Exclusive Interview

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The Future of Healthcare Reform in Japan

By Kazumasa Oguro

Japan's medical care has been the subject of much admiration in the international community, thanks to its universal health insurance system, which provides all citizens with equal access to a high standard of medical care. However, despite the explosive increase in inbound tourism, especially since the end of the pandemic, and the fact that Japan has become one of the most popular countries for foreign tourists, very few foreign patients stay in Japan for extended periods of time to receive treatment and recuperation for their illnesses through medical tourism. While other Asian countries receive between 500,000 and 1 million medical tourists annually, Japan receives only 20,000 to 30,000.

Why is this? What reforms are needed to make Japanese medical care more useful for people around the world, and could they lead to the enhancement and development of Japanese healthcare?

Our *Japan SPOTLIGHT* editorial board member Kazumasa Oguro, a professor at Hosei University and an economist who has specialized in healthcare issues, spoke with Prof. Keizo Takemi, a Japanese opinion leader in healthcare reform who also served as minister of Health, Labour and Welfare (MHLW) and is currently chairperson of the LDP Members' General Assembly in the House of Councilors.

(Interviewed on March 18, 2025)

Overview of Japanese Healthcare Issues

Oguro: As you are well aware, Japan's medical services are based on Universal Health Coverage, which means that everyone can enjoy its benefits equally. Until recently, the sustainability of healthcare finances had been a major concern as healthcare costs were rising faster than the nominal GDP growth rate due to the aging of the population. However, as Japan has turned into an inflationary economy, with the consumer price inflation rate exceeding 2% and a significant labor shortage, conventional "common sense" seems to have changed.

In fact, while the initial budgets for FY 2024 and FY 2025 show growth in healthcare costs of around 1%, the projected and actual nominal GDP growth rate has shifted upward to just under 3%, partly due to inflation, making it increasingly likely that healthcare costs, as a percentage of GDP, will decline. Rather, the most recent problem is that although costs for medical institutions are under increasing pressure from inflation and rising wages, reimbursements are not keeping pace with prices, leading medical institutions into a critical situation and even talented young doctors are leaving the profession due to low salaries. What are your thoughts on this situation of medical care in Japan?

Takemi: The basic concept of Universal Health Coverage is defined by the World Health Organization as leaving no one behind and ensuring that all people have access to appropriate health care, including prevention, at a cost they can bear. In Japan's case, according to this definition, Japan has achieved a universal health insurance system.

In this context, there are always issues such as new demographic changes, advances in medicine and medical care, and how these

advances will lead to higher costs in medical care. Our universal health insurance system, as far as the postwar period is concerned, has always worked effectively, in that it has been able to continue to provide a clinical level of service as a developed country. In the big picture, I see it as having done well in that it has sustainably managed the healthcare system, adapting to demographic changes and advances in medicine and medical care from era to era.

However, what has become very difficult is that, in terms of demographics, as far as the working population is defined as those between the ages of 15 and 64, the country as a whole is expected to lose 4.33 million people in the decade of the 2020s. The aging of the population will accelerate in the so-called metropolitan areas centering on Tokyo, with the loss of over 8.6 million people in the decade of the 2030s. Moreover, there is a dynamic analysis that shows that the increase of the percentage of the very elderly population over 80 years old is notable and that we are moving into a "super-aging" society.

In addition, looking at the analysis from the perspective of social characteristics, the core of the problem of the elderly in the past was in the rural areas. Nowadays, even the elderly population is decreasing in rural areas, and the overall population itself is declining. However, whereas the problems of the elderly in rural areas were problems in an era when family members and local communities still had the ability to support each other, the problems of the elderly in metropolitan areas in the near future will involve the nuclear family, which is much more advanced than in the past, and family support functions for the very elderly will be significantly reduced. The super-aging problem is occurring in the context of an even more diluted local community support system.

The problems of the elderly in the near future that will occur under such circumstances, especially in large urban areas, will create more serious problems for the elderly that are completely different in dimension from those in the past. At the same time, the elderly population will continue to decline in rural areas, so the demand for medical care in those areas will decline, while the demand for medical care in urban areas will continue to increase, as well as the demand for long-term care. However, in both cases, there will be fewer workers to support them, and fewer people to earn money. Over the 20-year period from 2020 to 2040, Japan will lose a working population equivalent to the current population of Tokyo (approximately 14.18 million people as of 2025), or approximately 12.95 million people, and not only will the number of people who consume be reduced, but the number of people who pay medical insurance premiums and pension contributions will also decline sharply.

As such, our country's health insurance system and levy-based pension system will be in an extremely difficult phase in 10 years, especially in large urban areas. This is precisely the challenge of health, medical care, and long-term care that we must seize today. Currently, for example, there is a shortage of medical doctors in rural areas due to the aging of medical staff, and in Tokyo there is a situation where medical malls are proliferating, and the number of doctors is rapidly increasing without sufficient regulation.

In addition, a significant number of the growing super-aged population will actually be elderly people living alone. At the same time, 80% of them will be women. Even if we design a system in urban areas that does not isolate these people socially and provides them with home medical care and home nursing care until the end of their lives through comprehensive community-based care, we have to wonder whether we will be able to secure the human resources to actually carry out this system. We need to think more seriously about these issues.

At the same time, as symbolized by the shortage of medicines, this can only be addressed in a temporary sporadic policy by simply increasing stockpiles with government money. When I was minister of Health, Labour and Welfare, I proposed that the hundreds of pharmaceutical companies be reorganized into five companies in order to create an industry that can produce medicines more efficiently and stably. In fact, under current circumstances, short-term and mid- to long-term reforms have effectively become indistinguishable, and we are entering an era of seriousness in which immediate problems cannot be solved simply by implementing immediate reforms.

Therefore, if we do not make constant efforts to resolve all immediate issues in combination with medium- and long-term issues, when we discuss them we will not only be unable to resolve the country's immediate problems, but we will also be unable to create a foundation for properly resolving the serious issues that will arise in our healthcare system in the near future, as well as 10 years from now. We are now in such a very difficult situation.

Oguro: You mentioned the decline in the working-age population, and the Ministry of Economy, Trade and Industry (METI) has reported that the working-age

population will decline by more than 20 million people by 2050. I think you are right that the situation is very severe, not only in terms of healthcare finances, but also in urban and rural areas, as well as in terms of the people who are responsible for the healthcare system. Do you think that conventional ideas and policies will be sufficient to cope with the situation?

Takemi: What I am trying to say is that we are entering an era in which the way regional medical care is designed in urban areas and the way it is designed in rural areas, where the population is shrinking, are significantly different. The question is whether or not it is really acceptable to formulate prefecture-by-prefecture policies on a simple-minded uniform thought based on a regional medical care concept centered on regional comprehensive care.

Impact of the Transition from Deflation to Inflation

Oguro: I agree with you. As I mentioned at the beginning, under such circumstances the economy has changed from a deflationary economy to an inflationary economy, and the nominal GDP growth rate is now hovering around a high rate of just under 3%, partly due to the inflation rate of over 2%. Nevertheless, according to the "Basic Policies for Economic and Fiscal Management and Reform", the Cabinet has decided to limit the real increase in social security-related expenses to the equivalent of the increase due to the aging of the population during the period of fiscal base consolidation, and the growth of medical expenses has been suppressed to around 1%.

As a result, medical expenses are being reduced in relation to GDP and prices, and this is beginning to have a certain impact on the income and expenditures of medical institutions.

The revision of medical fees (in FY 2024) was 0.88%, but the revision is made every other year, and in effect it is negative. Under such circumstances, it is becoming difficult to develop new technologies such as expensive medical technology, pharmaceuticals, and nursing care robots in Japan. I do not want to see medical expenses (as a percentage of GDP) expand as they have in the past, but they are currently decreasing, and it would be fine with increasing medical expenses if they were to grow in line with the medium- to long-term GDP growth rate. Do you have any concerns about this situation?

Takemi: I am extremely concerned. First of all, the increase in medical expenses due to the aging of the population has been taken into consideration to some extent and reflected in reimbursements, but there has been no mention of advancements in medicine and medical treatment or the soaring cost of living.

In fact, the Ministry of Finance and others have been very cautious about the ever-increasing medical costs, and medical costs have always been suppressed even during deflationary periods. On the other hand, in the current situation where we are finally trying to get out of deflation, the same approach has been used to keep medical costs down even as prices rise, and this has made hospital management more serious.

Until now, psychiatry has been relatively profitable. However, even hospitals with general beds now have a deficit of about -1%, and psychiatry is also falling into the red. In particular, children's hospitals, which are not profitable to begin with, and major children's hospitals in each prefecture, are running deficits of about 30%, and the situation has worsened to the point where sustainability has completely disappeared.

When I was health minister, the key issue was how to raise the wages of medical care workers so that they would be comparable to those in other industries, and how to raise them in a focused manner so that financial resources could be secured for this purpose.

Oguro: I think there is a hint for securing financial resources. In footnote 27 of the "Strategy for the Future of Children" approved by the Cabinet, which is related to measures to deal with the declining birthrate in another dimension, there is a statement that "the increase in insurance premium rates will be controlled to the maximum extent possible." Although this Cabinet decision may seem harsh, the

denominator of the macro insurance premium rate for medical care and long-term care is employer compensation, and the numerator is the social insurance burden for medical care and long-term care. Of these, the denominator, employer compensation, is almost half of GDP, and of the social insurance contributions for medical care and long-term care, the social insurance contributions for medical care cover about 56% or 57% of benefit costs, which are very stabilized.

In a sense, not increasing the insurance premium rate is equivalent to keeping the social insurance burden of medical care within the GDP range, but this also leads to the argument that medical benefit costs can grow at the same rate as the nominal GDP growth rate. Despite this, healthcare spending (as a percentage of GDP) is currently contracting, and the growth of healthcare spending is not keeping pace with the nominal GDP growth rate. What do you think about this?

Takemi: Although you have established guidelines for a certain level of medical expenditure linked to the basic macroeconomic situation, it is becoming increasingly clear that this is no longer sufficient to sustain operations, and that the pressure of high prices will only exacerbate the deficit structure, which is becoming more serious.

When considering what to do in the future, I believe that one of the first major guidelines is the rise in prices, and since tax revenues will surely increase as prices rise, we need to reestablish a mechanism to utilize this as a source of social security funds. I believe the current situation calls for the re-creation of a mechanism to utilize tax revenues as a source of funding for social security.

Oguro: If nominal GDP grows by 3% or 4% in the medium to long term, then naturally tax revenues and insurance premium revenues will also grow by 3% or 4%. Ultimately, this is a political decision, but I think it would be fiscally neutral to allocate that amount toward medical expenses.

Takemi: The consumption tax and other taxes have been discussed from the viewpoint of using them for social security, and the allocation of the increase in the consumption tax was actually decided upon. The easiest way to do this would be to use the increase in consumption tax revenues to finance social security.

The easiest thing to do is to allow the growth of medical expenses to match the rise in prices. I believe that both NHI drug prices and medical fee revisions can be tolerated in such a way. I think it is negligence on the part of the fiscal authorities that the tax revenues have not been connected at all to the discussion of what services need to be provided to the taxpaying public in the current climate.

How to Increase Medical Tourism?

Oguro: When considering Japan's future growth strategy, I think the tourism industry is still one of the most important sectors, as the number of foreign tourists is expected to reach a record high of 34 million in 2024. I think it is important to expand medical inbound a little more to wealthy people overseas. For example, Malaysia has 1.2 million and Japan has 20,000 to 30,000, so I think there is room to expand by a factor of 10 or 20.

Takemi: In terms of Japan's clinical level, not only is it comparable to these countries, but it stands out in particular for its high clinical level in oncology. Such comparative advantage can be said for a considerable number of medical departments. However, one limitation is that until now all medical care in Japan has been considered with a very domestic orientation, with medical schools and the medical community primarily focused on domestic demand.

In order to create new dynamism in our country's economy, we should consider how we can use this comparative advantage not only for domestic demand, but also for overseas demand, targeting inbound, outbound, and wealthy people in the private sector, and how we can create a new system for the private sector to provide medical care. In the case of the private sector, it is necessary to further enhance private medical insurance while, for example, considering how private medical services should be provided to supplement the universal health insurance system for inbound medical care, and to establish a more proactive framework for accepting inbound medical patients.

In particular, looking at the regulation of hospital beds, in the regional medical care concept, hospital beds have been regulated

and managed based on the supply and demand of medical care in each secondary medical care area, and this was actually also a tool to manage medical care costs. However, the number of inbound patients from abroad, as you mentioned, is small now, but it began to increase in about 2023, and the number of visas issued for medical stays is increasing rapidly, from about 1,900 to 2,500 in 2024.

So what happens is that we have a situation where beds are used to meet domestic demand, and we are increasingly admitting overseas patients who can afford high-cost treatments. The Cancer Institute Ariake Hospital, for example, has a reputation as a very high clinical level hospital in Asia, and many famous doctors are there, thus attracting a significant number of international patients. But I heard that the Cancer Institute has stopped accepting foreign patients temporarily. This is because it was no longer seeing domestic patients.

There are also a number of other places that accept visitors, and the number of people who come to Japan on a tourist visa to receive medical examinations or short-term treatment in Japan ranges from 30,000 to 50,000 people.

I am now asking the MHLW to find how many patients come from overseas for inpatient care, how many come for medical checkups, and how many people who come to Japan for tourism actually receive medical care for injuries and the like. I would also like them to let me know what is the amount of medical care provided to foreign workers who have been in Japan for a longer period of time, and for what types of illnesses. So we have asked them to conduct a survey to ascertain the actual status of medical care for foreign nationals.

Looking at these realities, clearly the number of foreign patients is beginning to increase. They are gradually getting used to the atmosphere of Japanese hospitals, and acceptance of foreign patients is becoming easier. Also, when you raise the price of medical care, the very wealthy people come and the behavior of the patients gets better.

In reality, some large local hospitals that used to accept foreign patients are now saying that they have stopped accepting them because they will not be able to provide adequate treatment for Japanese patients. In this situation, the National Center for Global Medical Research (NCGM) is trying to accept inbound patients. This is the only place where international interpreters in about five languages are actually available, and if you make an inquiry, we have a system in place to tie up with translators in 13 countries to respond to your needs.

Oguro: If medical inbound expands, the medical industry will naturally see a slight increase in revenue due in the context of private medical services.

Takemi: Nowadays, even if a hospital wants to establish beds for unrestricted treatment, it cannot do so on its own. In Tokyo, permission from the governor of the Tokyo Metropolitan Government is required in order to open a bed for unrestricted treatment. The governor of Tokyo then consults with the chairman of the Tokyo Metropolitan Medical Association and decides whether or not to grant permission.

If we are going to provide private medical services, we should be able to secure the number of beds a little more freely on our own initiative, separate from the current regulations on hospital beds. The price is currently about three times the official price, but considering the high level of clinical care in Japan, including proton beam therapy, heavy particle therapy, and anticancer drugs, there are enough patients coming from overseas even if the price is set higher. Therefore, we should increase the number of staff to a certain extent and ensure that about 20% of the total staffing can be allocated to private medical services, while providing a completely separate number of beds so that overseas patients can receive advanced medical care that is approved by the pharmaceutical affairs bodies but not covered by insurance at their own expense. If this is repeated, prices will steadily decline from a relatively high level. If a two-step approach is adopted, whereby drugs are covered by insurance when prices decline, problems such as the current drug loss will be solved in stages.

It is basically impossible for the current insurance system to cope with the progress and high cost of medical treatment. Therefore, I believe we must design a system in which each citizen can have access to all advanced medical care by combining it with a new system of private medical services in stages, first underwriting the private medical services portion of highly advanced medical care and then absorbing it into the universal health insurance system by controlling prices. I have come to believe that we need to design a system in which every citizen has access to advanced medical care.

On the other hand, we do not want to see doctors who are primarily motivated by profit through offering private medical

services. Therefore, I think it would be a good idea to apply certain restrictions, such as allowing hospitals with a high clinical level, including a certain number of staff, to provide private medical services.

Oguro: One more thing. In order to increase medical inbound, I think it is important to issue visas and to have doctors, nurses and staff who speak English and other foreign languages.

Takemi: It is absolutely necessary. When I was minister of Health, Labour and Welfare, I established a scholarship program for foreign students coming from abroad to study at medical schools. METI and the MHLW worked together to establish this program, and an ASEAN think tank called ERIA established a fund for this purpose. We have established a full scholarship program for outstanding students who wish to study medicine in Japan, mainly in the ASEAN region. The pilot program will start next year. It has already started at the International University of Health and Welfare. They have established a really good system for accepting students from abroad and have concluded MOUs with each sending country, so that if a student qualifies as a doctor in Japan, he or she will be recognized as a doctor in his or her home country, so that high-quality foreign students can be attracted. Last year, the first batch of students took the national examination, and all 15 of them passed.

Oguro: Is the national medical examination taken in English?

Takemi: Japanese. One of them, a Vietnamese boy, was a really good student. This boy also passed the US national certification. He passed in English in the US and in Japanese in Japan, and he took both at the same time last year and passed.

We should definitely have such excellent people work in Japan, whether as clinicians or researchers. We should encourage talented people from overseas to work in Japan. Furthermore, I believe that inbound hospitals will be established in the future, and if they are able to work in such inbound hospitals, foreign patients will be able to receive diagnosis and treatment in Japan from doctors with qualifications for medical treatment in Japan who speak the patients' native language.

After all, the same thing is done in Bangkok hospitals. There is one female doctor who is qualified as a doctor in Bangkok, and about five more are qualified as Japanese doctors, and they are working in outpatient clinics under the guidance of the Bangkok doctors. There are also 14 to 15 Japanese nurses and staff. This makes it easier for the Japanese patients in Bangkok to express their symptoms and other sensitive feelings in Japanese, which in turn makes it easier for the doctors and patients to build a relationship of trust.

Prof. Oguro (left) & Prof. Takemi (right)

Similarly in Japan, when trying to welcome inbound patients from overseas, it is necessary to train medical staff who can speak the language of the country as much as possible. And to be able to handle inbound patients more meticulously, it would be necessary to make it easy for doctors and patients to form trusting relationships. I think this is an important element when inviting patients from overseas.

In view of these ideas, we should no longer discuss the field of health, medical care, and long-term care in particular from the narrow perspective of domestic medical business, but rather reposition this field as an industrial policy, even as an economic measure for our country in the future. In particular, the demographic structure of Asia is now aging more rapidly than in other regions of the world. As societies age, disease structures naturally change dramatically, with cancer, ischemic heart disease, and stroke becoming the leading causes of death among chronic diseases. Cancer is also becoming more and more complicated.

At such times, Japan has been quick to respond to such situations

by developing high clinical-level medical care and medical technologies such as proton beam therapy and heavy particle therapy. Therefore, it is important for Japan to provide medical services to wealthy people from overseas whose elderly population has increased while their own countries have not yet reached such a clinical level. We will have them come to Japan and help them. And we will fill the healthcare gap.

At the same time, we will also make it possible to develop such a group of hospitals in Japan while maintaining a structure that allows overseas medical systems and medical communities to coexist properly. The Raffles Group in Singapore, for example, is now 30% owned by Mitsui Fudosan. Tokushukai is building a hospital in Indonesia, and SECOM has succeeded in India and is planning to build a second hospital there. However, all of them said that unless they can coexist and collaborate with the local medical community, they will only incur costs and will not be able to make a profit.

Global Health Outlook

Oguro: What are your thoughts on President Donald Trump's withdrawal from the WHO with regard to the global health outlook?

Takemi: The United States has been paying 22% of its Assessed Contribution to the WHO. With the withdrawal, no funds are coming in from the US, and now Germany, France, and the United Kingdom are all reducing their foreign aid budgets. Japan, too, is now seeking to optimize its spending on health care, and foreign aid is reaching a critical juncture across the board, pressured by the weak yen. Around the world, few countries are now offering new aid in the form that they have in the past.

Oguro: As the US is turning inward and the world becomes more multipolar, not only the issue of foreign aid but also various other issues may arise in the medical field, including global health issues. I believe Japan has more to contribute to the world because of this situation in the US. What are your thoughts in this area?

Takemi: I think you are right. There are two ways of thinking about it: one is a government-centered policy area, and the other is to contribute through the market mechanism in cooperation with the private sector in the form of inbound and outbound activities, as I mentioned earlier. This is precisely the area where the WHO is concerned. The current WHO system, which is beginning to suffer a revenue shortfall of about 40% due to the withdrawal of the US, in addition to profligate spending, has become a vital issue in global health, and how to strategically downsize it so that it can remain sustainable and meaningful in the future.

France and Germany were still going strong during the first Trump administration, with Chancellor Angela Merkel teaming up with WHO Director-General Tedros to create a hub at the Robert Koch Institute in Berlin to facilitate an early monitoring network for infectious diseases. Also, French President Emmanuel Macron created the WHO Academy in Lyon, also in partnership with Tedros. While the US was out of the picture, a sort of vacuum in global health was created in these countries, so they expanded their role significantly.

When Tedros was in his first term, I said to him, "Now that you are working with Macron and Merkel to create and deploy a strategic base, the WHO should essentially have a global strategy. Therefore, we should have such a strategic base in Asia as well." Furthermore, I told him to create a hub in Japan that is different in dimension from those created in France and the UK, and that focuses on Universal Health Coverage, especially in areas related to finance, as discussed at the G7 health ministers' meeting.

I also told him, "Since the World Bank has the largest capacity in finance, World Bank President Ajay Banga and you and your team should join hands to ensure that insurance financiers from low- and middle-income countries around the world receive training in Japan, as Japan is the host country and will pay for the training. The goal is to also expand insurance financing in your own countries, so that you can establish a foundation for achieving more sustainable Universal Health Coverage." Finally, I said, "Why don't we create such a strategic center in Japan?"

Tedros replied that this is a good idea and said "Let's do it." He talked with Ajay Banga about this idea and I was just in the position of minister of Health, Labour and Welfare when Ajay Banga came to Japan in January 2024. I talked with him and we decided that the World Bank should work on this as well.

As for the World Bank, we used to have a training program called the Flagship Course, which is related to the insurance system, but all of this was actually one of the many pockets of the Japan Trust Fund, which is owned by the Japanese Ministry of Finance, so we are

going to use this fund here and make it bigger, and the MHLW will also provide financial resources to the fund. The MHLW, the Ministry of Finance, the WHO, and the World Bank have formed a preparatory committee for the program, which will start in November 2025.

I am not thinking of Trump's inward-looking policies, but as a result, as you say, the diplomatic vacuum in the politics of global health created by him can be filled by Japan this time, as it was by Germany and France the last time. Japan will play a major role in leading the world by taking the lead in the area of comparative advantage in health, medical care, and long-term care under the leadership of the Japanese government, especially in the area of human resource development in health finance.

With such a picture, for example, when providing health, medical, and long-term care services inbound and outbound as an industry, the government can contribute through market mechanisms to address health disparities among the elderly in many countries that are still unable to cope with the changing disease structures resulting from the aging of Asia. While the national government contributes through government funds and multilateral organizations, the private sector can contribute through market mechanisms by creating networks of health, medical, and long-term care services in these regions.

If we look at it merely from an industrial policy perspective, it can only be viewed negatively, as if we are conducting human experimentation in our own country, as was once seen with pharmaceutical companies in the US and Europe. However, when paired with the larger goal of Universal Health Coverage, I believe it is necessary to promote an overall strategy that shows Japan as a country that, while pursuing its own interests as an industrial policy, is also thinking carefully about the state of human health in the international community as a whole. I believe that it is necessary to promote the strategy as a whole.

Oguro: Excellent opinion. Japan is the world's top runner in aging population, so data on rare diseases can be collected and many other things can be done.

Takemi: The MHLW had the Pharmaceuticals and Medical Devices Agency (PMDA) and the National Cancer Center establish a branch office in Bangkok. We are now working on harmonization of regulatory approval and networking of clinical trials throughout Asia.

In addition, since a domestic drug production infrastructure cannot be established within a single country at this time, we are working to establish an international investor network in key hubs such as Boston, California, and London, so that Japan can become one of the leading countries that provide the infrastructure for drug production within the international drug production ecosystem. I am suggesting that Japan should consider its future as one of the leading countries that provide the foundation for drug production.

I proposed a system that would directly connect the world's key players in drug production with those who can develop seeds in Japan's R&D, fund them for at least 10 years, and if they reach a certain level, connect them to venture companies, and then build a first-in-human clinical trial facility. I proposed a system in which facilities for first-in-human clinical trials would be built, which would then bring in more major pharmaceutical companies.

Research and development of today's seeds is proceeding through an international network, leading to mass production technology, clinical trials, and then final regulatory approval, with the majors becoming the final distributors. It is not completed within a single country.

There is already a limit to the idea of growing drug production from within a single country. Unless we can create a new ecosystem that precisely links overseas needs from the start, Japan's domestic R&D capacity will not grow. With more active drug production starting from Japan when the healthcare networks initiated by the PMDA and the National Cancer Center are neatly built up, if Japan's frameworks for physician-led clinical trials and regulatory approval are firmly established in Asia, and if a new major center for drug production is established in Asia, it will be one of the new leaders of Japanese industry. I believe there is a large customer base in Asia to achieve it, because the aging of the Asian population will make the Asian population richer and richer.

By integrating healthcare with industrial policy in this way, perhaps Japan will be able to continue to maintain the level of developed countries.

Article translated from original Japanese by Naoyuki Haraoka. JS

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