

POSITION PAPER

“AI That Does Not Change Frontline Operations” Will Save Japan’s Healthcare and Long- Term Care

Recommendations for Reforming Documentation and Administrative Work
in Healthcare and Long-Term Care in the Era of a National Vertical AI
Strategy

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Kurashitech Inc.

Executive Summary

On July 10, 2026, the Japanese government's AI Strategy Headquarters, chaired by Prime Minister Sanae Takaichi, published an interim report on its strategy for developing and implementing industry-specific "vertical AI." The report designated 19 fields, including healthcare, long-term care, and drug discovery, as priority areas for support. A national strategy is now underway that combines concentrated public- and private-sector investment through 2030 with "AI transformation (AX)," a fundamental rethinking of how work itself should be organized on the assumption that AI will be used.

This paper presents the realities of frontline operations, a path to solutions through AI, and recommendations for the government from Kurashitech Inc., a company that works inside healthcare and long-term care settings every day to apply AI to documentation and administrative work. Its argument can be summarized in three points.

First, the failure of healthcare and long-term care to digitize is not the result of negligence on the front line. It stems from five structural conditions: operations that cannot stop; high levels of individual variation; ambiguous rules coupled with strongly held convictions; the externalities of coordination; and an aging workforce. Unless these structures are confronted directly, no solution will take root in the field.

Second, AI is the first genuine solution to these structural problems. Success, however, depends on several conditions: do not change existing frontline workflows; enter the field equipped with knowledge rather than asking the field to explain everything; be prepared to customize for each workplace; earn the trust and affection of the industry; and provide security worthy of handling data more sensitive than that of any other industry.

Third, we make three recommendations to the government: (1) clarify ambiguous rules governing documentation and reporting, and issue national "recommendations"; (2) review rules, epitomized by requirements for originals and postal delivery, that are no longer appropriate in the AI era; and (3) shift from the idea of "installing one enormous common platform" to "using AI to connect systems that have evolved individually." Instead of moving A and B onto a large system X, realize a vision in which AI connects A and B while progressively building toward X. This is the practical answer for regional coordination in healthcare and long-term care in Japan.

Introduction: Vertical AI as a National Strategy, and Healthcare and Long-Term Care

In December 2025, the Japanese government adopted the Basic Plan on Artificial Intelligence by Cabinet decision, with the aim of making Japan "the country in the world where AI is easiest to develop and use." On July 10, 2026, the AI Strategy Headquarters explicitly placed strategic emphasis, for the first time, on vertical AI trained deeply on the expertise and data of individual industries, and presented a framework for concentrated public- and private-sector investment in 19 priority fields. Healthcare and long-term care are positioned at the heart of this framework, with the objectives of responding to worsening labor shortages and maintaining and improving service quality.

We fully support this direction. Healthcare and long-term care are precisely the fields in which vertical AI can demonstrate its greatest value. At the same time, we feel a constructive sense of urgency. If AI adoption in these fields proceeds without an understanding of frontline structures, it will advance as slowly as previous digitization efforts. The front line has no time to tolerate the addition of yet another "unusable system" or "system that no one uses."

The purpose of this paper is to connect a high-resolution understanding of frontline realities with national strategy. We describe, as faithfully and tangibly as possible, the facts we have observed in the field.

Many of the examples in this paper come from home- and community-based settings, particularly home-visit nursing. Home-visit nursing stations operate across both medical insurance and long-term care insurance and serve as a hub for home-based care, connecting physicians through orders, care managers through service provision schedules, and providers from multiple professions. Two insurance systems, documentation spanning both healthcare and long-term care, and regional coordination all converge here. It is fair to say that these settings contain the most concentrated form of the industry's documentation and administrative complexity. They are also the area in which we ourselves have worked most deeply. However, the structures and essential solutions discussed here apply not only to home- and community-based services but also to healthcare and long-term care settings as a whole, including hospitals and long-term care facilities. To demonstrate this, Chapter 4 depicts what AI can achieve through three cases: home- and community-based services, hospitals, and long-term care facilities.

Chapter 1: From Hospitals to the Home - An Irreversible Trend and Expanding Administrative Work

1-1 Why the Home?

The direction of healthcare and long-term care in Japan is shifting from hospitals to the home. This is not simply a matter of cost. It is intended to enable each person to live with dignity in a familiar place until the end of life, while also making efficient use of limited healthcare resources. Hospitals focus on highly complex treatment, while communities provide care where people live. This division of roles is a core design principle for Japan as a super-aged society.

1-2 The Enormous Volume of Documentation and Administration Created by Public Insurance Systems and by People

Healthcare and long-term care are built on public systems, including insurance. Because public funds are involved, accurate documentation and appropriate billing are required. Recent allegations and cases of misconduct have also caused public concern. And this industry is fundamentally built on people. When people act, records are created, documents are created, and administrative work is created. The following voices can be heard from the front line.

A Nurse's Voice

"I became a nurse because I wanted to provide nursing care. In reality, however, I am overwhelmed by an enormous volume of documentation. I want to nurse people, not spend my time doing desk work."

A Medical Administrative Staff Member's Voice

"I took an administrative job, but medical administration was nothing like an ordinary office job. The level of expertise required was far beyond anything I had imagined. There is so much to learn that I have to study outside working hours just to keep up. The responsibility is also immense. A small mistake can make an insurance claim impossible and halt the provider's cash flow. That is why I am instructed to check everything carefully, again and again. Sometimes I stop and ask myself: am I really being paid enough for this?"

Because home-based care depends on coordination, it generates even more documents and administrative work: hospitals and care managers; care managers and home-visit nursing stations; home-visit nursing stations and hospitals; as well as home-help services, adult day services, nursing homes, pharmacies, home-visit dentistry, and long-term care taxis. Regional healthcare and long-term care can never be completed by a single participant. Yet much of this coordination still relies primarily on telephone calls, fax, and postal mail.

Chapter 2: Why Digitization Failed to Progress - Five Structures Eroding the Front Line

The slow digitization of home-based healthcare and long-term care is often described as a problem with the front line. That is incorrect. The delay is caused by five structures specific to this industry.

Structure 1: Operations That Cannot Stop

The front line operates every day: visits, documentation, monthly insurance claims, billing users, and communication with related organizations. There is no break for Golden Week or the New Year holidays. A workplace that cannot suspend daily care has no time to allocate to a “business improvement project” or “digital transformation project.”

Structure 2: High Individual Variation - A Long-Tail Market

There are countless providers throughout Japan, and their methods and systems vary widely. Because everyone is so busy, workflows have not been organized and depend on tacit knowledge. Any third party attempting to improve operations must engage individually with each workplace. This is a classic long-tail market in which a uniform solution does not work.

Structure 3: Ambiguous Rules and Strong Convictions

The rules governing documentation in particular are often ambiguous. For example, Home-Visit Nursing Record II uses the SOAP framework, but some providers use it while others do not. It is also common for SOAP to be used in psychiatric home-visit nursing but not in general nursing. Some providers describe only the events of the current month in monthly reports, while others accumulate the patient’s course over time. Some want a detailed, chronological narrative like a novel; others want a compact summary of the month as a whole. Because the rules are ambiguous, the desired future state varies from provider to provider. As a result, when a system produces recommended text, some providers welcome it while others condemn it as entirely unusable.

Moreover, everyone engaged in healthcare and long-term care has their own philosophy of nursing or caregiving. When people with those convictions become managers, they shape the practices of their individual organizations. The strength of these convictions is one of the industry’s virtues, but from the perspective of standardization, it further amplifies diversity.

Structure 4: Without Coordination, Digitization Has No Value - The Externalities of Digitization

Care managers exchange performance reports, or service provision schedules, with each provider, and almost all of these exchanges take place by fax. Even if one provider independently switches to system-based transmission, it will not work unless the receiving party can support it. Care managers are aging, and since the COVID-19 pandemic many have worked alone from home. Digitizing only one side does not function.

There is another illustrative situation. Suppose a care manager is looking for a home-visit nursing station that can visit a new user every Tuesday at 9:00 a.m. Ideally, available stations would be identified automatically. In reality, however, staff are overwhelmed by schedules that change every day and cannot immediately say whether even their own team has capacity.

Because home-based services involve travel, only someone who knows the field can instantly determine whether “the staff member completing a previous visit at that location can reach the next location in time.” “That railroad crossing never opens in the morning” - decisions can hinge on this degree of local knowledge. As a result, an enormous volume of analog telephone communication continues every day.

Structure 5: An Aging Workforce and IT Literacy

The people who work in healthcare and long-term care are professionals, and many active veterans have spent their careers doing frontline work. Limited IT literacy is not something for which they should be blamed; it is a condition that must be assumed. This is why UI and UX matter more in this industry than anywhere else. A tool that users must learn before they can use it has already failed.

Chapter 3: AI Is the “First Genuine Solution”

This problem has remained unresolved because no solution previously existed. Even when an excellent consultant enters the field, the specialized nature of the work means that understanding it takes time. Even after the work is understood, the available measures are usually no more than macros and formulas in office software - a drop in the ocean given the breadth of operations. Comprehensive cloud adoption is beyond the literacy available on the front line, where there is no time to learn new tools. Developing bespoke systems may seem attractive, but the degree of individual variation is so high that development costs cannot be recovered from a single implementation. Moreover, an industry already struggling to improve working conditions finds it difficult to attract highly digitally literate talent.

As a result, the industry has operated only because “well-intentioned providers wager on the dedication of well-intentioned staff.” If even one person is missing, the collapse of healthcare or long-term care becomes a real possibility. This is not an exaggeration. The more deeply one enters the field, the more clearly one sees an industry operating at its limits. What if someone’s condition suddenly deteriorates? What if something unexpected happens to a service provider? What if, at that critical moment, that person had not sacrificed their private life? Everyone is working earnestly to fulfill their role on a fragile foundation where a single loose thread can lead to failure.

Then AI arrived. For the first time, AI can directly address all five structures eroding the front line. It can accumulate specialized knowledge and retrieve it at any time. Documents and administrative tasks are among the areas in which AI excels, allowing it to demonstrate its full power. Individual variation among workplaces can be absorbed through rapid, low-cost bespoke development using AI, or vibe coding. Unlike SaaS, there is no need to learn a new interface; users can simply converse in natural language, as naturally as exchanging messages with a colleague. AI neutralizes the very structures that have prevented digitization. For this industry, AI is the first genuine solution.

Chapter 4: What AI-Enabled Frontline Operations Look Like

The following three cases - home- and community-based services, hospitals, and long-term care facilities - illustrate frontline healthcare and long-term care with AI implemented. This is not a fantasy about the distant future. It is already achievable today.

Case 1: Home- and Community-Based Services

This is how home-based healthcare and long-term care, including home-visit nursing and home-help services, will change. First, the intake of new users will change. Draft care plans and physician orders will be generated automatically from conversations with users. AI will make telephone calls to find providers that can accept a case. At the receiving provider, AI will answer the call, read calendars and shift schedules, understand even tacit local knowledge about locations, and respond immediately on whether the request can be accommodated. In home-visit nursing, AI will read the attending physician's order, understand the care to be provided, and verify the applicable insurance and eligibility for additional reimbursements. If staff become uncertain during a visit, they can simply ask AI.

Daily documentation will also change. Nurses and care workers will only need to speak during or after a visit. Whether SOAP or another framework is used, AI will organize the record in the format desired by that provider and that individual, and automatically enter it into the billing software each uses. Shift schedules will be reconciled with registered performance data, and an alert will sound if services have not been registered - in other words, if there is a risk of missed billing.

For monthly work, reports and plans will be generated from daily records at the touch of a button. Through repeated conversations with AI, each manager will refine the output into the report they consider ideal. What matters here is that the output appears "in the format I prefer." If the output does not match a person's established practice, AI will be labeled "useless," and analog operations will continue. AI will detect and notify staff of missing documents needed for billing, such as insurance cards and documents related to publicly funded programs. At billing time, it will automatically reconcile performance records with codes and check additional reimbursements. When staff do not understand something, they can ask AI and receive an answer at the level of specialized expertise. No administrative staff member will need to shoulder excessive responsibility alone. Everyone will gain access to "the best administrative professional in Japan." No one will lose sleep at the beginning of the month or sacrifice New Year and Golden Week holidays to billing work.

Coordination will change as well. AI will manage the validity period of physician orders on both the medical institution and home-visit nursing station sides, and issue request forms automatically. There will be no need to create request forms across dozens of Excel sheets or manage their deadlines. When asked, AI will automatically fax performance reports to care managers, while AI on the receiving side will accept and import them. If anything is delayed, AI will issue an alert. For documents that currently require original copies to be mailed, the necessary documents for each user will be printed in a state where "all that remains is to put them in an envelope." AI will even count the remaining envelopes and automatically order more when supplies run low. No one will need to turn pale at the beginning of the month and say, "We have no envelopes."

Case 2: Hospitals

In hospitals, physicians carry an enormous document-creation burden alongside clinical care: referral letters, home-visit nursing orders, attending physician opinion forms, and medical certificates. Requests from home-based providers arrive by fax or post, and administrative staff manage and return them. Naturally, these staff are also expected to perform highly specialized work, including medical billing, management of facility standards, calculation of additional reimbursements, and responses to claim assessments and returns. Regional coordination offices communicate by telephone and fax with multiple participants, including care managers and home-visit nursing stations, to coordinate discharges and numerous related matters.

AI implementation will transform all of this dramatically. When conversations take place during outpatient consultations or conferences, AI can instantly produce a variety of outputs. Documents such as referral letters and discharge summaries will not be created separately. From information written once by a physician, AI will draft multiple outputs, each in the appropriate form. AI will receive and read order requests from home-visit nursing stations and, based on the physician's medical records,

prepare draft orders. The physician will only need to review and sign them. The same will apply to attending physician opinion forms. In medical administration departments, AI will support checks of facility standards and eligibility for additional reimbursements, as well as responses to claim assessments and returns. Administrative staff will no longer be burdened with excessive responsibility. In regional coordination offices, AI will use the condition of patients scheduled for discharge and information about local providers to telephone home-visit nursing stations and facilities, find those able to accept the patient, and even schedule conferences. Physicians and nurses will be able to focus on clinical care, while the hospital as a whole can concentrate on highly complex treatment.

Today, electronic health records and medical billing systems are often separate, and billing systems in particular are frequently very old on-premises products. For vendors, updating long-standing systems every time medical reimbursement is revised is also a major burden. In recent years, integrated cloud-based electronic health record and billing software has emerged, but implementation costs can exceed tens of millions of yen. As Chapter 2 explained, can a highly individualized hospital whose operations cannot stop really complete a core-system replacement project costing tens of millions of yen? Here too lies a problem that previously had no solution. AI can overcome it. The data only needs to be collected and stored in one place. It does not need to be organized and processed for human readability; AI can read data that humans find difficult to interpret. AI can then generate the necessary outputs. AI can solve problems that SaaS cannot. Now is the moment when hospitals can change the core software they have been unable to replace for many years.

Case 3: Long-Term Care Facilities

In facilities such as special nursing homes for older adults, geriatric health services facilities, and fee-based homes for older adults, care workers document meals, toileting, bathing, vital signs, and other information many times each day. If a fall or similar incident occurs, they must also prepare incident and near-miss reports. Facility care managers create care plans and conduct monitoring. Around the care itself, an enormous volume of administrative work accumulates: submitting data to the Long-term Care Information System for Evidence (LIFE); preparing plans and reports for additional reimbursements, including those for improved staff compensation; creating shifts that meet night staffing standards; submitting long-term care benefit claims to the National Health Insurance Federation; and communicating with and billing families.

AI implementation will significantly change this situation. Daily records will be organized into the required format simply by speaking between care activities, and data for LIFE submission will be generated automatically from daily records. Eligibility requirements for additional reimbursements will be checked continuously, and alerts will sound when there are signs that reimbursement has been missed or requirements are at risk of not being met. Shifts will be automatically reconciled with staffing standards. Even when an incident occurs, staff will be able to describe the situation and receive a draft report, allowing them to focus on the resident. Notices to families and monthly invoices will be prepared automatically, and AI will mediate communication with facility physicians and cooperating medical institutions. Staff will regain time that can be devoted to care.

Across every setting, the implementation of AI will also transform management. With operations automated to this degree, the headquarters of organizations operating multiple sites and facilities can minimize the indirect staff assigned to each site. The problem of dependence on particular individuals can finally be resolved. Organizations can establish models in which some nurses divide their time between care and administration, supported by headquarters. With the capacity freed up, larger providers can open more sites and systematically develop managers. In a Japan facing a shortage of care providers, creating room for organizationally capable providers to expand directly protects the supply of care in local communities.

Chapter 5: Five Conditions for Reaching This Future

The vision described in Chapter 4 will not be realized automatically through advances in AI technology. We believe that five conditions determine whether implementation succeeds. It is essential to proceed with implementation while keeping these conditions firmly in mind.

Condition 1: Do Not Change Frontline Workflows

The front line is busy - relentlessly busy. Every day connects to the next, and operations cannot stop. It is not that people do not want to change their work; they cannot. Telephone calls and fax could become unnecessary tomorrow if everyone could migrate to a new system simultaneously. But that is only an ideal. So they remain. Keep telephone calls as telephone calls and fax as fax, while using AI to make the work behind them more efficient. Do not change the workflow, but automate and streamline it. AI can do that.

Condition 2: Reduce the Cost of Interviews to Zero - Enter the Field Equipped with Knowledge

When an AI development company enters healthcare or long-term care, the first thing it typically does is conduct interviews. But the front line has no time to be interviewed. Medical insurance and long-term care insurance systems, billing methods, how to write nursing and care records, and how to engage with users - explaining all of this properly would take days. What the front line really wants to say is, "Learn it before you come." New entrants must arrive carrying industry knowledge data from the outset.

Condition 3: Be Prepared to Visit the Front Line and Customize

The software, surrounding systems, shifts, and documentation methods differ from one provider to another. A uniform product cannot absorb this variation. An approach based on rolling out a single SaaS product horizontally will never succeed. Providers must visit the front line and customize one workplace at a time. That commitment is essential.

Condition 4: Earn the Trust and Affection of the Industry

The people who work in healthcare and long-term care have a strong sense of social mission. Simply appearing before those who have devoted themselves single-mindedly to protecting the industry and saying "AI" will not earn entry into their community. Providers must continue the dialogue, build trust, and understand the views and current circumstances of each workplace. Relationships come before technology.

Condition 5: Provide a More Secure Environment Than Any Other Industry

Recently, simplistic proposals branded "AI x healthcare" or "AI x long-term care" have flooded the front line: systems that can write records, summarize reports, or produce a shift schedule instantly. But we must stop and ask: Is the security adequate? Will information leak? Healthcare and long-term care settings handle extremely sensitive medical and care information. Precisely because this industry has not historically had high IT literacy, the entire industry must sound the alarm and raise literacy before a serious incident occurs. Convenience always has a security dimension behind it, and both must be addressed.

Chapter 6: Recommendations to the Government

To make the national vertical AI strategy bear fruit in frontline healthcare and long-term care, we make the following three recommendations to the government. None requires a large budget. What is required is a change in rules and thinking.

Recommendation 1: Clarify Ambiguous Rules, Issue National “Recommendations,” and Deliver Them Through AI

The front line faces questions like these every day. How much should be written in a record, and what should it include? How should the progression of a patient’s condition be described in a monthly report? Should the report address the past, cover only the current month, or simply include a sentence pointing to a reference? When should a care plan be reviewed, and must it be sent every month? Staff want reports to include visits through the 31st, but plans must arrive by the 1st. Is there any way to satisfy both requirements other than forcing the work into the period between the visit on the 31st and the visit on the 1st? How much time should be allocated to documentation and administrative work?

Because cases are diverse, establishing a single nationwide rule is difficult. The government should therefore issue many “recommendations.” These recommendations should be delivered not only through traditional person-to-person channels such as notices and training, but also through AI. At the exact moment the front line faces uncertainty, AI can present the government’s recommendation. Clarifying rules and delivering them through AI function as a set.

Recommendation 2: Review Requirements for Originals and Postal Delivery, and Create New Rules for the AI Era

Home-visit nursing orders are a symbolic example. They are governed by an original-document principle, and because an original is required, they must be sent by post. Healthcare and long-term care rely heavily on postal mail. No matter how advanced digital technology becomes, postal delivery still requires someone to fold paper in thirds, place it in an envelope, and take it to the post office. Mistakes occur. Moreover, some medical institutions require a return envelope and others do not; some require postage and others do not; and in some cases the original must be enclosed, while in others it must not. Large hospitals specify destinations in minute detail. The use of postal mail makes the work extraordinarily complex. People who make mistakes in a busy workplace may be reprimanded severely, but these are not human errors. They are errors created by the system.

We fully understand the significance of physician orders as a foundational mechanism of home-based healthcare. However, if the reason for requiring an original is “proof of authenticity,” other methods of proof exist. Originals and postal delivery are not the optimal means of achieving that purpose. We want to work together to create new rules appropriate to the AI era.

Recommendation 3: Abandon the Idea of “Installing a Large System” and Make “Connecting with AI” the Center of Implementation Strategy

Connecting the participants in regional healthcare and long-term care is necessary and extremely important. In practice, however, an approach that attempts to introduce one enormous common platform everywhere at once will not work. Each workplace has evolved individually over many years. If it is suddenly told, “Move to the common platform tomorrow,” there is no viable migration process.

The conventional idea was: “Because connecting system A and system B is difficult, everyone should move to a large system X.” AI overturns this assumption.

AI can connect A and B as they are. While connecting A and B, AI can progressively realize the larger vision of X. We should draw the larger picture while creating the “in-between.” This should be the design philosophy for regional coordination in the AI era.

Chapter 7: Kurashitech’s Challenge

We have already begun putting the philosophy described in this paper into practice as a business. The following sections present our initiatives.

7-1 Bringing Japan’s Healthcare and Long-Term Care Knowledge into a Single Data Foundation

Kurashitech is turning expert knowledge concerning documentation and administration into a platform. Our proprietary context platform, CAIVA, brings together institutional knowledge, practical expertise, and tacit frontline knowledge, creating a cloud environment where anyone can access “the best administrative professional in Japan.” To ensure that this knowledge remains current, we employ domain experts and continuously convert tacit and specialized knowledge into data and update it every day.

7-2 A Product That Runs Entirely Through the Chat Tools People Already Use

“Do not change the front line or its workflows, but make the work easier.” This is our product policy. Frontline managers, administrative staff, nurses, and care workers only need to speak through the chat tools they already use, just as they would address a colleague. AI performs all processing and sends messages like the observations a colleague might offer. We will never deploy AI as “a new SaaS product.” Our watchword is: “Who has time to learn something like that? Could you tell your own mother, as she grows older, to use it?”

7-3 Not Being Bound to a Product - FDEs Visit the Front Line

We do provide products. At a newly opened site, a product can establish an operational standard from the outset. But a provider with established workflows does not need a uniform product. What it needs is for someone to “apply AI to our current operations as they are.” The method for creating shifts, the calendars, the way compensation is determined, and the division of roles within each site all differ. This is why Kurashitech employs Forward Deployed Engineers (FDEs). FDEs visit each site and deliver AI optimized for each individual workplace.

7-4 Building an Industry Community

We are currently building communities within the healthcare and long-term care industry. The front line contains countless practical innovations. We share those innovations and communicate knowledge about AI. Security in particular requires the industry as a whole to raise its literacy. We ourselves continue learning from the community. At Kurashitech, a salesperson is defined not as “someone who sells,” but as “someone who understands the front line.” By visiting, listening, and sometimes sharing a meal, we seek to understand this industry in its entirety.

7-5 Security That Provides Greater Peace of Mind Than Any Other Industry

The data in this industry is more sensitive than data in any other. No information could be more important. We make it a prerequisite of our business to handle data in a reliably secure environment that complies with Japanese government guidelines for the secure management of medical information.

7-6 Taking Responsibility for the “Connections” in Regional Healthcare and Long-Term Care

Outpatient care, home-based medical care, home-visit nursing, home-help services for older adults and people with disabilities, adult day services, nursing homes, and employment support are independent businesses. Seen at the regional level, however, they are all part of the same endeavor to support each individual's life. We enter every field and advance AI optimization site by site. Beyond that lies a previously unseen form of regional coordination in which AIs exchange faxes and call one another.

7-7 A World That No Longer Needs Electronic Health Records or Billing Software

Electronic health records and billing software were optimal solutions before the AI era. They are certainly more convenient than paper. In the AI era, however, if insurance cards, physician orders, and care records are simply converted into data, AI can immediately generate order request forms and detailed insurance claims. There is no longer an inherent need to transcribe the contents of paper into an electronic health record or billing system. In fact, using AI merely to transcribe data into SaaS is not the proper use of AI. The AI era has its own optimal solutions. Technically, this world could be realized today, but existing systems do not permit it. That is precisely why there is a world we can reach together after implementing AI step by step. We will continue working toward that world.

Conclusion: To Members of Government and the Media

We are now in the midst of the very challenge described in this paper. Of course, it is not ours alone. Together with frontline professionals, we have begun this challenge one provider at a time.

If possible, we invite you to accompany and report on our frontline initiatives. We want you to see the unembellished reality of the field. Spreading AI throughout society will not be easy. We will continue our efforts with the front line as our starting point. At times, however, we need the support of people with significant influence. We want to pursue the possibilities of the front line and AI together and begin, now, a broad discussion based on the premise that AI will be used. At this moment, when vertical AI has become a national strategy, we hope that we can join forces.

References

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Inquiries Regarding This Paper

Kurashitech Inc. (Representative Director: Ryota Ichioka)

Position Paper Team

Email: info@kteku.com / Tel: 050-1726-1253 / Web: <https://kteku.com/>