HGPI Health and Global Policy Institute

Medical Practitioner Interviews on the Current State and Issues for Interdepartmental Collaboration in Clinical Practice for Chronic Kidney Disease Summary Report

June 2026

Health and Global Policy Institute

Overview of interviews and objectives

Since the launch of the Kidney Disease Control Promotion Project in FY2022, Health and Global Policy Institute (HGPI) has been advancing efforts to elevate public awareness of chronic kidney disease (CKD) and to build momentum for more effective and organic CKD control measures.

Over the past three years, HGPI has often heard about the importance of implementing CKD policies alongside policies for other diseases at expert meetings and when compiling good examples of CKD control from local governments. CKD can have mutual effects with cardiovascular and metabolic diseases, and these conditions often share preventive measures and treatments. For this reason, there are many cases in which local governments, businesses, and providers of employee health insurance implement measures for CKD in conjunction with measures for other non-communicable diseases (NCDs).

On the other hand, the main driver of progress in medical science has traditionally been specialization in particular organs or diseases, meaning that opportunities for collaboration are limited among professionals serving in real-world clinical settings as well as among academic societies or across specialties in academia. Promoting effective CKD control measures in the future will require further strengthening collaboration both among nephrologists themselves and between nephrologists and specialists in other fields.

Aiming to promote CKD control measures and cross-disciplinary medical treatment for CKD that cuts across fields, this report summarizes opinions gathered through personal interviews with medical practitioners and clarifies the current state and issues regarding interdepartmental collaboration in clinical practice for CKD. Please note that the content of this report reflects the personal opinions of the medical practitioners who lent their cooperation in our interviews and does not represent a consensus among all departments.

Survey method

Interviews for this survey were conducted with individual medical practitioners other than nephrologists (for details, please see the next section, “Interview participants”). After gathering medical practitioners’ statements on items such as awareness and routine practices for CKD in their respective departments, the state of collaboration with nephrology departments, circumstances regarding referral decision-making, and restrictions on handling CKD due to differences in clinical environments and regions, the content of those statements was recorded and organized by HGPI.

Interview participants

To encourage participants to offer frank opinions during interviews and to protect private personal information, this report does not publicly disclose the names of interview participants. The region where their workplaces are located,[1] the size of their affiliated medical facility, and their department(s) are as described below (in no particular order). The department names listed below are based on the fields of specialty or subspecialty recognized by the Japanese Medical Specialty Board (JMSB). [2]

Participant	Region	Medical facility	Specialty/subspecialty
Medical practitioner A	Southern Kanto	Clinic	General practice, primary care, nephrology, endocrinology and diabetes, palliative care
Medical practitioner B	Kyushu	Clinic	General practice, primary care, cardiology, palliative care
Medical practitioner C	Southern Kanto	Municipal hospital	Orthopedic surgery
Medical practitioner D	Northern Kanto	University hospital	Diabetes, metabolism, and endocrinology
Medical practitioner E	Southern Kanto	Municipal hospital	Urology
Medical practitioner F	Kyushu	University hospital	Diabetes, metabolism, and endocrinology
Medical practitioner G	Southern Kanto	Municipal hospital	Psychiatry
Medical practitioner H	Southern Kanto	Municipal hospital	Anesthesiology
Medical practitioner I	Southern Kanto	Clinic, municipal hospital, and university hospital	Otolaryngology

1 Workplace regions are organized in accordance with Regional Classification A as described by the Cabinet Office. Cabinet Office. “Regional Classification,” https://www5.cao.go.jp/j-j/cr/cr16/chr16_04.html

2 Japanese Medical Specialty Board (JMSB). “List of Specialties and Subspecialties,” https://jmsb.or.jp/ippan

While our interviews were conducted with the intent of gathering a diverse range of opinions to reflect the differences between departments or healthcare facilities of different sizes, there were certain limitations to the target population demographics due to a regional bias in participants' workplaces. Given these limitations, please note that the information summarized in this report is based on the experiences and views of interview participants and does not necessarily extend to all regions or healthcare provision systems.

Method used to organize statements from interview participants in this report

Participants' views and experiences on clinical practice for CKD varied depending on their fields of specialty and the sizes of the healthcare facilities where they were employed. Therefore, this report summarizes real-world circumstances and issues related to collaboration in clinical practice for CKD based on the following four department categories (classified independently by HGPI based on participant backgrounds) as well as on the size of healthcare facilities (clinic, hospital, etc.).

Four department categories used in this report

i. Departments with a high affinity for CKD treatment
(cardiology; diabetes, metabolism, and endocrinology; urology): Includes departments that are responsible for managing hypertension, diabetes, and other primary diseases or complications of CKD, and that must immediately refer patients to nephrologists when appropriate.

ii. General internal medicine
(general internal medicine; primary care): Includes departments that are expected to conduct CKD screening, provide initial management for mild CKD, and serve as gatekeepers that refer patients with advanced CKD to specialists.

iii. Departments outside of internal medicine that provide holistic management
(anesthesiology): Includes departments that work to prevent acute kidney injury (AKI) before and after surgery or adjust drug dosages while monitoring the burden placed on the kidneys.

iv. Departments focusing on specific body regions
(orthopedics, otorhinolaryngology, psychiatry): Includes departments where blood tests are not routine, but that must keep kidney function in mind during drug selection, use of contrast media, etc.

While the summary provided below has issues arranged by departments i. to iv. , because each department has its own perspectives, we are unable to provide comprehensive coverage of all issues for each department from i. to iv. . Furthermore, because categories may include several departments (e.g. category i. , which includes three departments), there are some differences in opinion, even for the same issues.

Table of Contents

1. Treatment of patients with kidney disease

1.1. Responses provided in each department category

i. Departments with a high affinity for CKD treatment

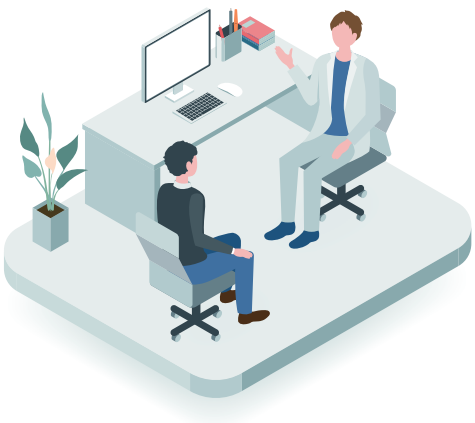
- These departments recognize CKD as a disease that affects many patients and that involves a combination of aging and lifestyle diseases. Based on this recognition, there are many cases in which these departments provide ongoing management directly to people with CKD who are not receiving maintenance dialysis or renal transplantation, and who are experiencing a chronic decline in kidney function alongside management for other diseases. That management includes lifestyle guidance, medication adjustment, and urinary protein evaluation.
- However, time is limited during outpatient visits, making it difficult for these departments to devote sufficient attention to every related disease in a single visit. In practice, even when a patient needs multiple interventions, there are limits to the amount of information patients can understand and process at once. These departments often only have time to provide sufficient information on a single item per outpatient visit, so in many cases, interventions for lower-priority issues are deferred.

iii. Departments outside of internal medicine that provide holistic management

- It is not uncommon for these departments to treat patients with CKD, and there are times when impaired kidney function is incidentally revealed by pre- or postoperative blood tests, even among patients without a CKD diagnosis. However, cases in which these departments proactively screen for CKD are extremely rare.
- On the other hand, some departments routinely test blood urea nitrogen (BUN), serum creatinine, and estimated glomerular filtration rate (eGFR) to check kidney function. Analgesics, antimicrobials, and many other drugs must be used with caution or in lower dosages when a patient has reduced kidney function. This is particularly important for drugs that are excreted through the kidneys, meaning that they limit the use of such drugs in patients with severely impaired kidney function. Given these considerations, patient treatment is altered according to the degree of kidney function impairment. When treating patients whose impairment is mild to moderate, the fact that drugs or procedures used during surgery do not often cause irreversible loss of kidney function is kept in mind. Conversely, for patients with severe kidney impairment and for whom surgery might lead to dialysis, consultations are held with their attending physician, nephrologist, urologist, anesthesiologist, and the patient and their family before the procedure. Adjustments are then made based on the patients' wishes. It is particularly difficult to arrive at a decision in cases where the patient strongly refuses dialysis immediately before its introduction.

iv. Departments focusing on specific body regions

- These departments do not recognize CKD as a condition they treat, and they practice under the assumption that CKD management is the responsibility of internists or nephrologists.
- While these departments base decisions regarding drug selection on test values related to kidney function when necessary, they do not actively screen for CKD.



1.2. Effective utilization of Guidelines*

*Here, the term "Guidelines" collectively refers to two guidelines presented by the Japanese Society of Nephrology: *"Evidence-based Clinical Practice Guideline for CKD"* and *"Clinical Practice Guidelines for CKD 2024."* Guideline titles will be clearly stated where required by context.

i. Departments with a high affinity for CKD treatment

The Evidence-based Clinical Practice Guideline for CKD 2023[3] has an easy-to-read layout, and it is freely available, making it easy to access. These departments refer to this Guideline when selecting drugs and assessing kidney function, and thereby make effective use of it in CKD treatment. They also voluntarily check for updated versions of the Guideline about once a year. When advancing treatment, they use the Guideline to check patients' CKD stages and standard treatment options, and refer to its "List of Problems" to confirm key principles of treatment and lifestyle guidance.

ii. General internal medicine

For medical practitioners who specialize in areas other than nephrology, the Evidence-based Clinical Practice Guideline for CKD 2023 is complex and difficult to use. As its content is generally best suited to nephrologists, physicians in clinics almost never use it. Instead, physicians in clinics tend to use Clinical Practice Guidelines for CKD 2024, which presents information in a simple, easy-to-understand manner using charts.

iii. Departments outside of internal medicine that provide holistic management

When problems emerge, these departments refer to current Guidelines on topics such as the use of drugs in kidney disease, AKI, and reduced kidney function. The Guidelines provide a basis for validating decisions when specialists are unavailable.

iv. Departments focusing on specific body regions

- One physician stated that they have never had a single opportunity to refer to the Guidelines or other clinical practice guideline on the kidney since their residency, and do not refer to such materials in routine medical care. In any field of specialty, it is generally more important that guidelines are comprehensive than easily readable.
- These departments are aware of the potential impact of analgesic use on kidney function. However, since analgesic use is highly dependent on whether a patient's chief complaint is pain, the extent to which these departments can prioritize kidney function in the prescription of analgesics is limited. As these departments must alter drug type or strength depending on the type or severity of pain reported by the patient, it is difficult for them to directly apply the ideal treatment for kidney function management indicated in Guidelines.
- While the Clinical Practice Guidelines for CKD 2024 were published for medical practitioners who are not nephrologists, "medical practitioners who are not nephrologists" applies to a wide range of medical practitioners, and it is difficult for them to all apply the same Guidelines to their respective clinical settings. In particular, there are points of incompatibility with the roles and characteristics of medical departments of physicians specializing in internal medicine but not nephrology, and of medical practitioners whose specialty is unrelated to internal medicine (such as otolaryngology or orthopedic surgery).

3 The Japanese Society of Nephrology has also released a condensed version of this guideline in English titled, "Essential points from evidence-based clinical practice guideline for chronic kidney disease 2023."

1.3. Collaboration among hospitals, clinics, and nephrologists

i. Departments with a high affinity for CKD treatment

- Frequent communication with nephrologists is not a part of daily practice, and there are many cases in which hospitals and clinics refer patients to nephrologists when it is necessary to determine the cause of a kidney-related issue or to provide specialized care. These cases include those in which the patient has a rapid decline in kidney function, needs specialized testing, or is expected to transition to dialysis. In real-world clinical settings, there are still many cases in which patients are not referred to nephrologists until their eGFR is below 30, and it is rare for them to be referred early on based on abnormal urinalysis findings or when they meet criteria for CKD stage G3a or G3b.
- A wide range of factors are taken into account when making decisions regarding referrals. In addition to eGFR level or rate of eGFR decline, and indicators like albuminuria, proteinuria, and hematuria, these factors also include patient age, comorbidities, and motivation toward treatment.
- In an aging society, the application of the Guideline's "eGFR less than 60" criterion causes many patients to meet the criteria for CKD, so the referral of patients to specialists based solely on numerical criteria is usually avoided. In practice, referrals are considered using various criteria including CKD stage 4 or higher, rapid decline in kidney function, and abnormal urinalysis results.
- In regions with too few nephrologists relative to the number of CKD patients, it is not realistic to refer every CKD patient who meets Guideline criteria to a specialist. In real-world clinical settings, attention is given to high-priority issues, and treatment related to the kidneys is often deprioritized.

iv. Departments focusing on specific body regions

When decline in kidney function has been detected, professionals serving in these departments make decisions regarding referrals to specialists primarily based on serum creatinine, eGFR, and age, as well as on their own clinical experience. In many cases, they do not go so far as to perform urinalysis. While patients with clear kidney function abnormalities are referred to specialists, those with mild abnormalities are often overlooked.

1.4. Obstacles to collaboration with nephrologists

i. Departments with a high affinity for CKD treatment

ii. General internal medicine *Shared for categories (i) and (ii)

Stable partnerships can be difficult to establish because the appropriate timing for referring patients to nephrologists is unclear. It can be also difficult for these departments to know the precise timing that a collaborating nephrologist feels referral is appropriate, as referring patients in early stages is sometimes perceived as "early," while waiting until after a certain period of observation is sometimes called "late." Furthermore, after primary care physicians make referrals, responses from specialists sometimes have abstract content. There are also cases in which nephrologists do not fully communicate specific details about diagnosis, the direction of treatment or management, or reasons for referring patients back to local medical facilities. Such deficiencies in two-way communication are hindering smooth collaboration.

iii. Departments outside of internal medicine that provide holistic management

When hospitals have no nephrologists on staff, it creates a psychological burden toward the consultation itself. There are also times when these departments hesitate before consultations because they are unsure if the specialists they intend to consult are available at the desired time.

iv. Departments focusing on specific body regions

- Collaboration with nephrologists is impersonal and unsystematic, and there is no well-defined process. The biggest obstacles are the lack of nephrology departments with which these departments regularly collaborate and the lack of clear information regarding the locations of nearby nephrologists or referral options. Because of these obstacles, it has become common practice to encourage patients to see their primary care physicians in general internal medicine to ask for referrals to specialists. Among certain clinics, there are many cases in which patients are provided with letters of referral and encouraged to find specialists on their own.
- For patients with certain disorders (such as psychiatric disorders), there are also cases in which the disorders themselves become obstacles to referral to nephrologists.

1.5. Measures for smooth interdepartmental collaboration

i. Departments with a high affinity for CKD treatment

ii. General internal medicine *Shared for categories (i) and (ii)

When problems emerge, these departments refer to current Guidelines on topics such as the use of drugs in kidney disease, AKI, and reduced kidney function. The Guidelines provide a basis for validating decisions when specialists are unavailable.If alerts were to automatically appear in electronic medical records when kidney function test results meet Guideline thresholds for specialist referral, it may lead to behavioral change. In addition, if notifications are only sent using push alerts, they tend to get ignored, so there should be frame-works that encourage people to check if patients are actually referred or not, and designs that compel referrals. Such designs might include a function to automatically display lists of patients who require referrals.

iv. Departments focusing on specific body regions

When problems emerge, these departments refer to current Guidelines on topics such as the use of drugs in kidney disease, AKI, and reduced kidney function. The Guidelines provide a basis for validating decisions when specialists are unavailable.It is unrealistic for departments in this category to directly refer patients with CKD or other internal diseases to specialists. These departments can only serve as patients' first point of contact with healthcare services, so the natural process is for these departments to encourage patients to visit departments that provide a wide range of initial care services (such as primary care or general practice) to receive referrals to specialists from there. Given this nature, expectations are high for efforts to examine interdepartmental referral systems centered on departments that provide initial care.

1.6. Collaboration with healthcare professionals other than medical practitioners

Collaboration with national registered dietitians

i. Departments with a high affinity for CKD treatment

As nutritional guidance is a necessary and effective tool for altering patient behavior, it is recommended whenever possible. Several measures have been implemented in the field of nutritional guidance to ensure effective counseling is provided. For example, for busy patients, there are flexible scheduling systems that allow for nutritional counseling to be held on the same day as medical appointments, or that have open slots set aside for walk-ins.

ii. General internal medicine

While few medical facilities have national registered dietitians on staff, nutritional guidance is effective in CKD management and is in high demand. Online nutritional guidance, in particular, is becoming a common option. However, despite understanding the importance of nutritional guidance, these departments tend to be less aware of the need to introduce nutritional guidance during the early stages of CKD.

Collaboration with pharmacists

iii. Departments outside of internal medicine that provide holistic management

- These departments do not regularly work with pharmacists as part of their everyday practice. While they sometimes communicate with hospital pharmacists when using drugs that affect kidney function, such communication only occurs once or twice a year.
- When further reinforcing the services provided by pharmacies and pharmacists, it will be necessary to consider developing laws and designing systems that cover responsibilities and the division of duties. For example, pharmacists could be entrusted with tasks related to determining drug dosage and therapy duration.

iv. Departments focusing on specific body regions

While some departments routinely consult pharmacists concerning the use of drugs that affect kidney function when conclusive evidence on those effects is unavailable, there are also departments that have few opportunities to consult pharmacists.

Areas lacking multidisciplinary cooperation

iv. Departments focusing on specific body regions

Nurses, pharmacists, national registered dietitians, and other such professionals in these departments have extremely limited experience collaborating for kidney disease and it is not common practice for them to be involved in multidisciplinary collaboration for kidney disease.

2. Actual conditions and challenges related to kidney disease treatment by size of medical facility (for clinics and hospitals)

While certain issues covered in the previous chapter were related to the size of the medical facility in question, this chapter summarizes the current state of kidney disease treatment and challenges that emerge when viewed against the backdrop of medical institution size, particularly for clinics and hospitals (including university and core hospitals).

2.1. The practicality of providing treatment according to Guidelines

At clinics

i. Departments with a high affinity for CKD treatment

ii. General internal medicine *Shared for categories (i) and (ii)

The Guidelines are well-organized but difficult to actually implement at clinics because they do not take laboratory equipment and time limitations into account. To overcome this issue, expectations are high for the development of simplified Guidelines that focus on what is necessary at the clinic level.

2.2. Handling of kidney disease patients in each department

At clinics

iv. Departments focusing on specific body regions

Since these departments rarely perform blood tests, they rely on self-reporting to understand patient kidney function. Such information is mainly obtained through patient questionnaires and verbal responses during medical examinations or when writing prescriptions. Additionally, these departments often overlook kidney function due to having few opportunities to measure it. Furthermore, because they do not have internists on staff, there are cases in which treatments are continued without sufficient assessment of systemic effects, and problems such as declined kidney function or drug-induced kidney injury are not discovered until later.

At hospitals

i. Departments with a high affinity for CKD treatment

- At university hospitals, CKD is seen as a very common disease and there is little recognition of CKD as a special condition. University hospitals generally recognize CKD as a disease to be managed by primary care physicians, and even when CKD is suspected in patients seeking treatment for other diseases, such patients usually do not receive direct referrals to in-house nephrology departments. This decision is based on the assumption that the primary care physician who referred the patient to the university hospital knows about the patient's kidney function and is providing management.
- The timing of referrals to in-house specialists varies depending on manpower at the facility. As university hospitals have many nephrologists, it is easy for them to provide referrals relatively early. Given this ease, some hospitals make referrals in a flexible manner, once at stages G3a to G3b, and then again after follow-up when necessary. Conversely, municipal hospitals have limited numbers of nephrologists and often only make referrals at stage G3b or later.

iv. Departments focusing on specific body regions

- In general hospitals, even departments that do not routinely take blood samples as part of daily clinical practice are prepared to do so quickly when necessary, making it possible for them to check kidney function during testing.
- Serum creatinine and eGFR levels are measured to confirm kidney function during preoperative testing and pre-chemotherapy evaluation. In particular, kidney function is always evaluated when using drugs that affect kidney function.

2.3. Obstacles to collaboration among nephrology and other departments

At clinics

i. Departments with a high affinity for CKD treatment

ii. General internal medicine *Shared for categories (i) and (ii)

- Given the affordability of kidney function tests, these departments feel little reluctance when outsourcing retesting. However, the chronic nature of CKD means it requires continuous hospital visits, so there are psychological hurdles to referring patients to other hospitals out of concern regarding patient leakage.
- Regional differences in clinical systems and numbers of nephrologists make it difficult to adopt and follow uniform referral criteria.

At hospitals

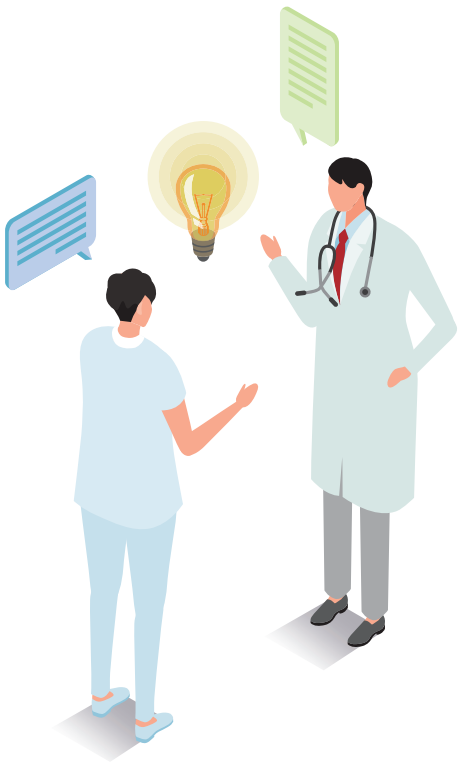
i. Departments with a high affinity for CKD treatment

ii. General internal medicine *Shared for categories (i) and (ii)

Hospitals lack in-house referral criteria and collaboration protocols for CKD. As a result, referral speed depends on whether or not a department is in regular contact with nephrology.

iv. Departments focusing on specific body regions

Even when systems for collaboration are in place and in-house nephrology departments are prepared to admit patients upon referral, nephrologists may be in high demand or have busy schedules, and consideration of these factors creates psychological hurdles for those who refer patients to nephrologists.



3. Opinions from medical practitioners who do not specialize in the kidney on desirable future actions for strengthening clinical practice for CKD

This chapter compiles suggestions on further strengthening clinical practice for CKD that we gathered from medical practitioners who do not specialize in the kidney. It also includes their expectations for parties such as the government, academic societies, industry, and medical facilities. Not all of the suggestions only apply to CKD treatment; they also include content or questions that span multiple disciplines. Such opinions apply to all fields of medical specialty and concern what knowledge medical practitioners who are not specialists in a particular field should acquire, and how medical practitioners can achieve effective collaboration with specialists in a cross-disciplinary manner to provide patients and other affected parties with the best care.

3.1. Expectations for kidney disease policy

3.1.1. Information provision

- Expectations are high for even more information to be disseminated to medical practitioners who do not specialize in the kidney. Cross-cutting collaboration among academic societies is likely to have a positive impact in the field of kidney disease treatment. Such collaboration might include having nephrologists share their expectations for kidney disease treatment from medical practitioners specializing in other areas at academic societies in other fields, or holding joint academic symposiums.

- CKD is an extremely common disease that affects many senior citizens, so the healthcare system cannot function with uniform standards for specialist CKD management (such as by requiring anyone whose eGFR is less than 60 to be immediately referred to a specialist). In addition, adopting the view that patients with CKD must be referred to a specialist as soon as possible may make it impossible for primary care physicians to provide adequate CKD management. The basic division of roles presented by the Japanese Society of Nephrology and in which primary care physicians lead CKD management and refer patients to specialists as necessary should be further promoted and made more concrete so that it is understood and implemented more widely in real-world clinical settings.

- There are aspects of standards for treatment or referral provided by academic societies and other such parties that are not always easy to implement in clinical settings due to differences in clinical systems or resources. While taking care to produce standards that all primary care physicians can observe, there should be regular collaboration and information-sharing among nephrologists, local governments, primary care physicians, and other such parties on how to best provide screening or treatment in accordance with local conditions.

3.1.2. Reinforcing data sharing and use based on actual clinical circumstances

- Because information on similar cases from other medical institutions describes specific individual cases, it can be difficult to generalize and link that information to decision-making in clinical settings. To address this issue, in addition to sharing individual case studies, expectations are high for the presentation of quantitative data on items such as nationwide prescription patterns or trends in the adoption of new drugs to enable cross-cutting comparisons of which drugs are being selected by kidney function stage or pathophysiology.

3.2. Improving information access and literacy in other fields of specialty: Current circumstances, efforts, and measures for improvement

Current circumstances

- After residency, medical practitioners have almost no opportunities to systematically learn about topics that do not closely relate to their specialties or daily practice, and few medical practitioners actively access information from other fields. The field of kidney disease is no exception.
- Many medical practitioners in general internal medicine specialize in clinical practice, and some have limited ties to an academic base. As a result, clinical guidelines or other treatment-related information from academic societies sometimes fails to reach them.
- In many cases, the materials that nephrologists create to disseminate information do not fit the contexts of other medical specialties. medical practitioners are interested in criteria that nephrologists actually use in clinical practice and other practical, real-world information that cannot be found in Guidelines, but such information is lacking.

Responses and measures for improvement

- Create opportunities for medical practitioners in each department to engage with information outside of their areas of expertise on a regular basis by sharing it through sources they frequently consult. The following list includes examples of such information sources. Please note that use of these sources may vary by age group.
  - Academic societies in specialized fields (including academic conferences and journals)
  - Study groups hosted by pharmaceutical companies
  - Personal networks (e.g. fellow medical practitioners, medical representatives (MRs) of pharmaceutical companies)
  - Feedback from specialists on treatment progress for referred patients
  - Social networks (e.g. posts on the personal accounts of medical practitioners in related fields or the official accounts of academic societies)
  - Online information services for medical practitioners
  - Search engines or generative AI
- medical practitioners need forums for sharing knowledge that is based on actual clinical experience. Rather than lectures that focus on academic explanations, there is demand for regular seminars (streamed in real time using chat functions or on-demand for limited periods) where medical practitioners would talk about specific decisions and share examples of ingenuity from routine clinical practice.
- Given the importance of “who transmits information to whom,” it will be necessary to create secondary guidelines from the perspectives of departments that want to convey information. It will also be important to transmit information from services or organizations that have ties to medical practitioners through multiple channels. Examples of such guidelines might be, “Essential Nephrology Knowledge for Otolaryngologists,” or “Key Points for Orthopedic Surgeons when Prescribing Painkillers: CKD Version.”
- Establishing and utilizing an official platform consolidating information on seminars and workshops from multiple academic societies would also be effective.

Acknowledgements

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This Survey Report was compiled by HGPI in its capacity as an independent health policy think tank based on interviews with medical practitioners who endorse our activities in this area. It does not in any capacity represent the opinions of those experts or any related party, nor of the organizations to which they are affiliated.

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We continue to present effective health policy options and advance efforts to address health and medical challenges, not only in Japan, but on a global scale.

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