Health and Global Policy Institute (HGPI) Cancer Project

Policy Dialogue
Considering Comprehensive Genomic Profiling from the Perspective of Patient Access: Utilizing the Medical Service Fee Reimbursement System and the Mixed Medical Services Program to Meet the Needs of Today

Discussion Points

November 2025

HGPI Health and Global Policy Institute

Purpose of This Policy Dialogue

Since comprehensive genomic profiling (CGP) was granted insurance coverage in 2019, people serving in clinical settings have built experience with genomic cancer medicine, and findings from various studies continue to accumulate. In June 2023, Japan enacted the "Act on the Comprehensive and Systematic Promotion of Policies to Ensure that the Public Can Receive High-Quality and Appropriate Genome Medicine with Peace of Mind" or the Genome Medicine Promotion Act, and momentum for the promotion of genomic cancer medicine continues to grow. However, various issues must be addressed before appropriate genomic cancer medicine can be broadly provided to patients.

With this backdrop, Health and Global Policy Institute (HGPI) launched initiatives for genomic and precision cancer medicine in 2021 and presented policy recommendations on promoting genomic cancer medicine in April 2025. Then, on June 11, 2025, a joint report titled "Briefing Report on Solid Cancer Treatment Based on Gene Panel Testing Using Next-Generation Sequencers" was presented by the Japanese Society of Medical Oncology (JSMO), the Japanese Cancer Association (JCA), and the Japan Society of Clinical Oncology (JSCO). Guidance provided by these three societies was utilized as an important foundation when CGP was granted insurance coverage in 2019, and the 2025 Briefing Report is another resource that should be used as guidance during the next revision of the medical service fee schedule. Now is precisely the time that it is critical for us to deepen discussions and take concrete action to promote genomic cancer medicine so its benefits can be delivered to patients in a more appropriate manner.

The policy dialogue described in this report was held as an opportunity for diverse stakeholders representing industry, government, academia, and civil society to come together and discuss current circumstances and challenges facing genomic cancer medicine as well as the future for this area.

Event Overview

- **Date & Time:** Monday, July 14, 2025, 18:00-19:30 JST
- **Venue:** Global Business Hub Tokyo
  (3F, Otemachi Financial City Grand Cube, 1-9-2, Otemachi, Chiyoda-ku, Tokyo)
- **Format:** In-person (Invitation-only | Chatham House Rule)
- **Organized by:** Health and Global Policy Institute (HGPI)

About the Chatham House Rule

The roundtable discussion will be held under the Chatham House Rules which means that your comments and statements during discussion will not be made public, and your name will be kept private. We also request that if you use any information from this meeting in the future, please do not reveal the names or affiliations of the meeting's participants.
This is important to provide anonymity to the panelists and to encourage openness and the sharing of information.
"When a meeting, or part thereof, is held under the Chatham House Rule, participants are free to use the information received, but neither the identity nor the affiliation of the speaker(s), nor that of any other participant, may be revealed". (Retrieved from: Chatham House)

Discussion Summary

Opening Remarks, Explanation of Purpose, and Overview of Policy Recommendations
Yui Kohno (Manager, Health and Global Policy Institute)

The purpose of this policy dialogue
This policy dialogue aims to serve as an opportunity for straightforward and constructive discussions on systemic issues in genomic cancer medicine and the future structure of related systems. We are joined by approx. 40 participants representing a diversity of perspectives, including healthcare professionals, researchers, government officials, the private sector, and patients. As the term "policy dialogue" suggests, rather than to quickly arrive at a clear conclusion, the main focus of this meeting is to hold a frank dialogue and exchange of opinions that transcends the boundaries of our respective positions. I wholeheartedly welcome everyone to share various opinions from a broad range of perspectives.

Positioning genomic cancer medicine as a form of cancer control in which no one is left behind
The fourth Basic Plan to Promote Cancer Control Programs, Japan's current plan, calls for "cancer control measures that leave no one behind" and emphasizes the importance of "patient-centered, patient-benefiting" genomic medicine. Efforts to formulate the "Basic Plan for Genomic Medicine Policies" will accelerate from August 2025. In addition, the interim evaluation of the fourth Basic Plan to Promote Cancer Control Programs is set to take place next year, in 2026. Next year will also mark twenty years since the enactment of the Cancer Control Act.

The Cancer Control Act was enacted with great contributions from patients and other parties with lived experience of cancer, and that act obligates the Ministry of Health, Labour and Welfare (MHLW) and prefectural governments to ensure "cancer patients, their families, or the bereaved" are represented on Cancer Control Promotion Councils. The movement to see meaningful involvement for patients and others with lived experience in councils and in other deliberation bodies has continued to expand. In addition to individual health conditions like allergy control and cardiovascular disease control, that movement has now extended to plans that cut across diseases and that are rooted in communities, such as Medical Care Plans and Health Promotion Plans.

At the same time, in the years since the Cancer Control Act was enacted, the nature of cancer care has changed drastically alongside progress in genomics and other scientific technologies. Due to this and the impacts of socioeconomic and demographic trends, it is now necessary that we reexamine cancer care from a "patient-centered, patient-benefiting" perspective.

Examining CGP as a new policy issue from a "patient-centered, patient-benefiting" perspective
Based on recommendations published by HGPI in April 2025 titled "Ensuring Equitable Access to Comprehensive Genomic Profiling and Key Considerations for Applying the Mixed Medical Services Program" as well as requests from academic societies and other related parties, this policy dialogue aims to deepen discussion on genomic cancer medicine, with a particular focus on CGP. Those recommendations are centered on three pillars:

- Providing CGP to the people who require it most and in a timely manner
- Paying mind to the fair and transparent use of the Mixed Medical Services Program
- The need for systemic improvements from the perspective of patient access

In Japan's current insurance system, the use of CGP is restricted to "patients who have completed standard treatment or who are expected to complete standard treatment." As attending physicians determine if either of these conditions are met, treatment timings can vary among patients depending on physicians' decisions. For example, some hospitals perform CGP at relatively early stages. Due to these circumstances, after disseminating correct understanding of the system, steps must be taken to allow physicians more flexibility to make appropriate decisions as necessary. We must also modify descriptions in the medical service fee reimbursement system to avoid the variation that occurs due to different interpretations among physicians. There are also regional variations in real-world usage of CGP as well as in the content of explanations provided to patients, and some are concerned that access disparities may further widen. With this backdrop, we would like to link this policy dialogue to mid- and long-term improvements that help establish an environment in which patients can undergo CGP at appropriate times and that ensure systems are operated in a fair and transparent manner.

Overview of the Latest Guidance from JSMO, JCA, and JSCO

Manabu Muto (Professor, Department of Medical Oncology, Graduate School of Medicine, Kyoto University)

Introduction

It has been six years since CGP was granted insurance coverage in Japan, and in that period, over 100,000 patients have been profiled. However, only 8.2% of patients actually arrived at treatments based on CGP findings and only 1.5% of patients gained access to clinical trials or clinical studies. There is a wide gap separating the broadening adoption of profiling and access to treatment.

In response to these circumstances, in June 2025, the JSMO, JCA, and JSCO published a joint report titled, "Briefing Report on Solid Cancer Treatment Based on Gene Panel Testing Using Next-Generation Sequencers." It was prepared by a task force of presidents and directors from each society and a working group of health professionals involved in testing, and it identifies twelve issues for this system and potential improvements for its design. Among those twelve issues, this presentation will introduce five that are directly related to patient treatment access.

1. Integrating operations for CGP for both its functions as a companion diagnostic (CDx) and as a tool for profiling

CGP should be conducted as a single test that both serves as a companion diagnostic (CDx) to identify drugs with insurance coverage and performs profiling to assess patient eligibility for clinical trials and new treatment methods. However, the current insurance system handles these two functions under different frameworks, and the medical service fee reimbursement (which is up to approx. 200,000 yen) is less than the cost of the test itself (approx. 460,000 yen). This makes it difficult to use CGP as a companion diagnostic. Using CGP for profiling generally alleviates the need for the hospital to cover a portion of the cost, but because patients are required to have completed standard treatment (or are expected to complete standard treatment) to be deemed eligible for testing, patients encounter difficulties such as when attempting to join clinical trials or clinical studies.

In the future, we must promote systems designed to enable the integrated use of CGP in testing, diagnosis, and treatment and to establish systems that enable more flexible and efficient operations in real-world healthcare settings.

2. Increasing timing flexibility for CGP

Currently, CGP is only eligible for insurance coverage for patients who have completed or are expected to complete standard treatment. However, recent years have seen a growing number of promising drugs in the clinical trial stage or that are provided in the early stages of treatment, meaning it is possible to select more appropriate treatments by identifying genetic mutations before treatment begins. Despite this potential, the aforementioned restrictions that the current system places on CGP mean that the clinical value of testing is not fully realized under current circumstances.

In fact, it has been reported that when CGP is performed after standard treatment, 10% to 30% of patients are unable to use the recommended drug due to deterioration in their general condition or organ function, and only 8.2% of patients are linked to treatment. However, under the Advanced Medical Care B framework, it has been confirmed that when CGP is performed prior to standard therapy, the rate at which patients are linked to treatment increases to 19.8%. This rate increases to 22.7% at one year.

Given these circumstances, in an opinion statement presented in March 2025, the Designated Core Hospitals for Genomic Cancer Medicine Liaison Conference of the Medical Care Working Group expressed the view that the "completion of standard treatment (or expected completion of standard treatment)" can be interpreted according to the clinical judgment of the attending physician. This made it possible for physicians to exercise more flexible judgment based on patient condition or course of treatment, and in practice, it is becoming more common for physicians to rely on their own discretion regarding this criteria. In the future, it will be necessary for the system to provide explicit support for such circumstances and for action to be taken to optimize the use of CGP based on greater flexibility and clinical usefulness and in a manner that is suited to the characteristics of cancer types or drug indications.

3. Addressing the lack of exit strategies post-CGP (or, the need to clarify pathways connecting testing and treatment)

Japan's current system lacks clear pathways or exit strategies that enable the smooth transition to clinical trial participation or drug administration based on CGP findings. Examining circumstances overseas, other countries have established systems to support access to unapproved or investigational drugs based on CGP findings. For example, the United States has introduced expanded access programs for compassionate or off-label use which allow for the provision of unapproved drugs when specialists determine that they are likely to be medically effective. It has also been reported

that over 60% of patients are being linked to treatment in Belgium and other countries in Europe.

Moving forward, it will be important to establish a framework that links information obtained through testing to various treatment pathways, such as approved drugs, drugs that are likely to have their indications expanded, clinical trials, compassionate use, and off-label use. We must build a framework that systematically assures there are links between testing and treatment so CGP can provide patients with a door of hope to treatment.

4. Operating expert panels (EP) in a flexible manner

The current system requires EPs to be held for all cases, which delays the return of results and increases burdens for healthcare professionals. For mutations where the evidence level has been established, holding an EP becomes a formality. This is inefficient and can delay the start of treatment.

Overseas, when it is difficult to decide a treatment, it is common practice to convene meetings of multidisciplinary groups called Molecular Tumor Boards and to follow the decisions of those Boards to ensure patients have access to drugs. Efforts to operate EPs with greater flexibility are now advancing in Japan, following a July 2025 notice from the MHLW that stated, “It is not mandatory for EPs to meet in real time when a consensus has been reached by circulating the case among panel members for approval.” Expectations are high for the establishment of systems that enable the effective use of this practice in the future, including its addition to the medical service fee reimbursement system.

5. Frameworks for providing drug access based on the discretion of specialists

Even if a genetic mutation is detected through CGP, the corresponding drug may lack regulatory approval, and systems enabling the off-label use of that drug or enrollment in a clinical trial are sometimes insufficient for securing access. Such structural issues rooted in social systems have significantly lowered the clinical value of CGP, and the rate at which patients are linked to treatments remains low.

Meanwhile, overseas, the United States has established a system for compassionate use in which drugs are provided based on the discretion of specialists, and a number of companies have introduced programs that provide drugs free of charge. In Belgium, there has been progress in creating an evaluation system that uses real-world data, and it is reported that over 60% of patients are linked to treatment. As these examples demonstrate, systems can be designed in a manner that makes it possible to secure paths from testing to treatment. In Japan, there is also a need to build systems in which the clinical judgement of specialists is followed and that steadily links test findings to treatment.

In conclusion

Now is the time for Japan’s system for conducting CGP to transition from the introductory phase to the phase for widespread adoption and fixation. We must design a system that is integrated from diagnosis to treatment and establish system operations so patients can be tested at the appropriate times and to ensure results are linked to treatment. I look forward to future discussions that aim to build a sustainable and patient-centered healthcare provision system and that are focused on flexible timing for testing, the perspective of cost-effectiveness, fair access, correcting regional disparities, and making effective use of a wider range of medical facilities.

Roundtable Discussion (Designated remarks)

Naomi Sakurai (Vice President, Japan Federation of Cancer Patient Groups/ President, CSR Project, General Incorporated Association)

Introduction

In our capacity as a patient advocacy organization, we presented a written request on June 11, 2025 titled, "Request on Eliminating Drug Lag and Drug Loss Caused by Lag in Comprehensive Genomic Profiling for Cancer." In our patient support activities, we have received many consultations from patients who say, "I want to be tested, but I do not know when or where I can undergo testing." Despite the growing importance of optimizing treatment options through CGP, insufficient efforts to establish systems for performing CGP or for providing information are resulting in missed testing opportunities and are causing disparities in terms of who is linked to treatment.

While capivasertib was recently approved, the only genomic profiling test approved for capivasertib in Japan was FoundationOne®CDx. As this example shows, even when a drug has been approved, delays in the approval and dissemination of the companion diagnostic needed for that drug causes delays in its use. This is referred to as "testing lag" and has been identified as a factor that impacts drug access. Furthermore, there have been reports of cases in which testing lag caused patients whose standard treatment had progressed to a certain regimen to miss opportunities to join global clinical trials because they failed to meet eligibility requirements. While the company that offers the FoundationOne®CDx genomic profiling test is operating a compassionate use program which provides the test for free, this alone is not enough to solve structural issues. We must establish an environment for treatment and testing that provides the right treatments to the right patients at the right time, from the viewpoint of patients.

The current insurance system's restrictions on the timing of CGP: A misunderstanding in system operations and the impact on patients

In the current insurance system, a patient must have "completed standard treatment or be expected to complete standard treatment" to be eligible for insurance coverage for CGP. However, in practice, there are some physicians who interpret this requirement incorrectly as, "CGP cannot be performed until the patient has completed *all* standard treatments listed in the guidelines." There are also many cases in which attending physicians do not provide patients with explanations on CGP. This delays the start of testing and causes some patients to miss opportunities for treatment.

In a notice issued by the MHLW on May 31, 2019 (Inquiry Response no. 16), in response to the inquiry, "Who does 'persons who are expected to complete standard treatment' refer to?" the MHLW specified, "Persons whom the attending physician expects to complete standard treatment based on medical judgement." This response indicates that the timing of the CGP can, to a certain extent, be determined according to the discretion of the attending physician. In a document presented in April 2025 ("Opinion on the Clinical Interpretation of 'Completion' or 'Expected Completion' of Standard Treatment for Performing CGP for the Purpose of Genomic Profiling"), the Designated Core Hospitals for Genomic Cancer Medicine Liaison Conference of the Medical Care Working Group agreed that the completion of all standard treatments is not a condition for performing CGP. Instead, while taking into account factors such as the patient's condition, the progression of their disease, and their capacity for continuing treatment, that Group considers it crucial to perform CGP in a timely manner during primary treatment so that the feasibility of providing treatment based on the profile test can be placed under consideration.

Implementing CGP requires attending physicians to possess a correct understanding of the current system as well as the medical judgment of attending physicians. There are many cases in which cancer patients experience a rapid decline in their condition and cannot advance to the next stage of treatment. In addition to having a correct understanding of the CGP system at medical facilities and among individual healthcare professionals, efforts to improve literacy must be advanced with a sense of urgency so the conditions for CGP can be interpreted in a flexible manner.

Regional disparities in explanations on CGP and systems for performing CGP: Identifying how to best conduct Expert Panels (EPs)

Expert Panels (EPs) convene to recommend treatments based on CGP findings, but they sometimes require time to present their decisions. This leads to delays in the start of treatment and increased burden for medical staff. In particular, a framework must be introduced that allows for EPs to be omitted so patients with mutations that are known to be Evidence Level A can transition to treatment based on the discretion of a specialist physician. On July 7, 2025, the MHLW issued a notice stating, "Operating EPs by circulating cases among panel members for approval will be permitted for all

cancer types," and expectations are high for real-world EP operations to become more flexible in the future.

There are also personnel shortages among genetic counselors and other specialists, even at designated core hospitals for genomic cancer medicine. Addressing this will require establishing a system for collaboration among regions that includes utilizing part-time staff and providing online support. Steps must be taken to improve both system operations and real-world support in clinical settings to create a system that enables patients to be tested at appropriate times without missing out on options for their next treatment.

Roundtable Discussion (Plenary discussion)
Moderator: Shu Suzuki (Senior Associate, Health and Global Policy Institute)

Overview of discussion
During this session, we held a lively exchange of opinions on systemic issues and future prospects for genomic cancer medicine from a broad range of positions including healthcare professionals, government officials, researchers, industry representatives, and patient groups.

Discussion Point 1: Cost-effectiveness and investments in medical technology

- Some participants expressed concern about the financial impact of CGP on national funds as it becomes more commonplace. At 460,000 yen per test, it is by no means inexpensive, so it is absolutely essential that the cost-effectiveness of CGP is accurately evaluated. Current medical expenditures for CGP amount to approx. 10 billion yen per year, so even if the number of patients profiled were to increase, the cost would still be less than that of a single anticancer drug. Another participant shared the opinion that the cost of immune checkpoint inhibitors can be reduced when driver genes are identified. However, when discussing cost-effectiveness, it is not enough to only consider the direct costs of testing and treatment. Rather, a number of other factors must be considered to comprehensively evaluate the social benefits of CGP, such as long-term participation in socioeconomic activity or contributions to labor productivity and tax revenue for patients who complete testing or treatment.

- On the other hand, factors such as the diversity of diseases and variation in treatment effects make it extremely complicated to accurately calculate cost-effectiveness, and CGP is no exception in this regard. In fact, the academic community has yet to reach a clear consensus on calculation and evaluation methods. It has also been pointed out that overly strict cost-effectiveness evaluation may hinder the dissemination of new health technologies and delay medical innovation. Rather than limiting cost-effectiveness calculation and evaluation to cost-benefit analysis over the short term, it should be utilized for future investments in health technology.

- As of July 2025, efforts are currently underway to consider shifting the practice of performing CGP before standard treatment from Advanced Medical Care B to Advanced Medical Care A. It was pointed out that according to past data accumulated through the Advanced Medical Care B framework, the annual cost of treatments using CGP amounts to approx. 200 billion yen while the economic value of life-years gained through such treatments is only about 50 billion yen. In other words, CGP is not currently cost-effective. However, cost-effectiveness is likely to improve if more patients are linked to treatment by increasing the types of approved drugs and expanding the system for profiling. On October 3, 2025, the Advanced Medical Care Council approved “CGP performed on patients with advanced or recurrent solid tumors before the completion of standard treatment” within the framework of Advanced Medical Care A at the National Cancer Center Hospital. Given this backdrop, expectations are high for broad consideration to be given to items such as how to best determine cost-effectiveness in validation under Advanced Medical Care A in the future.

Discussion Point 2: Increasing flexibility in CGP timing and systemic operations

- In Japan’s current insurance system, the use of CGP is restricted to “patients who have completed standard treatment or who are expected to complete standard treatment.” However, in some clinical settings, the interpretation of these criteria is overly stringent, so the timing of CGP varies among medical facilities. As the MHLW has expressed in a notice, the original intent of this criteria was to allow for flexibility based on the “medical judgement of the attending physician,” but it is currently difficult for patients to undergo CGP at the optimal times. As a result, despite the fact that 23% of patients are linked to therapies when CGP is performed prior to standard treatment, there is a strong tendency for the claim that “the rate at which CGP links patients to treatment is only around 10%” to be taken out of context as a single criterion for evaluating the system. This is a major issue. Reviewing the design of the system with the assumption that CGP will be performed is likely to further boost the rate at which patients are linked to treatment.

- Japan’s unique “testing lag” is also impacting global clinical trials and new drug development. Because Japan restricts CGP to after the completion of standard treatment, even when new drugs are approved, patients who could have used those drugs from first-line treatment do not even have opportunities to undergo testing. As a result, they are prevented from benefiting from new drugs. In addition, even though the current system allows the use of CGP as a companion diagnostic when such use is approved, in practice, this use is hindered by the cost burden it

places on hospitals. This makes it difficult for actors in the private sector to select sufficient numbers of eligible participants for global clinical trials, causing the global headquarters of those companies to proceed with caution when developing drugs in the Japanese market and increasing the risk that they will forgo entering it. It is urgent that we review the testing system and reinforce collaboration in drug development.

- The use of CGP prior to standard treatment has been validated under the Advanced Medical Care B framework. As Advanced Medical Care B is a framework for evaluating the effectiveness and safety of technologies, facilities that implement those technologies must fully observe standards and guidelines, establish detailed protocol, and meet other such requirements. While this allows for data to be gathered carefully, it places major restrictions on the rapid introduction of new medical technologies. Efforts are now advancing to consider systems designed to balance the accumulation of evidence and the rapid introduction of new medical technologies in real-world healthcare settings. This involves the use of flexible and highly effective systems like the Mixed Medical Services Program in a manner that supplements the Advanced Medical Care B framework. It is also worth noting that, as mentioned above, on October 3, 2025, the Advanced Medical Care Council approved "CGP performed on patients with advanced or recurrent solid tumors before the completion of standard treatment" within the framework of Advanced Medical Care A.

- The omission of EPs must be considered in conjunction with the revision of the medical service fee schedule. As of July 2025, the medical service fee schedule included EPs among reimbursement conditions when applying for premiums like the "B011-5 Cancer genome profiling evaluation," so facilities that perform cancer genome profiling but omit EPs may become ineligible for such premiums. However, even if EPs are omitted, the medical judgment of the attending physician is essential, so careful handling will be necessary for any reductions to points that are assigned to profiling evaluation premiums and that evaluate medical expertise. Furthermore, given that notices on holding EPs by circulating cases among panel members and on member selection criteria have already been provided and the fact that efforts to establish systems for EP omission are now advancing, it will be necessary for the medical service fee reimbursement system to provide support that ensures the omission of EPs occurs in an appropriate manner.

Discussion Point 3: Regional disparities, human resources, and systems

- Peripheral tasks that accompany implementing CGP (such as providing patients with explanations on consent or profiling, or performing data entry and management) are becoming more complicated. Such tasks can become major hurdles at facilities that perform CGP, particularly ones that are not major hospitals. On top of this, genetic counselors, medical oncologists, and specialists in molecular oncology are concentrated in urban areas. The difficulty of securing such human resources in rural areas is causing delays in the establishment of systems for performing CGP. This has resulted in a major gap between urban and rural areas in expectations for and the implementation of CGP. People in rural areas now tend to hold the view that "Testing does not lead to treatment," and they feel unmotivated toward the implementation of CGP. Given these circumstances, we must build systems for flexible collaboration that transcend regions and promote online support (e.g., holding conferences or providing explanations remotely), building collaborative networks among base hospitals, and splitting duties through task shifting.

- There is also a lingering perception of CGP as "a test for finding medicines," but CGP is not only a test for identifying effective drugs. It also contributes to optimizing treatment strategies, linking patients to clinical trials, and establishing the foundation for the development of future treatments. Steps must be taken to broadly inform both patients and healthcare professionals that even when CGP results do not immediately lead to treatment, those results are an important form of information that is connected to future treatment options and research participation.

- As the clinical utility of CGP varies by cancer type and pathology, rather than operating testing systems in a uniform manner, they should be optimized to match the state of evidence and testing options. For genetic abnormalities with a high level of evidence (e.g., equivalent to Evidence Level A), steps must be taken to allow for EPs to be omitted, to return test results to patients without delay, and, after academic societies develop guidelines, to establish operations that enable the rapid transition to treatment at the discretion of specialists.

Discussion Point 4: Issues for and the future direction of the draft of the "Basic Plan for Genomic Medicine Policies"

- As of July 2025, the Government has presented a draft version of a "Basic Plan for Genomic Medicine Policies" that will cover the next five years. While it mentions education, awareness-raising, and human resource development among its priorities, there is room for improvement in terms of systematically ensuring that testing is linked to treatment. It was also pointed out that the draft "does not adequately reflect the sense of urgency felt in real-world clinical settings." Another participant shared the opinion, "Instead of being biased toward education and awareness-raising, concrete steps should be taken toward systemic reform or eliminating the two-tiered structure of the insurance system." Another concern shared was, "Drug loss and drug lag will continue to worsen if steps are not taken to address the dichotomy between the CDx and profiling functions of CGP."

- The next five-year plan should redesign the foundation of the system to enable the integrated utilization of testing, diagnosis, and treatment and to provide support to realize genomic medicine that is linked to treatment. To achieve this, the national Basic Plan should offer clear guidance stating that CGP can be performed as part of standard treatment at facilities like core hospitals for coordinated cancer care, and not only at facilities like designated core hospitals for genomic cancer medicine. In response to recommendations from academic societies, MHLW deliberation bodies and a notice from the Director of the Division of Cancer and Disease Control have already expressed the intent to expand the scope of facilities where CGP can be performed, stating, "While introducing measures that will achieve operational improvements, it will be important to build systems for providing high-quality genomic cancer medicine by making it possible for core hospitals for coordinated cancer care and other facilities that are required to provide standard treatments for cancer to be able to provide genomic cancer medicine."

Policy Dialogue Participants

(Titles omitted; in alphabetical order. Affiliations and other information current as of time of meeting.)

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Health and Global Policy Institute (HGPI) is a non-profit, independent, non-partisan health policy think tank established in 2004. In its capacity as a neutral think-tank, HGPI involves stakeholders from wide-ranging fields of expertise to provide policy options to the public to successfully create citizen-focused healthcare policies. Looking to the future, HGPI produces novel ideas and values from a standpoint that offers a wide perspective. It aims to realize a healthy and fair society while holding fast to its independence to avoid being bound to the specific interests of political parties and other organizations. HGPI intends for its policy options to be effective not only in Japan, but also in the wider world, and in this vein the institute will continue to be very active in creating policies for resolving global health challenges. HGPI's activities have received global recognition. It was ranked second in the "Domestic Health Policy Think Tanks" category and third in the "Global Health Policy Think Tanks" category in the Global Go To Think Tank Index Report presented by the University of Pennsylvania (as of January 2021, the most recent report).

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