Health and Global Policy Institute, Fiscal Year 2025 Kidney Disease Project Policy Recommendations

# Reliable Policy Implementation for Early Detection and Early Intervention of Chronic Kidney Disease (CKD)

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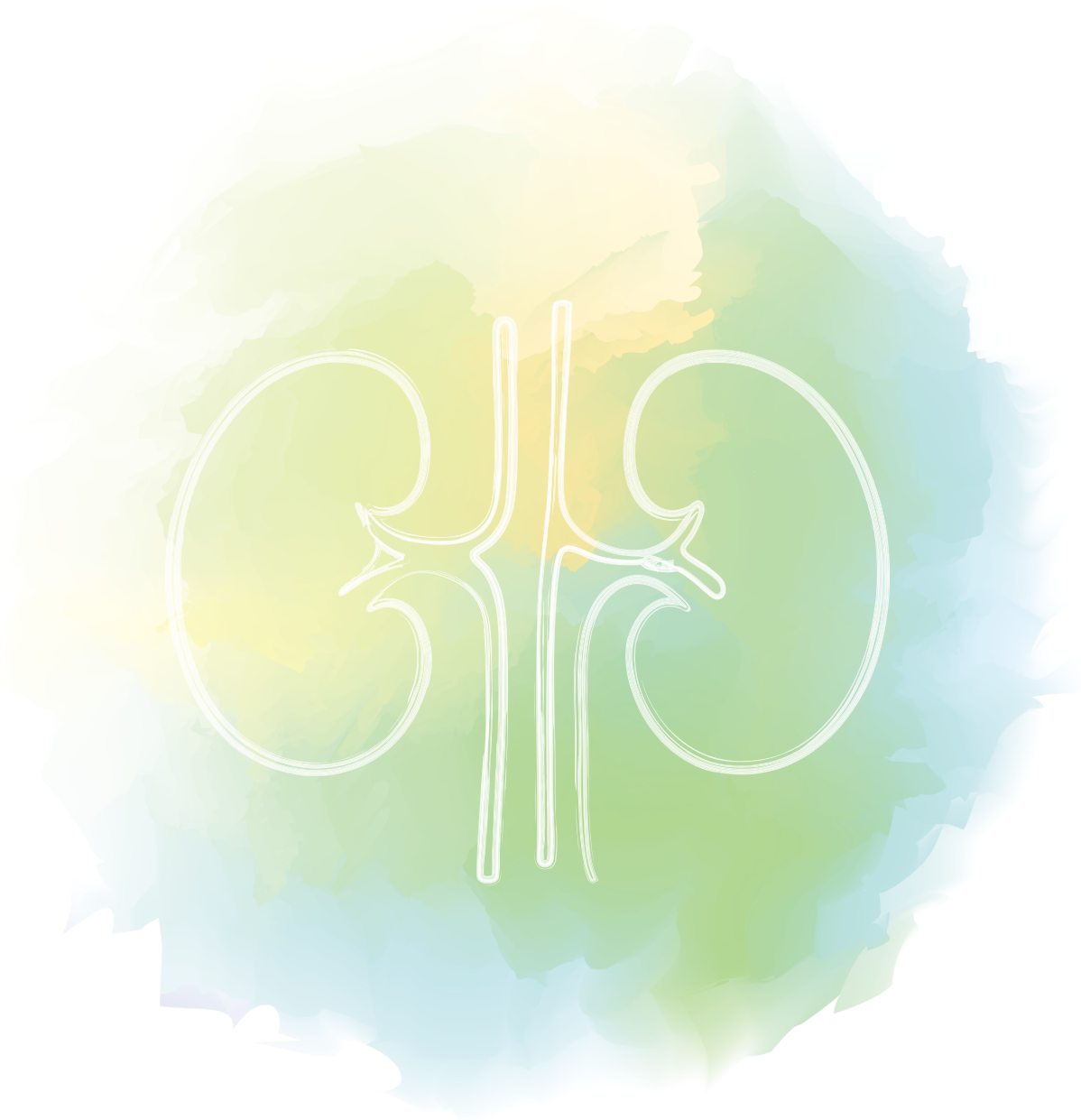

HGPI Health and Global Policy Institute

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# Overview of Policy Recommendations

These policy recommendations identify challenges and set a direction for connecting the early detection of and intervention for chronic kidney disease (CKD) to reliable policy implementation. They are centered on the perspectives of local governments and workplaces and aim to ensure that people with abnormal kidney function detected during health checkups receive timely treatment and ongoing management. Specifically, we offer the following recommendations arranged under three perspectives: (1) establishing data and institutional infrastructure; (2) optimizing health checkup operations and subsequent follow-up; and (3) reinforcing collaboration between insurers and physicians/healthcare institutions and standardizing healthcare provision.

## Perspective 1 Establishing Data and Institutional Infrastructure

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# Introduction

Chronic Kidney Disease (CKD) is defined as a condition in which decreased kidney function or kidney damage persists for more than three months. In Japan, CKD is estimated to impact around 1 in 5 adults aged 20 years or older, which corresponds to over 20 million people.[1)]

In a study using data from the Health Insurance Association for Architecture and Civil Engineering Companies, among approximately 70,000 people who received specific health checkups in FY2014, only around 5% of those who received an initial diagnosis of CKD attended a medical consultation.[2)] In other words, around 95% of people have yet to be examined. Situations in which health checkups detect the possibility of decreased kidney function but do not lead to medical consultations are a major issue in kidney disease control. Recognizing these circumstances, in FY2024, Health and Global Policy Institute (HGPI) conducted quantitative and qualitative surveys to identify the choices, decisions, and difficulties that people whose health checkups detect potential CKD encounter between checkup and treatment. We then met with our advisory board to discuss the survey findings and examined potential solutions with experts from industry, government, academia, and civil society. The results of those efforts are compiled in Policy Recommendations on Strengthening Chronic Kidney Disease Strategies: Challenges and Solutions in Seeking Medical Care from the Perspective of Patients and Those Affected, where we highlighted the need to establish evidence-based guidelines for recommending medical consultations, to identify priority target populations for intervention, and to consider how to adapt methods of approaching people to suit their characteristics.

In light of these circumstances, our FY2025 activities aimed to achieve reliable policy implementation for CKD control, centered on health checkups and subsequent consultations, or early detection and intervention. To identify obstacles and solutions for implementation, we conducted individual interviews and hosted two meetings of our advisory board. Our first meeting focused on local governments (including National Health Insurance (NHI) and the Medical Care System for the Advanced Elderly), while the second meeting focused on the workplace (including employers and employee health insurance providers). These policy recommendations were then compiled based on key issues crystallized through those interviews and discussions. It is our sincere hope that these recommendations help to further countermeasures for CKD.

# Background to These Policy Recommendations

One characteristic of CKD is its lack of subjective symptoms, which results in few people seeking medical consultations when kidney abnormalities are detected during a health checkup. This hinders efforts to provide appropriate early CKD intervention and creates a challenge for public health. Health checkups in Japan are conducted in accordance with laws such as the School Health and Safety Act, the Health Promotion Act, the Occupational Safety and Health Act, and the Act on Assurance of Medical Care for Elderly People. This system ensures many age groups undergo annual urinalysis and is one of the most comprehensive systems in the world. In addition, a December 2025 report presented by the Ministry of Health, Labour and Welfare (MHLW) Study Group on Items Included in General Health Checkups Conducted under the Industrial Safety and Health Act concluded that serum creatinine testing should be included in general health checkups for workers aged 40 years and older.[3)] Together with conventional urinalysis, this addition strengthened Japan's system for the early detection of declining kidney function. While continuing to strengthen existing urine protein screening and intervention measures, if we are to ensure that the inclusion of serum creatinine testing and other reforms to this system are effective, providing support and establishing an environment that ease transition from checkups to treatment or that encourage medical care-seeking behavior after health checkups will be more important than ever before. Focusing on the viewpoints of local governments and workplaces, these recommendations compile solutions to issues in CKD initiatives that emerge throughout the process from health checkups to visiting a healthcare institution for medical care.


1) Japanese Society of Nephrology. (2024). Evidence-based Clinical Practice Guidebook for Diagnosis and Treatment of Chronic Kidney Disease 2024. Tokyo Igaku-sha.

2) Yamada Y, Fukuma S. et al. Undiagnosed and untreated chronic kidney disease and its impact on renal outcomes in the Japanese middle-aged general population. J Epidemiol Community Health. 2019 Dec;73(12):1122-1127.

3) MHLW. Report of the Study Group on Items Included in General Health Checkups Conducted under the Industrial Safety and Health Act. https://www.mhlw.go.jp/stf/newpage_67821.html. Last retrieved on April 14, 2026.

# Policy Recommendations

Perspective

## 01 Establishing Data and Institutional Infrastructure

Addressing CKD requires a multi-layered approach that spans a wide range of fields including health checkups, lifestyle guidance, healthcare, and private health services. However, these sectors manage their data separately, and Japan has yet to establish the infrastructure for obtaining a comprehensive, cross-sectoral understanding of the situation or for evidence-based policymaking. An important step in overcoming this situation will be building a cyclical framework for evidence-based CKD control that forms an ecosystem for cross-sectoral collaboration in gathering, managing and analyzing data as well as translating that data into action. It would be ideal for the formulation of CKD policies to take place after this data-sharing infrastructure is established and it becomes possible to grasp real-world circumstances surrounding the transition from health checkup to medical care. This chapter identifies current challenges for establishing a data infrastructure and suggests possible solutions for consideration.

### 1-1 Establishing systems for collecting and utilizing data (including real-world data) for CKD initiatives

#### 1-1-1 Build systems to integrate and utilize health checkup and medical claims data held by insurers as well as with data from voluntary health programs

#### Current Situation and Issues

The National Database of Health Insurance Claims and Specific Health Checkups of Japan (NDB) is a highly comprehensive database with approximately 90% of all insurance claims that also includes data on specific health checkups and specific health guidance. However, the primary purpose for the establishment of NDB was for reviewing medical service fee reimbursements and managing specific health checkups. It was not established to serve as a database for the storage or centralized management of data from individual interventions provided in voluntary programs from local governments or workplaces (such as health guidance or independent programs). In other words, Japan's current system is structured in a manner that makes it difficult for insurers (local governments and workplaces) to independently conduct comprehensive analyses on the effectiveness of health promotion programs (i.e., to determine who was provided with an intervention and how that intervention impacted medical claims or kidney function) or to improve those programs using evidence (through the PDCA cycle). There are emerging developments for the unified management of CKD-related health checkup data collected in workplaces. Data from employer-sponsored health checkups will be added to the NDB starting in FY2026, and it will be mandatory for such checkups to include serum creatinine testing, an indicator for assessing kidney function, from FY2027. However, this will not address the lingering fundamental problem that data from other voluntary programs or tests are not organically linked to health checkup and medical claims data held internally by insurers.

#### Pathways to Solutions

Given the aforementioned circumstances, we must establish a data integration infrastructure that allows for existing health checkup and medical claims data to be cross-referenced or linked with data from voluntary programs at the insurer level. We should also create an environment in which insurers can proactively utilize data to develop effective CKD initiatives to reduce the administrative and technical burden on insurers. For example, this might be achieved by creating automated systems for aggregating and analyzing diverse data sets, or by promoting standardization.

## 1-1-2 Provide an infrastructure that allows insurers to share health checkup and medical data, and reinforce collaboration among insurers

### Current Situation and Issues

While underlying diseases and symptoms differ from person to person, CKD often progresses gradually over years to decades, so it is important to provide long-term observation and intervention. However, when someone transitions between insurers (e.g. because they changed jobs or retired), it can create gaps in health checkup data that make it impossible to continuously monitor their health status. This is one structural issue for Japan's health checkup system and it is not limited to workplaces. Local governments cannot access health checkup data for residents who enrolled in or transitioned to NHI after retiring, leading to serious, long-standing issues when considering health measures for residents throughout the life course. There are cases in which prior consent from the person in question is necessary for data to be shared, or when individual arrangements must be made with multiple insurers to gather data due to a lack of a shared infrastructure that allows them to easily import past data from other insurers. These issues are causing difficulties for receiving insurers when incorporating prior health checkup data for individuals.

In addition, while insurers are responsible for utilizing data to approach beneficiaries (such as to recommend medical consultations), insurers lose contact with beneficiaries when they change insurers due to a job change or retirement. This occurs even when data is continuously linked across workplaces or between workplaces and local governments. Furthermore, even if employee health insurance providers strengthen preventive care for working-age employees, these efforts ultimately benefit the local governments to which those employees switch for insurance after retirement. This creates a mismatch between investments and benefits that makes it difficult to incentivize investments in prevention. Certain sectors have high internal job mobility, so an effective and feasible first step will be to establish frameworks for data-sharing and collaboration among insurers that cover the same sectors.

### Pathways to Solutions

Given the importance of long-term follow-up CKD measures, systems and an infrastructure that enable insurers to share data should be developed. When building that infrastructure, we must delve deeper into discussions for two perspectives: establishing connections in medical information, and utilizing Personal Health Records (PHRs). Regarding the former, data linking mechanisms are currently being established among some employers, insurers, and healthcare institutions (though these mechanisms do not link insurers). After a partial amendment to the "Enforcement Regulations of the Act for Promoting Comprehensive Measures for Securing Regional Medical and Nursing Care," plans are in place to create a framework in which employers will register workplace health checkup results into a shared system that insurers can access. With consent from employees, healthcare institutions will also be given access. In the area of specific health checkups, the Act on Assurance of Medical Care for Elderly People already establishes a mechanism for insurers to share information with each other using systems like the online eligibility verification system. We have high expectations for such mechanisms to be expanded to other fields.

In addition to mandatory items described in the Industrial Safety and Health Act, with consent from the person in question, PHRs can contain test data from voluntary programs and various other types of information. The promotion of PHRs through Mynaportal and other such platforms will provide a very effective method of ensuring continuity in health checkup data over time. However, a number of challenges must be overcome before insurers and local governments can utilize this data for providing consultation recommendations or conducting health programs. For example, citizen consent must be obtained and data use permissions must be set. It is our hope that the national Government provides overarching guidelines in a timely and proactive manner to help ensure that businesses that are part of circulating health checkup data can participate effectively in building this infrastructure as well as to efficiently promote public-private partnerships.

## 1-1-3 Design for data analysis and utilization from the data collection phase as a vital aspect of achieving evidence-based policymaking

### Current Situation and Issues

When external experts verify the effectiveness of health programs from local governments, one of the first challenges they encounter is the data collection method. There are cases in which data held by local governments is stored in a manner that makes it difficult to analyze without conversion. For example, basic information (such as the attributes of target groups for intervention, or intervention content) is sometimes stored in single cells as strings of text, with commas and line breaks. Such problems are caused by a lack of communication regarding appropriate data entry methods or the purpose of gathering data during the planning phase for data collection. Furthermore, even though "data" is an umbrella term, the characteristics of each data source vary. For example, as medical claims data was originally designed primarily for medical service fee claims and was intended to be printed on paper, it is not fully suited to secondary use. Conversely, the Diagnosis Procedure Combination (DPC) was originally designed for acute inpatient care, but with secondary use in mind, making it easier to use for purposes like research. As these examples show, it is important to select data sources that are appropriate to the objectives or measures when evaluating public health programs.

### Pathways to Solutions

Collecting data in analysis-ready formats will require developing tools and systems that enable the people who perform data entry in real-world healthcare settings and who are not specialists in data analysis to enter or collect data without excessive burden. Such collection will also require broadly informing people of data entry rules. For example, standardizing and unifying individual record formats for data that is mandatory for local governments to submit to the national Government will make it possible to harmonize data and perform comparative analysis across local governments. It will also be necessary to improve literacy among entities that collect and utilize data so they are informed of the characteristics and limits of each form of data, and are able to select and use the appropriate data for the intended purpose.

## 1-2 Redesigning policies and systems surrounding health checkups and encouraging post-health checkup care-seeking behavior

### 1-2-1 The national Government should specify calculation criteria and methods of determining evaluation indicators and corresponding funding measures so insurers can visualize and appropriately evaluate CKD initiatives

#### Current Situation and Issues

●Objectives and evaluation indicators for addressing health concerns are set in accordance with Health Data Plans for insurers and with Medical Cost Optimization Plans for local governments. However, the national Government has not set standardized methods for calculating evaluation indicators in CKD initiatives. As a result, each insurer and prefecture must independently develop ad hoc evaluation and calculation methods to verify if programs are effective and to determine if they should be continued. This creates burdens for people working in real-world healthcare settings and leads to concerns about the validity of the indicators they establish.

●There has been growing emphasis placed on the cost-effectiveness of insurer programs in recent years, but some programs are being kept in place simply to follow a precedent, even without sufficient evaluation of CKD measures. “Number of new dialysis patients” is often used as an outcome indicator for CKD prevention programs, but given the nature of CKD as a chronic disease and the extensive length of the predialysis phase, the effects of health programs that only last one year do not directly correlate with the introduction of dialysis. In other words, “number of new dialysis patients” is not always appropriate as a short- to medium-term evaluation metric.

●Insurers can establish and track metrics leading up to the process in which someone seeks a medical consultation. For example, they can track if people provided with consultation recommendations actually visit a healthcare institution, or if interventions for people who discontinued treatment led to reexaminations. However, they cannot track details that fall within the category of healthcare, such as what tests or treatments were provided after a medical consultation. This restricts insurers’ ability to accurately assess disease progression prevention or hospital-clinic collaboration.

#### Pathways to Solutions

●The national Government should prioritize setting standardized calculation methods for the key indicators that are essential for program assessment. Another major challenge is securing funding, especially for local governments. A program called the “Severe Diabetic Nephropathy Prevention Program” was successfully implemented after the national Government established fiscal measures and policy priorities through the NHI “Health Up” Initiative. Sources of funding for CKD initiatives may include the Insurer Initiatives Support System and points earned through the “Health Up” subsidy, but there is an urgent need for the national Government to determine how to best provide fiscal measures that are integrated with the presentation of indicators.

●Insurers must evaluate the current status of existing CKD programs and identify areas for improvement. When doing so, instead of only tracking the number of new dialysis patients, they must also consider outcome-based indicators that reflect actual health behaviors or stage of disease. These indicators may include behavioral changes (e.g. if consultation recommendations lead to care) or program impact on postponing dialysis onset. While rate of health checkup uptake is an evaluation metric for the Ministry of Economy, Trade and Industry (METI) Health and Productivity Stock Selection, that Selection does not fully reflect factors like implementation of follow-up or actual consultation-seeking behavior. In the future, it will be necessary to consider similar indicators in evaluation criteria for health and productivity management. As part of that, it may be effective to encourage the calculation and utilization of indicators like labor productivity, presenteeism, and absenteeism.

●While it will be important to perform evaluations and to track outcomes, insurers operate with limited human resources and budgets. To help insurers decide how much should be invested in a single initiative, it will be necessary for the Government to provide overarching guidelines on objective criteria for assessing cost-effectiveness.

## 1-2-2 Reshape the Insurer Initiatives Support System and the Penalty and Incentive System into effective evaluation and incentive systems

### Current Situation and Issues

●The Penalty and Incentive System in Medical Care Assistance for the Elderly Aged 75 and Over is an insurer performance evaluation mechanism that adjusts contribution amounts based on target achievement. However, because this mechanism collects funds from underperforming insurers to redistribute to high performers, the financial resources it needs to function as an incentive are effectively unsecured. It is difficult to argue that this mechanism is sufficient for encouraging insurers to proactively change their behavior.

●Under the Penalty and Incentive System in Medical Care Assistance for the Elderly Aged 75 and Over, the assessment of diabetic nephropathy is limited primarily to a process evaluation, namely, “whether or not measures were implemented,” and does not reflect the substantive effects or quality of the measures. In addition, in the Insurer Initiatives Support System, quantitative indicators such as “number of health guidance sessions provided” tend to be overemphasized in the point distribution. These structural issues are factors causing these systems to diverge from their original purpose of improving health outcomes.

### Pathways to Solutions

We hope that the review of the Penalty and Incentive System in Medical Care Assistance for the Elderly Aged 75 and Over scheduled for FY2027 will mark a shift away from the mechanism that relies solely on financial incentives in favor of diverse evaluation and incentive methods, including the introduction of an award system for high-performing insurers. Specifically, in addition to the number of interventions provided, CKD will require output indicators (such as if interventions actually led to medical care) and outcome indicators (such as maintenance or improvement of health status) similar to those in place for hypertension, diabetes, and dyslipidemia. At that time, it will be important to gradually build an effective framework with cross-sectoral consensus among stakeholders like local governments, workplaces, and healthcare professionals on overall design principles and resources to be invested.

## 1-2-3 Redesign specific health checkups and specific health guidance to encompass screening and intervention for CKD and other chronic diseases

### Current Situation and Issues

Specific health checkups and specific health guidance are likely to have a certain degree of effectiveness as CKD measures because they are widely implemented and because there is an overlap in CKD risk factors and the components of metabolic syndrome. However, in a study that analyzed changes in various metrics (body weight, waist circumference, blood pressure, HbA1c, LDL cholesterol, etc.) before and after specific health guidance for working-age men, despite mild improvements in body weight and waist circumference, there were no significant improvements in direct risk factors for CKD (such as blood pressure, HbA1c, and LDL cholesterol).[4] This finding does not negate the significance of specific health guidance itself. Instead, it suggests that the current health checkup system which focuses on addressing metabolic syndrome may have limited impact on independent risk factors such as blood pressure, HbA1c, and LDL cholesterol. Further consideration is necessary to redesign the health checkup system in an evidence-based manner that improves CKD risk factors.

### Pathways to Solutions

Taking into account the relationships between CKD and metabolic diseases, cardiovascular diseases, and metabolic syndrome, it would be fitting to discuss the positioning of CKD within the specific health checkups and specific health guidance system at the upcoming Study Group on Specific Health Checkups and Specific Health Guidance (Term 5). In addition to their conventional role within the framework of metabolic disease control, we must consider how specific health checkups and specific health guidance can function as measures that cut across various related diseases, including the serious national health challenge of CKD. After verifying which evidence-based intervention methods are effective in CKD initiatives, it will be important to obtain both a quantitative and qualitative grasp of obstacles in real-world clinical settings to identify necessary measures.

4) Fukuma S, Iizuka T, Ikenoue T, Tsugawa Y. Association of the National Health Guidance Intervention for Obesity and Cardiovascular Risks With Health Outcomes Among Japanese Men. JAMA Intern Med. 2020 Dec 1;180(12):1630-1637. doi: 10.1001/jamainternmed.2020.4334. PMID: 33031512; PMCID: PMC7536624.

## 1-2-4 Provide guidance on the utilization of private healthcare services to transform frameworks for health maintenance into a self-sustaining industry

### Current Situation and Issues

As there are limits to the burdens that local governments or insurers can bear, as well as to the medical resources that can be allocated to diseases with many potential patients like CKD, we must also consider utilizing healthcare services provided by private companies. However, even if evidence for preventive interventions is prepared, the question remains if developers can use that evidence as a resource for sustainable services. Another issue is if consumers (citizens), insurers, and employers will consider those services to be worthwhile investments. Simply having evidence in place while developers provide services will not be enough to sustain a market, so the challenge lies in how to connect frameworks for health maintenance to a self-sustaining industry. While some have suggested methods like forming a core revenue stream through investments in point-based incentives, the fact remains that it is difficult to achieve economic stability through healthcare tools alone.

### Pathways to Solutions

The formulation of national guidelines for the utilization of private healthcare services will be vital in overcoming this structural challenge. Beyond gathering evidence, the national Government should play a leading role in establishing frameworks that guarantee the sustainability and investment value of these services.

Perspective

# 02 Optimizing Health Checkup Operations and Subsequent Follow-up

Aiming to develop consultation recommendations that lead to behavioral changes among patients, affected parties, and citizens, this chapter presents key perspectives for local governments and workplaces on the need to operate health checkup programs and establish comprehensive standards for criteria and methods for consultation recommendations.

## 2-1 Standardize and eliminate inconsistencies in consultation recommendation criteria through cross-disciplinary discussions

### Current Situation and Issues

Criteria for providing consultation recommendations for suspected CKD based on health checkup results vary among relevant academic societies and government agencies. For example, criteria are not standardized across the Japanese Society of Nephrology's Evidence-based Clinical Practice Guideline for CKD 2023 (hereinafter referred to as the "CKD Clinical Practice Guidelines"), the Japan Society of Ningen Dock and Preventive Medical Care's FY2025 Criteria Table, and the MHLW's "Standard Health Checkup and Health Guidance Program (FY2024 version)." Individual local governments and workplaces decide which criteria to adopt, resulting in discrepancies that contribute to inconsistent practices among insurers and healthcare institutions, or among employers and their health insurance associations.

### Pathways to Solutions

Standardizing consultation recommendation criteria for people with suspected CKD is urgent for achieving equitable quality in post-health checkup consultation recommendations. Advancing discussions will require collaboration among nephrologists, primary care physicians, employers, insurers, government agencies, and other stakeholders involved in health checkups.

## 2-2 Reevaluate methods for identifying who is eligible for consultation recommendations and prioritize those whose treatment is more urgent

### Current Situation and Issues

The current CKD Clinical Practice Guidelines define consultation recommendation criteria in a uniform manner based on factors like age and test results, resulting in an overly broad eligible population. Staffing and cost constraints prevent both local governments and workplaces from providing sufficient consultation recommendations or adequate follow-up. Given the limited nature of healthcare resources, it is also unrealistic for healthcare institutions to refer all candidates to specialized medical facilities.

In addition, most health checkup report forms list results spanning several years. While this makes it possible to confirm changes over time, many insurers do not take those changes into account. Instead, they base consultation recommendation decisions solely on a single year's test results. This causes gradual increases in health risk over time to go unnoticed. As a result, if their current level does not meet referral criteria, even individuals at high baseline risk who experience a rapid decline in estimated glomerular filtration rate (eGFR) may be deemed ineligible for a recommended consultation. The existing framework is structured in a way that detects more eligible individuals than the healthcare system has capacity to handle while placing those who are truly at high risk in danger of being overlooked.

### Pathways to Solutions

It will be important to revise the consultation recommendation framework to move away from relying solely on age and a single year's test results and to identify high-risk individuals who require prioritization using evidence-based criteria. For example, people who have no history of care-seeking or with rapidly declining eGFR would be considered high-priority candidates. We must adopt a framework that stratifies such candidates in an evidence-based manner according to their characteristics and that provides consultation recommendations according to level of risk. To achieve this revision, it will be vital for academic societies in health checkups and kidney disease to collaborate on defining evidence-based criteria that can be used to categorize candidates while remaining easy for insurers to use. However, because target populations vary by insurer, the system should be designed to be flexible enough as to enable insurers to make decisions regarding its operations. In addition, those consultation recommendations should be evaluated and encouraged by incentivizing phased and efficient operations similar to the Penalty and Incentive System in Medical Care Assistance for the Elderly Aged 75 and Over.

## 2-3 Engage in communication to make consultation recommendations more effective

### Current Situation and Issues

●CKD is a disease that presents few symptoms and is not generally perceived as life-threatening. Given these characteristics, people living with CKD are less inclined to seek medical care in the early stages compared to those with other diseases. Not only is there insufficient recognition and awareness of CKD among citizens, there is also room for improvement with regard to how the condition is conveyed or addressed in consultation recommendations from insurers. In fact, there have been cases in which insured parties who received consultation recommendations misread the Japanese characters for "kidney" as "liver," as well as reports from real-world care settings that wording used by insurers in recommendations is too harsh. These examples highlight challenges in methods of conveying information or communication.

●How people respond to consultation recommendations varies greatly from person to person. While some people have high health literacy and can take action on their own, a certain number of people do not seek medical care even after repeated recommendations. Some members of the latter group are reluctant to seek care due to previous experiences in which they were not provided with appropriate care at a healthcare institution after overcoming the psychological barriers to seeking care. As such, it will not be possible to fully address this issue with a one-size-fits-all approach.

### Pathways to Solutions

●MHLW guidelines on specific health checkups titled "Providing Health Checkup Results and Other Necessary Information (Sample Sentences for Feedback)" state that individuals with urine protein levels of +1 or higher or eGFR below 45 should be encouraged to seek medical care, but insurers may not be making full use of those guidelines. Any changes made when standardizing consultation recommendation criteria should be reflected in "Providing Health Checkup Results and Other Necessary Information (Sample Sentences for Feedback)" and efforts should be made to ensure those criteria are widely disseminated and adopted in real-world clinical settings.

●We must shift to a stratified approach in which consultation recommendations are tailored to the characteristics of each target group. It will be particularly important to prioritize groups that are reluctant to change their behaviors and provide them with comprehensive support. Groups with high health literacy and who are more likely to take action can be approached through automated notifications utilizing tools introduced during digital transformation (DX) or Information and Communications Technology (ICT) initiatives. Efforts for groups who are less likely to change their behavior should involve collaboration with employers, and should cover potential employment restrictions should they continue going without medical care. People who exhibit strong feelings of reluctance toward medical care should be given time and individual attention from occupational physicians and other professionals using a personal approach that takes their backgrounds or values into account. Such efforts should begin with understanding narratives to grasp reasons for deprioritizing health.

**Reference**

Examples of effective communication strategies and methods shared during Advisory Board meetings are provided below.

- Provide members of the general public with easy-to-understand explanations, such as "The kidneys are made of blood vessels, and damage to those blood vessels leads to CKD. Similar damage to the blood vessels in the brain or heart can cause life-threatening conditions like stroke or heart attack. The two main causes of blood vessel damage are diabetes and hypertension, so treating those conditions helps treat CKD and cardiovascular disease."
- Improve the wording used in consultation recommendation letters and switch from letters in envelopes to pressure-sealed postcards.
- Have occupational physicians, occupational health professionals, or municipal public health nurses who are trusted, familiar faces provide consultation recommendations.
- Provide same-day consultation recommendations when health checkup results are obtained on the day they are performed.
- Display results of urine protein tests relative to the overall chart.

Perspective

# 03 Reinforcing Collaboration Between Insurers and Physicians/Healthcare Institutions and Standardizing Healthcare Provision

While insurers are continuously working to guide people with potential CKD to medical care through health checkups and health programs, there are many cases in which such people are told they do not need treatment once they visit a healthcare institution, even without detailed testing. There are also many cases in which people do not stay in contact with healthcare until the disease progresses. In some regions, public health nurses are conducting home visits to provide consultation recommendations or follow-up, but such efforts remain limited among many insurers due to human resource and time constraints. It is precisely because different entities are responsible for each stage in the process from health checkups, medical consultations, and post-consultation treatment and management that it will be vital to redesign CKD initiatives so that each of their roles are clearly defined and so the entire process is connected seamlessly. In this chapter, we will describe the ideal structure of collaboration between insurers and physicians (or healthcare institutions) and share measures for preventing severe CKD that will be necessary after those collaborative ties are in place.

## 3-1 Strengthen collaboration among local governments, workplaces, and physicians to ensure seamless follow-up care after health checkups

### Current Situation and Issues

If a patient whose health checkup detects an abnormality visits a health institution and is asked a question like, “Why did you come in for symptoms this mild?” by a physician, it can prevent them from feeling the significance of attending a medical consultation. Such experiences can cause people to lose trust in the entire consultation recommendation system. It has also been pointed out that there are lingering issues facing the systems that local governments and workplaces use for follow-up after providing consultation recommendations. For example, when occupational physicians or physicians performing checkups at outsourced healthcare checkup facilities refer someone to a department of internal medicine or another department for early-stage CKD, there are many cases in which patients are effectively sent back with instructions like, “Observe progress at next annual checkup.”

There are also times when it is not possible to obtain sufficient understanding or cooperation from physicians. For example, local governments have shared difficulties such as, “We receive negative responses from primary care physicians when people who receive consultation recommendations for CKD are already undergoing treatment for another condition, like hypertension,” or, “Although we asked local medical associations to cooperate in efforts to prioritize referring patients to specialists for the prevention of severe CKD, this initiative has yet to fully penetrate.”

### Pathways to Solutions

●It will be important to disseminate and share the information needed to enable primary care physicians to take appropriate action when seeing patients whose checkup findings suggest early-stage CKD. One effective method is to provide intensive training programs on health checkups to establish systems for post-checkup patient guidance to healthcare institutions providing specific health checkups. In some regions, primary care physicians who have completed CKD training are designated as “collaborating physicians,” and consultation recommendations are used to guide patients to their facilities. To reduce the burden placed on basic municipalities when implementing such programs, some prefectures certify and provide a list of collaborating physicians for local governments and employee health insurance providers to use when referring patients. In one good example, a local government and regional medical association collaborated to create a treatment pathway, demonstrating that collaboration between insurers and physicians (including parties like medical associations and local universities) can be effective for strengthening follow-up on consultation recommendations.

●The Japanese Society of Nephrology should collaborate with relevant stakeholders to develop “Manuals for Encouraging Action After Health Checkups” for each of the fields of primary care, health checkups, and occupational health. In addition to connecting people who receive consultation recommendations to appropriate healthcare, such manuals could serve as practical guidelines that help insurers and healthcare providers collaborate in providing follow-up. In addition to calling for the inclusion of serum creatinine testing, the report from the Study Group on Items Included in General Health Checkups Conducted under the Industrial Safety and Health Act also mentioned that “relevant academic societies should develop manuals to help occupational physicians and related parties manage individuals with abnormal findings.” It is safe to say that the need for manual development initiatives has been officially acknowledged.

●In one good example, a local government is seamlessly providing post-checkup consultation recommendations and health guidance through an intervention that combines secondary testing and health guidance. To provide consultation recommendations while removing obstacles to secondary testing, the local government provides residents whose urinary protein is positive or higher with vouchers for free quantitative urine tests at the local healthcare institutions where they underwent a specific health checkup. Regardless of the result, residents are provided with health guidance from public health nurses within three months of testing. Previously, residents had to pay 500 yen out of pocket, but after the tests became free, uptake increased to over 60%, demonstrating that combining financial incentives and personal follow-up can directly impact consultation-seeking behavior.

## 3-2 Intensify cross-disciplinary discussion and collaboration in guideline development and other such efforts to appropriately standardize physicians' responses following health checkups

### Current Situation and Issues

In addition to encouraging physicians to provide appropriate care to patients who visit in response to consultation recommendations, it will also be necessary to promote appropriate interventions for patients who are already being treated for CKD-related diseases. One issue that must be addressed is "clinical inertia." For example, this might occur when a primary care provider does not order additional tests, share checkup data, or adjust treatment for a patient with high blood pressure who is routinely prescribed the same medication, even after a health checkup has detected urinary protein or impaired kidney function. In such situations, transforming awareness and encouraging behavioral change among healthcare providers cannot be accomplished only through discussions among specialists, so it will be essential to reinforce collaboration with primary care physicians who provide routine medical care.

To date, academic societies have developed clinical practice guidelines based on expertise and evidence. As guidelines have conventionally been created through efforts led by societies specializing in specific organs, they tend to emphasize certain treatment management strategies. It has been pointed out that this emphasis may have caused other important perspectives to go overlooked, or that content may overlap or have discrepancies among societies. Furthermore, because it is not uncommon for patients to have multiple chronic diseases, and because health challenges change by life stage, there are an increasing number of situations where management is difficult with guidelines that focus on single organs or diseases. Patients with CKD are often treated by physicians who do not specialize in the kidney, and the fact that inconsistencies among clinical practice guidelines are resulting in inconsistent treatment strategies cannot be denied. We may be reaching the limits of what can be achieved through the conventional approach in which each academic society formulates separate guidelines for specific organs or diseases. The limitations of this siloed approach are particularly evident in the area of CKD, where the condition is associated with many chronic diseases and where countermeasures are closely linked to various stakeholders in areas from school health to workplace and community health, primary care, and specialized medicine.

### Pathways to Solutions

Realistic perspectives are essential for raising awareness among primary care physicians. In addition to nephrology, primary care physicians must complete training in a wide range of areas (including for conditions like dementia), and their time is limited. Taking the realities faced by primary care physicians into account, the medical community and Government should design efficient training programs that do not result in excessive burden and develop models for collaboration that primary care physicians can easily participate in.

It is crucial that we hold ongoing discussions on how to best achieve cross-cutting care that spans specialties as well as revise clinical practice guidelines to support care provided by physicians other than primary care physicians and nephrologists. When introducing those revisions, in addition to further delving into the advanced expertise that has been cultivated by each specialist academic society, there is a stronger need than ever before that we confirm that their criteria are acceptable and practical from the perspectives of other fields such as primary care and public health. Adopting this multifaceted awareness should become the standard for all specialist academic societies. In other words, their visions for clinical practice guidelines should not merely focus on delving deeper into each field in isolation. Rather, it will be important to expand those guidelines into platforms that span and connect disciplines while maintaining a high degree of expertise. We have reached a stage where we must ask how to ensure harmony among clinical practice guidelines in the future. Intentionally connecting fields by where they intersect is likely to help change awareness among healthcare professionals in various fields and provide seamless, cross-disciplinary care that patients can feel. In addition to supporting the provision of treatment in real-world clinical settings, clinical practice guidelines formulated with cross-disciplinary consensus can provide a shared foundation for collaboration among diverse stakeholders in policymaking. One possible approach in the future would be to reverse the roles and have primary care physicians lead guideline development while academic societies specializing in specific organs would be involved as advisors. Such an arrangement would result in CKD being positioned as a key disease within routine medical care for specialists in primary care, as well as make it possible to formulate guidelines that are tailored to real-world clinical practice and that combine expertise with a public nature. Discussions are divided on whether the overarching vision for guidelines should be presented by the MHLW or by specialist academic societies, but an important first step will be to form relationships and lay the groundwork for collaboration through exchanges of opinion in informal settings.

# Conclusion

Launched in FY2022, Health and Global Policy Institute (HGPI) Kidney Disease Project has held repeated discussions with multi-stakeholders representing industry, government, academia, and civil society, has developed research-based policy recommendations, and has hosted public symposiums and Diet Member briefings to build a track record of policy communication. One item that has become clear throughout the course of these activities is that multi-stakeholder collaboration from industry, government, academia, and civil society that cuts across sectors and diseases will be essential for addressing the national health challenge of CKD. As various organizations and settings are experiencing personnel and funding shortages, rather than leaving the entire burden to be shouldered by certain entities, stakeholders must draw out each other's strengths, maintain a mutual understanding of each party's role, and continue to demonstrate a willingness to cooperate and collaborate to achieve measures centered on patients and others with lived experience of health concerns. The accumulation of such initiatives is precisely what will lead to truly effective CKD measures that leave nobody behind. It is our sincere hope that these recommendations will contribute to future societal reform that builds a sustainable society where everyone can lead a healthy life.

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