-sharing rate for children was extended from those under three to all children not yet enrolled in elementary school. Reductions for the elderly

moved in the opposite direction, supported by an increasingly prominent political framing of older people as a comparatively affluent group. That characterization operated less as a neutral demographic description than as a political resource for justifying the withdrawal of benefits, and it obscured the considerable income dispersion within the older population. However, most local governments did not consider these reductions sufficient, and have independently developed their own measures, funded from their own budgets, to reduce cost-sharing for children—for example, providing free healthcare for children up to age 18 (Sugahara, 2017). The national government had imposed financial penalties on local governments adopting such measures, but, amid the broader expansion of policies to counter the declining birthrate, announced the abolition of these penalties in 2023 (Cabinet Secretariat, Government of Japan, 2023, p. 14). By contrast, cost-sharing reductions that had been provided to elderly people who are not low-income have gradually been withdrawn (Kato et al., 2022).

The political process surrounding reform of the statutory health insurance system often becomes complex, involving numerous stakeholders, depending on the specific proposal under consideration. This complexity stems in part from the issues surrounding tax injections and inter-insurer financial transfers. First, the SHIS includes mechanisms under which substantial tax subsidies are automatically injected, by rule, into National Health Insurance insurers, the operator of the Health Insurance System for the Advanced Elderly, and the Japan Health Insurance Association, among others. In addition, other insurers are obligated to provide cross-subsidies to the Health Insurance System for the Advanced Elderly, meaning that the burden placed on this system is a matter of significant concern to other insurers as well (Ikegami et al., 2011; R. Matsuda, 2019; Sakamoto et al., 2018).

Healthcare Delivery System Reform: Complex Central–Local Politics

Reform of the healthcare delivery system is implemented through a legal framework carried out at the prefectural level (Ikegami et al., 2011; S. Matsuda, 2019). Since the 1990s, hospital reform has centered on the downsizing and functional reorganization of the hospital sector, driven by the MHLW's sustained commitment to the idea of “differentiation and collaboration of healthcare functions” (*iryō kinō no bunka renkei*), which has provided ideational continuity across successive waves of reform (Ryu, 2019). While hospital reform has long been the primary focus, in recent years reform efforts have increasingly extended to primary care, including clinics, and to home-based care. Furthermore, given the large number of hospitals in Japan, consolidating functions such as surgery has also become an issue driven by demands from clinicians themselves. This reform direction has also been positioned within broader social security reform policy, which in turn shapes the healthcare reform agenda (National Council on Social Security System Reform, 2013).

Because the healthcare delivery system is composed of a complex mix of public and private actors, the politics of its

reform corresponds to a dual policy space: on one hand, reform policy concerning the hospital sector as a whole, involving the central government's formulation of prefectural healthcare guidelines and the introduction of incentives; and, on the other, reform policy limited specifically to public hospitals. In both spaces, the formation of reform consensus at the prefectural level is emphasized, and top-down policy approaches have met with strong resistance (Ito, 2023).

As already noted, the government has introduced prefectural-level restrictions on the number of hospital beds; however, the guidelines for the Health Care Delivery Plan placed primary emphasis on developing regional healthcare functions and lacked mechanisms to promote reorganization. In response, the Regional Healthcare Vision (Chiiki-Iryo-Koso) was newly introduced through the 2014 amendment to the Medical Care Act (Sakamoto et al., 2018). This Vision aimed to have prefectures, drawing on projections of healthcare demand toward 2025, formulate a vision for the reorganization of hospital beds within their jurisdiction with the agreement of relevant healthcare institutions, and to carry out bed reorganization on the basis of that agreement. To support the formulation of this Vision, the government's authority to collect hospital information necessary for reorganization was strengthened. Because policy concerning the healthcare delivery system is highly technical, it is often examined through ad hoc expert study groups before being decided upon deliberation by the Social Security Council. With respect to public hospitals established by local governments, the central government has promoted reform—through the formulation of reform guidelines and the provision of subsidies—from the standpoint of sound local government finances (Zhang & Oyama, 2016).

In this way, reorganization at the regional level requires the formation of consensus within each region and calls for organizationally innovative responses on the part of administrative bodies. While the national government thus provides policy direction and related information, the formation of consensus within each region and the substantive policymaking that follows depend on local political actors. These actors include prefectural governors, local assembly members, influential local figures, local medical associations, hospital managers, and labor unions, although research on them remains limited (Ito, 2023).

The Emergence of a New Healthcare Politics?

Looking back over the past three decades, traditional healthcare politics has gradually been transformed. The electoral system reform carried out in the mid-1990s brought about the collapse of the long-standing single-party LDP government, ushering in a system in which changes of government became possible (Machidori, 2023). Furthermore, “theatrical politics” and, in the 2010s, a populist political climate emerged alongside the growth of social networking services (Fahey et al., 2021). In the mid-2020s, Komeito, which had governed in coalition with the LDP, withdrew from that coalition, and from 2025 the

LDP has been building a new partnership with the Japan Innovation Party (Ishin) (Takao, 2026). Amid these developments, pressure to curb social insurance contributions has increasingly driven the push to contain healthcare expenditure, giving rise to arguments such as the exclusion of “low-value care” from insurance coverage (Miyawaki et al., 2025).

Meanwhile, the central government reorganization carried out at the turn of the century shifted the model of policy-making from a bureaucracy-led coordination model to a political leadership model driven by the ruling party (Mishima, 2022; Shinoda, 2023; Takenaka, 2019). Politics that had previously proceeded bottom-up—with bureaucrats primarily drafting policy, interests being coordinated through the advisory councils established within each ministry, and “preliminary review” conducted before formal government decisions within the LDP’s Policy Research Council—has, through the electoral and central-administrative reforms carried out during this period, shifted toward top-down politics driven by the Prime Minister, the staff of the Prime Minister’s Office who support him, and various ad hoc meetings (Innami, 2021; Machidori, 2023).

The Spillover of Social Insurance Contributions Politics

One example of this shift is the emergence of new forms of pressure to contain healthcare expenditure. In the run-up to the 2026 general election, the Japan Innovation Party (Ishin) and others called for reductions in social insurance contributions (Nippon Ishin no Kai, 2025). In addition to increased cost-sharing for the use of originator drugs under an already-introduced reference-pricing-type mechanism, increased patient cost-sharing for prescription drugs that have over-the-counter (OTC) equivalents (OTC-ruiji-yaku) became a focal point of healthcare politics (Yakuji Nippō, 2025).

Policies that increase patient cost-sharing in this way carry the risk of conflicting with the principle of universal coverage, and, even in the 2010s, were not easily achieved for political reasons (Campbell et al., 2014; Innami, 2021). However, amid a changing party-political landscape, increases in cost-sharing not previously seen are gradually being advanced. In other words, redistributive politics concerning taxation and social insurance contributions is increasingly being expressed within healthcare policy, particularly in a form concentrated on patient cost-sharing, with increases justified on various grounds such as cost-effectiveness and fairness of user burden according to income.

Patient Voice

Over the past two decades, the voice of patients has come to be given greater weight—a marked departure from the pattern observed in the late 1990s, when the protection of elderly interests occurred largely without organized advocacy, driven instead by age-based benefit design and politicians’ electoral calculations relating to unorganized elderly voters rather than by interest-group mobilization (Talcott, 2001). However, rather than being systematically

incorporated into healthcare-system decision-making, patient input remains, for the most part, given a degree of consideration in various individual settings. One example is the provision of opportunities for individuals regarded as representing patient voices to participate in policy deliberations (Kaneyasu, 2025; Kodate, 2018; Tanaka, 2025).

Very recently, however, an instance emerged in which patient voice dramatically influenced a policy decision. In 2025, the government proposed increasing user cost-sharing under the High-Cost Medical Care Benefit System, which mitigates catastrophic financial burdens; this proposal met with fierce resistance from cancer patients receiving continuous high-cost drug therapy, and the government—in a relatively unusual move—withdrawed the proposal it had already put forward (Nishimura, 2026). This kind of politically prominent development is new, and its future trajectory warrants close attention.

Challenges and Future Directions

This paper has outlined the actors and institutional arrangements that structure Japanese healthcare politics, and has shown that distinct policy arenas form around different policy issues, each characterized by its own policy process. Under a statutory health insurance system composed of multiple insurers and a mixed public–private healthcare delivery system, strategic direction has been set through consensus-building centered on advisory councils; revisions to medical fees and drug prices have proceeded through periodically recurring price negotiations; reorganization of the insurance system has proceeded through the legislative processes involving both the Cabinet and the Diet; and reform of the healthcare delivery system has proceeded through complex central–local coordination centered on the prefectures. At the same time, over the past three decades of political reform, the shift from a bureaucracy-led coordination model to a political leadership model driven by the ruling party has progressed, and, against a backdrop of party-political fluidity and mediation, new dynamics that do not fit within the traditional framework of healthcare politics have begun to emerge—including the spillover of redistributive politics concerning social insurance contributions into healthcare policy, and the influence of patient voice on policy decisions.

Regarding this overall picture of Japanese healthcare politics, one issue that should first be noted as a task for future research is the scarcity of individual empirical studies. This paper has offered a bird’s-eye view of the institutional arrangements and policy processes within each arena, but research probing the power relations and actor behavior within each arena remains limited. In particular, analyses of local political actors—such as governors, local assembly members, local medical associations, and hospital managers—involved in the formation of reorganization consensus at the regional level; diachronic analyses of the recurring political process of medical fee revision; and studies tracing the process through which patient voice brought about the withdrawal of a policy—remain largely unexplored territory.

The inaugural article of this journal identifies, as challenges for health politics as a field, insufficient theorization of power relations and a weak methodological foundation centered on causal inference (Chung & Muntaner, 2026). This diagnosis applies directly to research on Japanese healthcare politics. At the same time, the Japanese case—situated within an institutional transition from consensus-oriented, bureaucracy-led coordination toward political leadership, and rich in variation suited to causal analysis, such as regional disparities in the progress of insurer reorganization and Regional Healthcare Visions—offers fertile material for testing and advancing the theory and methods of health politics. It is hoped that this paper may serve as a starting point for elucidating the specific processes of Japanese healthcare politics, drawing on theoretical frameworks such as historical institutionalism and veto-player theory—as well as ideational approaches that treat institutional structures not merely as constraints but as opportunity structures shaping the realization of policy ideas (Ryu, 2019)—in combination with pluralistic methods.

Author Contributions (CRediT)

Ryozo Matsuda: conceptualization, data curation, formal analysis, funding acquisition, investigation, methodology, project administration, resources, validation, preparation of the original draft, and review and editing. The author read and approved the final manuscript.

Funding

This research was partially funded by JSPS KAKENHI Grant Number JP25K24683.

Ethical Statement

This study is an institutional and policy analysis based on publicly available statistics, policy documents, and prior literature. It does not involve human participants, animal subjects, or personal/identifiable data, and therefore ethical approval was not required.

Conflict of Interest

The author declares no conflict of interest.

Data Availability Statement

This study did not generate new datasets. The data supporting the findings are publicly available statistics, policy documents, and previously published literature, cited within the article.

References

- Cabinet Office, Government of Japan. (2021). *Basic Policy on Economic and Fiscal Management and Reform 2021*. https://www5.cao.go.jp/keizai-shimon/kaigi/cabinet/honebuto/2021/2021_basicpolicies_en.pdf
- Cabinet Secretariat, Government of Japan. (2023, June 13). *Kodomo mirai senryaku hōshin [Basic Policy for the Future of Children] [Cabinet decision] [in Japanese]*. https://www.cas.go.jp/jp/seisaku/kodomo_mirai/pdf/kakugikettei_20230613.pdf
- Campbell, J. C. (1992). *How Policies Change: The Japanese Government and the Aging Society*. Princeton University Press.
- Campbell, J. C., & Ikegami, N. (1998). *The Art of Balance in Health Policy: Maintaining Japan's Low-cost, Egalitarian System*. Cambridge University Press.
- Campbell, J. C., Ikegami, N., & Tsugawa, Y. (2014). The political-historical context of Japanese health care. In N. Ikegami (Ed.), *Universal Health Coverage for Inclusive and Sustainable Development: Lessons from Japan* (pp. 15–26). World Bank Publications.
- Chung, H., & Muntaner, C. (2026). Why Health Politics? Power, Institutions, and the Political Determinants of Health in an Age of Converging Crises. *Health Politics*, 1(1). <https://doi.org/10.66534/hp.2026.0002>
- Director of the Regional Healthcare Planning Division, Health Policy Bureau, Ministry of Health, Labour and Welfare. (2018). *Chiiki iryō kōsō no susumekata ni tsuite [On the process for advancing the Regional Healthcare Vision] [in Japanese]*.
- Estévez-Abe, M. (2008). *Welfare and Capitalism in Postwar Japan*. Cambridge University Press.
- Fahey, R. A., Hino, A., & Pekkanen, R. J. (2021). Populism in Japan. In R. J. Pekkanen & S. M. Pekkanen (Eds.), *Oxford Handbook of Japanese Politics*. Oxford University Press.
- Fiscal System Council. (2021, May 21). *Zaisei kenzenka ni muketa kengi [Recommendations toward fiscal consolidation] [in Japanese]*. https://www.mof.go.jp/about_mof/councils/fiscal_system_council/sub-of_fiscal_system/report/zaiseia20210521/01.pdf
- Health and Global Policy Institute. (2019). *Japanese Health Policy* (2nd ed.). <http://japanhpn.org/en/jhpn/>
- Health, Labour and Welfare Statistics Association. (2025). Kokumin eisei no dōkō 2025/2026 [Trends in national health 2025/2026] [in Japanese]. *Journal of Health and Welfare Statistics*, 72(Suppl. 9).

- Ikedo, S. (2020). Shingikai (advisory councils in Japan) as instruments of political control [in Japanese]. *The Annals of the Japanese Political Science Association*, 71(1), 316–340. https://doi.org/10.7218/nenpousei.jigaku.71.1_316
- Ikegami, N. (2019). Case study: Japan. In S. L. Barber, L. Lorenzoni, & P. Ong (Eds.), *Price Setting and Price Regulation in Health Care: Lessons for Advancing Universal Health Coverage* (pp. 133–164). World Health Organization and Organisation for Economic Co-operation and Development.
- Ikegami, N., & Anderson, G. F. (2012). In Japan, all-payer rate setting under tight government control has proved to be an effective approach to containing costs. *Health Affairs*, 31(5), 1049–1056.
- Ikegami, N., & Campbell, J. C. (2004). Japan's health care system: Containing costs and attempting reform. *Health Affairs*, 23(3), 26–36.
- Ikegami, N., Yoo, B.-K., Hashimoto, H., Matsumoto, M., Ogata, H., Babazono, A., Watanabe, R., Shibuya, K., Yang, B.-M., & Reich, M. R. (2011). Japanese universal health coverage: Evolution, achievements, and challenges. *The Lancet*, 378(9796), 1106–1115.
- Innami, I. (2021). Kanja jiko futan o meguru seisaku katei: Gōi keisei no kōritsuka [The policy process surrounding patient cost-sharing: The efficiency of consensus formation] [in Japanese]. *Iryō to Shakai [Journal of Health Care and Society]*, 31(1), 71–85. <https://doi.org/10.4091/iken.31-71>
- Ito, H. (2023). Critiques and cosmopolitics on municipal hospitals reorganization: A case study of the Northwest Aomori region [in Japanese]. *Japanese Journal for Science, Technology & Society*, 32, 3–30.
- Kaneyasu, T. (2025). Value and implementation of patient and public involvement and engagement in health technology assessment for Japan: Implications from systematic searches. *International Journal of Technology Assessment in Health Care*, 41(1), e14. <https://doi.org/10.1017/s026646232500008x>
- Kato, H., Goto, R., Tsuji, T., & Kondo, K. (2022). The effects of patient cost-sharing on health expenditure and health among older people: Heterogeneity across income groups. *European Journal of Health Economics*, 23(5), 847–861. <https://doi.org/10.1007/s10198-021-01399-6>
- Kitayama, T. (2011). *Fukushi kokka no seido hatten to chihō seifu: Kokumin kenkō hoken no seijigaku [Institutional development of the welfare state and local government: The politics of National Health Insurance]* [in Japanese]. Yuhikaku.
- Kitayama, T. (2024). The welfare state in Japan. In K. Agata, H. Inatsugu, & H. Shiroyama (Eds.), *Public Administration in Japan* (pp. 133–148). Palgrave Macmillan. https://doi.org/10.1007/978-3-031-58610-1_8
- Kodate, N. (2018). Regulating risks in healthcare in Japan: Between new politics and the tradition of liberal practice in medicine. *Contemporary Japan*, 30(2), 204–226. <https://doi.org/10.1080/18692729.2018.1501794>
- Löer, G. (2026, March 6). *Challenges facing Japan's Social Security system: Lessons for Germany / Europe*. <https://www.kas.de/documents/287213/43287287/Challenges+Facing+Japan%E2%80%99s+Social+Security+System.pdf/56384176-e715-9a41-3a23-05c96fabe068>
- Lowi, T. J. (1964). American business, public policy, case-studies, and political theory. *World Politics*, 16(4), 677–715. <https://doi.org/10.2307/2009452>
- Machidori, S. (2023). *Political Reform Reconsidered: The Trajectory of a Transformed Japanese State* (T. S. Harris, Trans.). Springer.
- Matsuda, R. (2010). Changes in responsibilities for health care and funding mechanisms by the 2006 health care reform [in Japanese]. *The Japanese Journal of Health and Medical Sociology*, 21(1), 1–8. https://doi.org/10.18918/jshms.21.1_1
- Matsuda, R. (2016). Public/private health care delivery in Japan: And some gaps in “universal” coverage. *Global Social Welfare*, 3(3), 201–212. <https://doi.org/10.1007/s40609-016-0073-1>
- Matsuda, R. (2019). Health system in Japan. In A. Levy, S. Goring, C. Gatsonis, B. Sobolev, E. van Ginneken, & R. Busse (Eds.), *Health Services Evaluation* (pp. 837–847). Springer US. https://doi.org/10.1007/978-1-4939-8715-3_45
- Matsuda, S. (2019). Health policy in Japan – Current situation and future challenges. *JMA Journal*, 2(1), 1–10. <https://doi.org/10.31662/jmaj.2018-0016>
- Mishima, K. (2022). Politicization of civil service Japanese-style: politico bureaucratic relations under Prime Minister Shinzo Abe (2012–2020). *Asian Journal of Political Science*, 30(2), 182–202. <https://doi.org/10.1080/02185377.2022.2117714>
- Miyawaki, A., Mafi, J. N., Fukui, T., Kimura, Y., Kobayashi, D., Odawara, S., Abe, K., Goto, R., & Tsugawa, Y. (2025). Low-cost, high-volume health-care services contribute the most to low-value care spending in Japan. *Health Affairs Scholar*, 3(12). <https://doi.org/10.1093/haschl/qxaf225>
- Morita, A. (2016). *Chūikyō no jitsuzō [The Reality of the Central Social Insurance Medical Council]* [in Japanese]. Jigakusha Shuppan (distributed by Daigaku Toshō).
- National Council on Social Security System Reform. (2013, August 6). *Shakai hoshō seido kaikaku kokumin kaigi hōkokusho: Tashikana shakai hoshō o shōrai sedai ni tsutaeru tame no michisuji [Report of the National Council on Social Security System Reform: A path to passing on reliable social security to future generations]* [in Japanese]. https://www.mhlw.go.jp/file/05-Shingikai-12601000-Seisakutokatsukan-Sanjikanshitsu_Shakaihoshoutantou/0000014937.pdf
- Nippon Ishin no Kai. (2025). *Seiken kōyaku 2025: Kikan seisaku (koa porishī) [Core policy platform 2025 (core policies)]* [in Japanese].
- Nishimura, A. (2026). *Kōgaku ryōyōhi seido: Hirogaru Nihon no “kenkō kakusa” [The High-Cost Medical Care Benefit System: Japan's Widening Health Disparities]* [in Japanese]. Shueisha.
- OECD. (2015). *OECD Reviews of Health Care Quality: Japan 2015: Raising Standards*. OECD Publishing. <https://doi.org/10.1787/9789264225817-en>
- OECD. (2025). *Health at a Glance 2025: OECD Indicators*. OECD Publishing. <https://doi.org/10.1787/8f9e3f98-en>
- Ryu, M. (2019). Consistency in change in system reform of medical service [in Japanese]. *Journal of Public Policy Studies*, 19, 90–102. https://doi.org/10.32202/publicpolicystudies.19.0_90
- Sakamoto, H., Rahman, M., Nomura, S., Okamoto, E., Koike, S., Yasunaga, H., Kawakami, N., Hashimoto, H., Kondo, N., & Abe Krull, S. (2018). *Japan Health System Review* (Vol. 8). World Health Organization, Regional Office for South-East Asia.
- Schwartz, F. J. (1998). *Advice and Consent: The Politics of Consultation in Japan*. Cambridge University Press.
- Shinoda, T. (2023). The Japanese prime minister and the executive institutional setting. *Asian Journal of Comparative Politics*, 8(1), 68–82. <https://doi.org/10.1177/20578911221107189>
- Shizume, M., Kato, M., & Matsuda, R. (2021). A corporate-centered conservative welfare regime: Three-layered protection in Japan. *Journal of Asian Public Policy*, 14(1), 110–133. <https://doi.org/10.1080/17516234.2020.1829834>
- Steslicke, W. E. (1973). *Doctors in Politics: The Political Life of the Japan Medical Association*. Praeger Publishers.
- Sugahara, T. (2017). Analysis of regional variation in the scope of eligibility defined by ages in children's medical expense subsidy program in Japan. *Frontiers in Pharmacology*, 8, 525. <https://doi.org/10.3389/fphar.2017.00525>
- Sullivan, A. A., Yeo, J., & Kim, S. (2024). Am I my brothers' keeper? A critical review of mandated collaboration research. *The American Review of Public Administration*, 54(4), 323–336. <https://doi.org/10.1177/02750740241229989>
- Takao, Y. (2026). Constraint and uncertainty ahead for Japanese politics. *East Asia Forum Quarterly*, 18(1). <https://doi.org/10.59425/eabc.1774648800>

- Takenaka, H. (2019). Expansion of the Prime Minister's Power in the Japanese Parliamentary System: Transformation of Japanese Politics and Institutional Reforms. *Asian Survey*, 59(5), 844–869.
- Talcott, P. D. (2001). Atsuryoku gurūpu to Nihon no iryō seisaku (1995–2000-nen) [Pressure groups and Japanese healthcare policy, 1995–2000] [in Japanese]. *Kikan Shakai Hoshō Kenkyū* [Quarterly of Social Security Research], 37(1), 29–43.
- Tanaka, M. (2024). Seifu shingikai no yakuwari wa ikani henka shita ka: Seifu zeisei chōsakai sōkai gijiroku no bunseki 1959-nen–2023-nen [How has the role of government advisory councils changed? An analysis of the minutes of the Government Tax Commission plenary sessions, 1959–2023] [in Japanese]. *Nenpō Seijigaku* [Annals of the Japanese Political Science Association], 2024(1), 88–113.
- Tanaka, M. (2025). Hikōsoku meiboshiki hirei daihyōsei to dantai daihyō: Iryō kankei shokushu o chūshin ni [The non-binding proportional representation system and organizational representation: Focusing on healthcare-related professions] [in Japanese]. *Ryūkei Hōgaku* [Ryutsu Keizai Law Review], 24, 1–43.
- Taneda, K., Kakinuma, T., Nakanishi, Y., Kobayashi, K., & Akahane, M. (2023). Community Health Care Vision: Toward realizing the desired medical service system. *Journal of the National Institute of Public Health*, 72(1), 43–51.
- Yakuji Nippō. (2025, June 30). OTC-ruiji-yaku to wa: 2027-nen 3-gatsu jisshi mezasu seido minaoshi to 'sentei ryōyō' [What are OTC-equivalent drugs? The system revision aiming for March 2027 implementation and "selective medical care"] [in Japanese]. <https://www.yakuji.co.jp/entry/119841.html>
- Yamagishi, T. (2022). *Health Insurance Politics in Japan: Policy Development, Government, and the Japan Medical Association*. Cornell University Press (ILR Press).
- Yamaguchi, J. (2016). Nihon Ishikai ni okeru seiji senryaku no henka [Changes in the political strategy of the Japan Medical Association] [in Japanese]. In F. Miyamoto & J. Yamaguchi (Eds.), *Riaru dēmokurashī: Posuto "Nihongata rieki seiji" no kōsō* [Real Democracy: Toward a Vision Beyond "Japanese-Style Interest-Group Politics"] (pp. 39–62). Iwanami Shoten.
- Yomiuri Shimbun. (2025, December 25). Shinryō hōshū: Hontai 3.09% ōhaba age, shushō saitei, byōin keiei akka uke [Medical fee schedule: Core component raised sharply by 3.09%, prime ministerial decision, amid worsening hospital finances] [in Japanese] [Morning edition, national edition] (p. 2).
- Zhang, X., & Oyama, T. (2016). Investigating the health care delivery system in Japan and reviewing the local public hospital reform. *Risk Management and Healthcare Policy*, 9, 21–32. <https://doi.org/10.2147/rmhp.S93285>

日本の医療政治：複数アリーナにおける差異化された政策動態

松田亮三 ^{1*}

¹ 立命館大学（京都、日本）

* 責任著者：松田亮三（r.matsuda7425@chpjp.org）

背景: 戦後日本の福祉国家は、多様な保険者・提供者・政府主体が関与する複雑な官民混合の仕組みである、皆保険を実現した法定医療保険制度（SHIS）を中心に発展してきた。多くの医療提供者が政府の直接的な統制の外で活動しているため、医療機関の規制と SHIS の支払い水準の設定は、日本の医療政治における中心的な関心事であり続けてきた。しかし、医療政策の異なるアリーナにわたる制度的配置と政策形成過程の多様性については、体系的な検討がこれまで限られてきた。

方法: 本稿は、政策文書、報道資料、学術文献の制度分析を通じて、過去 30 年間の日本の医療政治を検討する。

結果: 本稿はまず、SHIS の制度構造と主要なアクターを概観する。次に、医療政策形成における 4 つの主要なアリーナ——審議会を中心とするコンセンサス形成、診療報酬・薬価の隔年改定、保険制度全体の再編、そして中央—地方の複雑な関係を伴う医療供給体制改革——を検討する。さらに、これらのアリーナが近年の政治的変容からどのような影響を受けているかを考察する。この変容には、政治主導の強まり、政党間競争の変化、費用抑制と患者負担をめぐる対立の先鋭化が含まれる。分析はまた、患者の声と世論の、新たに現れつつあるが、ばらつきのある影響力にも注目する。これらの力は全体として構造的には限定的であるものの、時として決定的な役割を果たすことがある。

結論: 現代日本の医療政治は、単一の統一的な過程というよりも、複数の政策アリーナにわたって複数の政策過程が並存する、差異化されたシステムとして理解するのが最も適切である。同時に、変化する政治構造は、伝統的に皆保険を掲げてきた医療制度のなかで、とりわけ患者負担に集約する形で、分配をめぐる対立のあり方を再編しつつある。

キーワード: 日本; 医療政治; 医療政策; 法定医療保険; 医療制度改革; 患者負担