Pain Policy Series

Policy Recommendations on Migraine

— Toward the Diffusion of Innovation for People Living with Migraine —

Health and Global Policy Institute (HGPI)

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Executive Summary

Migraine is a major public health condition affecting approximately 8.4 million people aged 15 and over in Japan. In reality, however, it continues to be socially trivialized as “a headache that anyone gets,” and many patients remain without specialized diagnosis or treatment, chronically repeating self-management with over-the-counter analgesics—a state of clinical inertia. The epidemiological characteristics of migraine—female patients outnumbering male patients by roughly 3.6 to 1, with cases concentrated among people in their 30s and 40s at the peak of their working lives—link migraine measure to national policy agendas such as the advancement of women, labor productivity, and countermeasures to the declining birthrate.

These recommendations were developed by integrating findings from expert interviews with three migraine specialists conducted by the Health and Global Policy Institute (HGPI), an ethnographic survey of two physicians and two patients each who were proactive and not proactive about migraine treatment (four people in total), and a review of the international literature. What these investigations brought into relief was the structural mechanism of a robust clinical inertia formed by the overlapping of “rational choices” made by patients, healthcare providers, and the healthcare system respectively. Breaking through this structure requires not merely awareness-raising activities but cross-cutting and comprehensive policy interventions spanning medical fee schedules, the education system, legal frameworks, and industrial policy.

In advancing migraine measures, it is necessary to take into account four perspectives: (1) Burden (the burden on patients: the suffering caused by pain and its interference with daily life and work); (2) Awareness (the strikingly low level of disease awareness); (3) Stigma (misunderstanding and social stigma); and (4) Advocacy (promoting understanding of and support for migraine). Migraine measures are an important policy agenda that contributes to extending healthy life expectancy, improving productivity, supporting women’s participation in society, and further improving quality of life through better brain health.

Clinical inertia in migraine care remains at a standstill and has yet to begin moving. Thanks to progress in headache research, Japan is not behind Europe or the United States in the approval of new drugs, but the advancement of the underlying headache care infrastructure remains delayed. Because migraine care revolves around patients’ subjective symptoms, it is a field that can only develop together with the promotion of patient-centered and patient-participatory medicine. In order to raise national awareness of migraine, we make the following eight policy recommendations, focused on the importance and ROI of education (for citizens, primary care, and specialists), regional collaboration, health and productivity management, improved access to new drugs, and more efficient public administration.

First, institutionalizing migraine and headache education in school education; second, developing a systematic referral pathway from primary care to specialists; third, revising the medical fee schedule so that specialized headache care is appropriately valued; fourth, strengthening the incorporation of migraine measures into corporate health and productivity management initiatives; fifth, improving access to new therapeutic agents and reducing economic barriers; and sixth, establishing an implementation structure within government and a legal basis for it. These six recommendations are intended as an integrated policy package whose elements complement one another, aiming at substantive progress in migraine measures.

Chapter 1 The Current State of Migraine and the Challenges It Poses

1-1 The Disease Burden of Migraine and Its Social Impact

Migraine is a chronic neurological disease characterized by recurrent severe headache attacks. Globally, an estimated 1.1–1.2 billion people are affected[1], and over the 30 years from 1990 to 2021 both the absolute number of people affected and disability-adjusted life years (DALYs) increased by approximately 58%[2], raising international recognition of migraine as a major global public health issue. The prevalence in Japan corresponds to approximately 8.4% of the population aged 15 and over, estimated at some 8.4 million people[3]. The sex difference is striking, with the number of female patients reaching roughly 3.6 times that of male patients. Prevalence is highest among women in their 30s and 40s[4]—precisely the generation at the core of society, bearing the burdens of work, child-rearing, and caregiving. This means that migraine measures are closely interlinked with policies to advance women's participation in society and to address the declining birthrate.

From the perspective of economic loss as well, the social burden of migraine is enormous. In the United Kingdom, for example, the total annual productivity loss due to migraine is estimated to exceed £8.8 billion[5]. According to an in-house survey by Fujitsu, the annual labor loss per employee due to headache amounts to approximately ¥100,000, equivalent to about 1% of the company's total payroll—a figure that corporate management cannot ignore[6]. Furthermore, when broken down by headache type, the economic loss attributable to the migraine type is the largest, with significantly more days on which work efficiency fell to less than half of normal compared with the tension-type headache group[7] (ref). Between 59.4% and 71.8% of migraine patients have never consulted a physician, and only 1.3% to 7.3% attend medical appointments regularly. Moreover, given the reality that only 11.6% of patients are aware that they have migraine[8,9], the scope for improving productivity losses through appropriate therapeutic intervention is extremely large. It should also be noted that even among those under 15, migraine prevalence has been shown to reach 9% (Saitama City survey, 2019); adding children to the 8.4 million people aged 15 and over brings the total migraine population to an estimated 10 million. Migraine is by no means an adult-only problem; it is a disease that requires early response from childhood.

In addition, migraine has a bidirectional relationship with anxiety disorders and depression, imposing a compound burden across both mental and physical health. In adolescence there are not a few cases in which it causes school non-attendance, and in severe cases it has been confirmed to seriously affect children's ability to continue their studies and their choice of career path. A longitudinal study in Norway showed that approximately 19% of adolescents who experienced frequent headaches once a week or more remained in the same state 14 years later[10], providing international evidence for the importance of early intervention.

1-2 The Structural Mechanism of Clinical Inertia

One of the difficulties of headache care is that most symptoms are subjective—known only to the patient—and are not easily visualized or evaluated objectively. As a result, under beliefs such as "it's just a headache, so painkillers will do," "if the MRI shows nothing abnormal, there's nothing wrong with my brain," and "my family lives with headaches too," many

patients give up on seeking care or on continuing treatment, endure the pain, and sometimes end up overusing analgesics.

Taken together, the findings of the expert interviews and ethnographic survey conducted in this project made clear that, in migraine care in Japan, a structure of clinical inertia spanning three layers—patients, healthcare providers, and the healthcare system—functions in a mutually reinforcing manner. This structure arises when the "rational choices" made at each layer combine under particular institutional conditions, and it is robust enough that simple awareness-raising alone cannot break it down.

(1) Barriers on the Patient Side That Prevent Seeking Care

Multiple interrelated factors lie behind patients' failure to visit a medical institution, or their discontinuation of care. First, migraine has a strong genetic predisposition, and for patients who have seen family members' headaches as an "everyday occurrence" since childhood, their own symptoms tend to be perceived not as a disease but as "an ordinary headache that anyone gets." The continued ability to "get by" during attacks with over-the-counter analgesics removes the motivation to seek care, and there are even cases in which patients use OTC drugs on a daily basis without recognizing this as a problem. Such chronic use of OTC medication itself carries the serious risk of causing medication-overuse headache (MOH). MOH is one of the core pathological states of chronic migraine and has the paradoxical structure whereby analgesic use beyond a certain number of days per month actually makes headaches more refractory and chronic. Leaving unaddressed the clinical inertia in which patients keep getting by on OTC drugs can lead, via MOH, to a worsening of the disease state—and herein lies the rationale for why early connection to a specialist is clinically indispensable.

Even more serious is the "paradoxical structure" in which patients who have finally sought care drop out of treatment. In this ethnographic survey, it was confirmed that both interviewed patients shared the experience of visiting a neurosurgery department, undergoing MRI, and being told there was "nothing abnormal"—an experience that became the trigger for dropping out of treatment. Because migraine attacks recur intermittently, they do prompt patients to seek care, but at the time the MRI is performed an attack is not necessarily ongoing, and no abnormality appears on the images. Since neurosurgery is a department whose core function is the diagnosis and treatment of organic diseases such as cerebral infarction and cerebral hemorrhage, a finding of "no abnormality"—which should by rights be a relief—instead accumulates for the patient as an experience in which the question "why does this pain continue?" is left hanging, leading to distrust of medical care and withdrawal from treatment.

(2) The Structural Rationality of Non-Proactive Care by Non-Specialists

There are several rational reasons why non-specialists do not intervene proactively when patients ask for headache medication as an "add-on" during regular visits to internal medicine or dermatology. The internal medicine physician interviewed for this study (one not proactive about migraine treatment) candidly explained that migraine is outside his specialty; that

proactive intervention from a non-specialist position entails risk; that providing detailed lifestyle guidance does not change reimbursement under the medical fee schedule; and that even when lifestyle guidance is given, patients cannot remember it, so he judged its effectiveness to be low. If a patient asks for “headache medicine, please,” there is no reason to refuse, and it is prescribed. This is the structure that stably sustains a pattern of care in which medication is received “on the side,” and as the rationality of both parties meshes together, therapeutic stagnation reproduces itself.

Problems in the medical fee schedule further reinforce this structure. Appropriate examination of migraine requires 15 to 30 minutes of consultation time, including history-taking, interviewing, and lifestyle guidance, yet the current fee schedule contains no add-on payment commensurate with that time. As a result, a distortion arises whereby it is more economically rational to see many patients in a short time and prescribe painkillers, and this continues to strip physicians of the motivation to engage in specialized headache care. In addition, the extremely limited opportunities to encounter migraine in medical school education and initial postgraduate clinical training structurally produce a lack of knowledge and experience among primary care physicians. Initial clinical training focuses mainly on inpatients, and there is almost no opportunity during the training period to accumulate experience in treating migraine, an outpatient chronic condition.

(3) How Connecting to a Specialist Changes the Patient’s World

This survey also offers important insights into the conditions under which this structure of stagnation collapses. The interview with a patient proactive about migraine treatment revealed a transformation in which, after encountering a headache specialist, migraine was redefined from “uncontrollable pain” into “a chronic disease that can be predicted, managed, and coped with in one’s own way.” Three conditions had to converge for this transformation. The first was the experience, through consultation, of feeling that “my pain was understood”—which, in contrast to earlier experiences of “nothing abnormal” and “it’s only a headache,” becomes the foundation of a trusting relationship with the physician. The second was trial and error with medications premised on that trusting relationship; the proactive patient tried as many as 11 different drugs under a trusted specialist and ultimately arrived at an optimal combination including a CGRP-related antibody drug. The third was the visualization of pain through a headache diary, which functions as a tool with which patients themselves construct provisional answers to the question “why is this pain happening now?” and makes it possible to identify triggers and revise treatment plans.

In the interview with the physician who was proactive about treatment, the role of the headache diary was likewise emphasized repeatedly. Changes in daily life that patients find hard to articulate verbally—for example, sleep deprivation caused by a pet’s illness, the burden of caregiving, or stress at work—are recorded in the diary, and by reading and interpreting it the physician can deepen the dialogue of consultation and refine the treatment plan. This accumulation, in turn, cultivates a sense in which patients, rather than living through headache-free periods with the anticipatory anxiety of “when will the next headache come?”, understand their own pain patterns and manage them proactively. The shift from a life dictated by pain to a life in which one can manage one’s own pain is precisely the essential goal of migraine treatment.

At the heart of migraine care lies the perspective of “patient-participatory medicine.” Much about headache can be known only by the patient, and an attitude of learning from patients is indispensable in clinical practice. The headache diary in particular is an important tool that visualizes the degree of pain, treatment effects, and impact on daily life, and it also plays a role in raising patients’ own self-care awareness.

Chapter 2 International Trends and Japan's Position

2-1 The Shift in Global Problem Recognition

Migraine has long been treated as "a personal problem" or "only a headache," but recent international trends are fundamentally transforming this perception. Headache clinical guidelines recommend considering preventive therapy when a patient has two or more attacks per month, or headaches that interfere with daily life on three or more days per month; although a considerable share of migraine patients meet these conditions, it has been reported that only 3–13% actually use preventive medication[11]. This treatment gap is now internationally recognized not merely as a problem of individual care-seeking behavior but as a structural issue of the healthcare system, encompassing disparities in access to care, inadequate diagnostic systems, and a lack of physician education[12]. International movements centered on the International Headache Society (IHS) and GPAC (Global Patient Advocacy Coalition for Headache) are appealing to governments to make overcoming the "treatment gap" a policy agenda, and progress is being made simultaneously on three fronts: academia, patient advocacy, and policy.

The CaMEO-I study (Lanteri-Minet et al., 2024), conducted in six countries centered on Europe (Canada, France, Germany, Japan, the United Kingdom, and the United States), quantitatively demonstrates the severity of this problem[13]. Of 8,330 migraine patients judged to require support, only 35.1% were currently under the care of a healthcare professional. Furthermore, only 23.0% of the total had cleared the two barriers of consulting a professional and receiving an accurate diagnosis, and merely 11.5% had cleared all three barriers of consultation, diagnosis, and treatment to receive minimally appropriate pharmacotherapy. Limiting the analysis to chronic migraine, the situation is even more serious, with only 7.3% clearing all three barriers. In cross-country comparison, Japan's diagnosis rate was statistically significantly lower than that of the United States, with international data thus corroborating the delay in migraine care in Japan.

2-2 Advanced Initiatives Overseas and Implications for Japan

One example of advanced international practice is the standardization of stepwise treatment according to severity. The IHS and the AHS have established treatment algorithms corresponding to attack-frequency stages—low-frequency (episodic), high-frequency episodic (frequent episodic), and chronic migraine—and the implementation of guidelines on determining eligibility for preventive therapy and on drug selection is progressing in various countries. That said, as CaMEO-I showed, the actual care gap remains large, and it should be noted that the dissemination of guidelines does not directly translate into uniform quality of care[14].

With respect to access to CGRP-related antibody drugs, Europe and the United States have moved ahead in establishing insurance reimbursement systems. This drug class delivers effects for patients with chronic and refractory migraine that could not be obtained with conventional agents, and as the proactive patient interviewed in this study put it—"my life changed"—its clinical significance is extremely great. Insurance coverage has been realized in Japan as well, but as a survey of members of the Japanese Headache Society (2024)

shows, cost accounts for approximately 28% of prescription requests and approximately 24% of reasons for discontinuation, making cost the greatest limiting factor[16]. In Japan, statutory benefits (the High-Cost Medical Expense Benefit system) are common to all insurers, but the supplementary benefit schemes voluntarily established by health insurance societies and mutual aid associations do not exist under National Health Insurance. For high-cost drugs such as CGRP-related antibody drugs, the presence or absence of these supplementary benefits creates large differences in patients' effective out-of-pocket costs, giving rise to a de facto access disparity between employees of large corporations and freelancers, non-regular workers, and the self-employed.

International interest is also growing in social approaches delivered through workplaces and schools. A longitudinal study in Norway showed that approximately 19% of adolescents who experienced frequent headaches once a week or more remained in the same state 14 years later[10], and as data suggesting the need for response at an early stage before headaches become chronic, this provides grounds for supporting the policy introduction of headache education in schools. In addition, an International Headache Advocacy Summit hosted by JPAC (Japan Patient Advocacy Coalition) is scheduled to be held in Osaka in November 2026, and it is hoped that this will be used as an opportunity to grasp international patient advocacy trends and deepen collaboration.

Viewed against these international trends, Japan's current situation lags behind in the following respects. The absolute number of headache specialists remains insufficient, and in the expert interviews several specialists pointed out that accelerating the training of specialists is an urgent task. Diagnostic and referral systems in primary care are undeveloped, and organized headache education in schools and workplaces has only just begun. There is no administrative department with cross-cutting jurisdiction over chronic pain and headache measures, and the institutional foundation for sustained policy promotion is lacking. Concrete policy recommendations for resolving these issues are presented in the next chapter.

Chapter 3 Policy Recommendations

Based on the above analysis of the current situation and international comparison, the Health and Global Policy Institute makes the following eight policy recommendations. These are designed as an integrated package whose elements complement one another; rather than implementing individual measures in isolation, the greatest effect can be expected when schools, workplaces, medical institutions, and government work together.

Recommendation 1: Promoting Public Awareness Across Society and Raising Disease Awareness

The foundation of every measure against migraine is a correct understanding of migraine by patients themselves and by society as a whole. The clinical inertia that these recommendations have repeatedly pointed out is rooted in the perception—widely shared among patients, healthcare providers, and society—that migraine is "only a headache" or "a pain that anyone has," and unless this perception is transformed, individual measures cannot be fully effective. It is necessary to spread, as a shared understanding across society, the facts that migraine is a treatable disease and that appropriate care-seeking and continuous management can greatly improve quality of life.

Awareness-raising requires different channels and content depending on the target audience. Outreach to children, guardians, and school staff through school education (Recommendation 2) and awareness-raising for employees in companies (Recommendation 4) are representative examples, but in addition to these, continuous information dissemination aimed at the general public not affiliated with any particular setting is indispensable. Through public lectures for citizens, collaboration with the media, and the development of trustworthy online information sources, accurate knowledge of migraine and motivation to seek care must be made to permeate society.

To ensure that such awareness-raising does not end as a sporadic effort, it is important for the national government to clearly designate the entity responsible for driving it. Centering on the relevant department of the Ministry of Health, Labour and Welfare (Recommendation 8), continuous awareness-raising in collaboration with relevant academic societies and patient organizations should be positioned as a national undertaking, and a structure should be put in place to advance it while continuously tracking progress in raising awareness.

Recommendation 2: Institutionalizing Migraine and Headache Education in School Education

According to the expert interviews, approximately 90% of adolescent headache outpatients are already severe at the time of their first visit, and more than 20% of them are in a state of school non-attendance[15]. In a school-wide lecture questionnaire conducted at a private girls' school in 2025, 8% of respondents had headaches every day, and 89% of those respondents answered that "my life now would be better if I did not have headaches." Through the expert interviews it became clear that although

"complaints of headache" are the most common reason for repeated visits to the school nurse's office, no clear guidance exists on the timing at which the school nurse (yogo teacher) should recommend seeing a physician. If patients can be connected to a specialist early, there is the possibility that their condition improves before expensive medications become necessary, which also carries great health-economic significance.

It is also important to disseminate knowledge that ensures the quality of initial response in the school nurse's office. The expert interviews pointed out the reality that even when students visit the nurse's office with a headache, they are frequently sent home after a fixed period (generally about one hour). Unlike in adults, migraine in children often resolves in about two hours, and if an environment is created in which students can rest appropriately in the nurse's office, benefits can be expected such as return to class (avoiding unnecessary early departure), suppression of analgesic overuse, and avoidance of being mistakenly regarded by those around them as avoiding school or being truant after returning home. Practical guidance, including a benchmark for rest time, should be developed so that school nurses can understand the natural course of pediatric migraine and respond with recovery through rest in mind.

Furthermore, education for school physicians and school pharmacists—the health professionals of school health—must be clearly positioned separately from awareness-raising for teaching staff. Because these professionals differ from teaching staff in both role and approach, and are positioned to engage in school health on the basis of medical and pharmaceutical expertise, the content of the knowledge required and the channels of outreach should also be designed independently. School physicians can play a role in identifying students who complain of headaches through health check-ups and health guidance and, where necessary, connecting them to specialist care. School pharmacists, for their part, can advise on appropriate use so that students and guardians do not fall into overuse of over-the-counter analgesics, thereby contributing to the prevention of medication-overuse headache (MOH). Establishing a system in which school physicians and school pharmacists are equipped with the latest knowledge on pediatric migraine and can respond in coordination with school nurses and homeroom teachers is an indispensable element in making schools the front line of early detection and intervention.

The key to headache education in schools lies in a tripartite approach that targets students, teachers, and guardians simultaneously. Because children cannot seek medical care on their own, it is essential that guardians recognize migraine as "a disease that should be treated"; and teachers having the knowledge to encourage appropriate care-seeking rather than misconstruing it as "slacking off" fundamentally changes children's care-seeking behavior. The Japanese Headache Society is planning, for example, a nationwide project in which its members (approximately 1,150 people) give lectures at their own alma maters, but for dissemination to public schools, explicit inclusion in the Courses of Study of the Ministry of Education, Culture, Sports, Science and Technology is indispensable as an institutional foundation. What is required is to put in place an institutional framework that positions schools as the front line of early detection of and intervention in migraine—including epidemiological surveys conducted with the involvement of boards of education, the creation and distribution of manuals for school nurses on recommending medical consultation, and, in the future, the development of

content for elementary school students.

The development of clinical guidelines for pediatric headache is also an urgent task. At present there are no standard clinical guidelines targeting children, and school nurses, guardians, and family physicians are forced to respond according to their own individual judgment. Alongside guideline development, it is necessary to strengthen associations of school nurses and parents' associations and to build concrete collaborative arrangements with administrative bodies such as boards of education.

Recommendation 3: Developing a Systematic Referral Pathway from Primary Care to Specialists

Regarding where migraine patients first seek care, a large-scale study using Japanese claims data (Takizawa et al., PLOS ONE, 2024) found that internal medicine accounts for 44.4% and neurosurgery for 25.9%, with visits to headache specialists remaining a small minority[17]. In addition, according to the OVERCOME Japan 2nd Study (Suzuki et al., 2025), only 26.7% of patients who first consulted a family physician subsequently transitioned to a specialist, with the great majority continuing to be managed by their family physician[18]. To break the "stagnation produced by two rationalities" revealed by the ethnographic survey—patients' orientation toward self-management and non-specialists' rational reticence—developing a pathway by which primary care physicians can refer to specialists with confidence is an effective structural solution. The moment when a neurosurgery department communicates "no abnormality" is both the timing at which patients are most likely to drop out of treatment and the intervention opportunity at which appropriate information provision and referral to a specialist outpatient clinic can function most effectively. It is important to harness this paradox in policy terms and to build referral at the point of "no abnormality" into standard clinical procedure. Moreover, more than 80% of women with menstruation-related headaches who meet the criteria for migraine or suspected migraine manage on their own with over-the-counter drugs, and only 15.5% have ever visited a hospital. Designing referral pathways that use the timing of gynecology visits as an opportunity for migraine screening is especially important as a way to improve access for women patients who have been overlooked. Similarly, a mechanism whereby pharmacists recommend medical consultation to patients who frequently purchase over-the-counter analgesics at pharmacies could be an effective approach that also reaches non-regular workers, full-time homemakers, and older people for whom access to medical institutions is difficult. In particular, patients who repeatedly purchase over-the-counter analgesics on 10 or more days per month are at high risk of medication-overuse headache (MOH), and having pharmacists focus on purchase frequency to advise on appropriate use and, where necessary, recommend medical consultation serves as a front line of MOH prevention. Recovery from MOH decisively requires the introduction of preventive medication and management by a specialist, and pathways that detect OTC overuse early and connect patients to specialist care must be established. Furthermore, to eliminate access disparities in regions with no headache specialists, the use of online medical care (applied after screening for secondary headache) and the standardization

of a collaborative model that returns post-diagnosis management to the family physician are realistic and effective responses. Migraine measures need to be promoted as "integrated care" in which self-care, primary care, specialist care, the workplace, and government work together.

To make such collaboration possible, the perspectives of "patient-participatory medicine" and "patient-centered medicine" are indispensable. In particular, visualization of symptoms using a headache diary promotes patients' own understanding of their disease and dialogue with healthcare providers, and becomes an important foundation supporting appropriate continuation of treatment. It is also necessary to achieve smooth connection to specialist care through regional healthcare collaboration (hospital–clinic and clinic–clinic collaboration).

In addition, to strengthen the functions of specialist headache outpatient clinics, it is effective to train and institutionalize not only physicians but also headache specialist nurses ("headache nurses"). By taking on assistance with history-taking, instruction in the use of headache diaries, patient education, and support for continued care-seeking, headache nurses raise the efficiency of specialists' practice while also supporting the building of continuous relationships with patients. Furthermore, it is necessary to build an integrated model that organically combines smartphone-app-based support for self-diagnosis and self-management of headache with online medical care. Such a mechanism would provide the foundation for patients to remain continuously connected to appropriate care even in regions where access to headache specialists is difficult.

Recommendation 4: Appropriate Valuation of Specialized Headache Care Through Revision of the Medical Fee Schedule

Among the structural factors behind clinical inertia, distortions in the medical fee schedule are the most fundamental and the most urgently in need of correction. Appropriate migraine care requires 15 to 30 minutes of consultation time at the initial visit, including detailed history-taking, interpretation of the headache diary, lifestyle guidance, and explanation of the treatment plan, yet the current fee schedule has no mechanism for valuing that time and effort. Care that makes use of a headache diary has important medical significance in that it continuously visualizes the patient's symptoms, QOL, and treatment response and promotes the patient's own self-care behavior. At the same time, reading, evaluating, and adjusting treatment plans on that basis requires a commensurate investment of physicians' time and expertise, and appropriate valuation under the fee schedule is therefore required.

As was also pointed out in the expert interviews, as long as the situation persists in which "it is more economically rational to prescribe painkillers in short consultations," there are limits to what awareness-raising and educational programs alone can do to change physicians' behavior. Designing incentives through the medical fee schedule is the most powerful policy instrument for structurally changing physicians' clinical behavior.

Specifically, although detailed history-taking for migraine and evaluation of headache

diaries require far more time and specialized knowledge than an ordinary outpatient consultation, the current outpatient management add-on fee (52 points) does not appropriately reflect this. The creation of a time-based add-on for history-taking and evaluation at specialist headache outpatient clinics, and the establishment of a valuation framework for continuous management using headache diaries, are required. Moreover, migraine is not included among the diseases eligible for the current Specified Disease Treatment Management Fee, and the Chronic Pain Disease Management Fee (clinics only, once a month, 130 points) is designed mainly with musculoskeletal disorders in mind; a new add-on framework encompassing continuous management, lifestyle guidance, and evaluation of preventive therapy for chronic migraine is therefore needed. In addition, although CGRP-related antibody drugs have been progressively covered by insurance since 2021, the current indication requirements effectively demand a step-up approach premised in principle on failure of two or more existing preventive drugs, restricting early access for patients for whom efficacy is clear. In light of the AHS's 2024 positioning of CGRP-related drugs as first-line therapy, explicitly placing the rationalization of Japan's indication criteria on the agenda of Chuikyo (the Central Social Insurance Medical Council) deliberations is an important policy task.

Recommendation 5: Strengthening the Incorporation of Migraine Policy Measures into Health and Productivity Management Initiatives by Companies (Employers and Insurers)

The headache e-learning project covering the entire Fujitsu Group (approximately 80,000 or more people) provides concrete evidence of the effect that in-house corporate education can have on workplace migraine management. The corporate health and productivity management strategy known as the "Headache Project" is an extremely effective approach to migraine as a disease countermeasure. In particular, as the Fujitsu project shows, a company-wide implementation structure in which occupational physicians, the human resources department, frontline managers, and employees work together under the understanding and commitment of senior management is important. After taking the course, the proportion of employees who recognized that "headache is an illness that greatly interferes with daily life" improved from 46.8% to 70.6%. According to a large-scale survey conducted jointly by Fujitsu and the WHO Regional Office for the Western Pacific (WPRO) (2018, approximately 2,500 participants), on days with migraine, work efficiency and productivity fall to 47% of normal, the annual economic loss per person with migraine is approximately ¥250,000, and extrapolated to the country as a whole this reaches approximately ¥1.5 trillion per year. The survey also found that approximately 40% of migraine patients are aware of accompanying symptoms even on headache-free days, with effects on their work, indicating that the actual scale of loss is far more serious than conventional estimates. These are concrete figures that management can understand as the ROI of health investment. To make such initiatives truly effective, it is a prerequisite that managers recognize migraine not as an issue limited to female employees but as a health issue affecting all employees regardless of gender. What is important is that the greater part of such loss arises not from absence from work (absenteeism) but from "presenteeism," in which employees

continue working while suffering from headaches. In fact, while the number of days off taken by migraine patients is not necessarily large, reduced concentration, reduced vitality, and reduced work efficiency are pronounced, and "productivity loss that is hard to see because the employee is at work" accumulates within companies.

Under the Certified Health & Productivity Management Outstanding Organizations Recognition Program, assessing and addressing presenteeism (a state of reduced productivity while attending work with an illness) is positioned as an evaluation item, and migraine is cited as one of its representative target diseases. However, revisions explicitly designating migraine measures as an independent evaluation item have not been made, and the current situation leaves this to companies' voluntary efforts. Revising the recognition criteria so that advanced cases such as the Fujitsu model are more clearly evaluated, together with active dissemination of case examples, would help drive uptake. In addition, as a response for non-regular workers, full-time homemakers, sole proprietors and others whom corporate health and productivity management measures struggle to reach, a multi-channel information provision system is needed through pharmacies, community health centers, gynecology clinics, and public lectures for citizens. It is also effective to use the Data Health Plans of municipal National Health Insurance and National Health Insurance associations as an institutional vehicle for delivering migraine measures to those who fall outside employee insurance. Furthermore, a 2024 report by a Ministry of Health, Labour and Welfare study group recommended incorporating health issues specific to women into employers' action plans under the Act on Promotion of Women's Participation and Advancement in the Workplace; within this framework it is important to explicitly position migraine—whose prevalence is particularly high among women of working age—as a disease distinct from menstrual pain and menopausal disorders. According to the Ministry of Economy, Trade and Industry's "Survey on the Promotion of Working Women's Health," migraine and headache rank higher than menopausal disorders and women-specific cancers as causes of giving something up in the workplace or considering leaving or resigning from a job[19], and this should be used as grounds for raising the priority of workplace migraineinitiatives.

Moreover, corporate health and productivity management initiatives can be made considerably more effective through collaboration with insurers (health insurance societies, the Japan Health Insurance Association, mutual aid associations, National Health Insurance, and others). First, the Data Health Plans formulated by insurers are fundamentally based on a PDCA cycle using claims and health check-up data, and migraine and chronic headache—which are readily identifiable in outpatient claims and for which the risk of OTC drug dependence and MOH can be inferred from data on frequent analgesic prescriptions—could be positioned illustratively as one of the plans' priority themes. Second, within the framework of "collabo-health," in which employers, the principal actors in health and productivity management, cooperate with insurers, which hold the data, positioning migraine measures as a good practice and establishing a model of collaboration—in which insurers use the claims and health check-up data they hold to demonstrate to employers the need for headache measures and thereby lead to concrete interventions such as headache e-learning—would allow the Fujitsu case to be expanded beyond a single company into a model that other employers and insurers can

adopt. Third, early specialist intervention leading to appropriate treatment and improvement in patients' condition not only enhances patients' own quality of life but also reduces the long-term burden on medical resources associated with the worsening and chronification of headache. For insurers as well, implementing migraine management programs for their enrollees contributes both to maintaining productivity and to optimizing medical expenditure.

Recommendation 6: Shifting to Migraine Policy Grounded in Patient and Citizen Participation

Most migraine symptoms are subjective, known only to the patient, and cannot be adequately assessed from test values or imaging findings alone. For this reason, in building migraine policy and care systems, it is essential to position patients not merely as "recipients of care" but as agents who jointly shape medical care and policy.

In the management of migraine, "patient-participatory medicine"—in which patients themselves continuously record and visualize their symptoms, QOL, life interference, and productivity loss and share them with healthcare providers—is central. The headache diary is its most basic tool, but in recent years digital headache diaries using smartphone apps and linkage with PHRs (personal health records) have also advanced, and the standardization of mechanisms for using patient-recorded daily data in clinical care is required. Patients' lived experience also constitutes important knowledge for policy formation in areas such as clinical guidelines, awareness-raising, employment support, and school responses.

Internationally, the IHS (International Headache Society) and GPAC (Global Patient Advocacy Coalition for Headache) place patient advocacy at the center of the policy agenda, and patient participation in guideline development and research design is becoming standardized. In Japan as well, the International Headache Advocacy Summit hosted by JPAC and scheduled to be held in Osaka in November 2026 will be an important opportunity to connect these international trends with Japan's patient community.

For this reason, the national and local governments need to provide financial and institutional support for patient associations, headache classes, peer support activities (headache cafés and the like), and patient advocacy activities, and to explicitly position patient and citizen participation within policy formation. Specifically, what is required is to advance the participation of patient representatives in the research groups and policy study councils of the Ministry of Health, Labour and Welfare (MHLW); to secure opportunities to hear the views of patients and citizens at the Central Social Insurance Medical Council (Chuikyo); to expand patient participation in the Pharmaceuticals and Medical Devices Agency (PMDA)'s regulatory review process, the MHLW Health Sciences Council, and similar bodies; to appoint patient members to clinical guideline development committees; and to institutionalize patient participation in the planning and evaluation of awareness-raising projects. Furthermore, drawing on the track record of patient organizations participating as committee members in policy study councils

and promotion councils in cancer control and intractable disease policy, mechanisms should be established that enable patient representatives to be continuously involved in policy discussions in the field of migraine and chronic headache as well.

Recommendation 7: Improving Access to New Therapeutic Agents and Reducing Economic Barriers

New therapeutic agents such as CGRP-related antibody drugs are innovative treatments with the potential to transform the lives of patients with chronic and refractory migraine. In this study as well, as a patient who had participated since the clinical trial stage put it—"when CGRP drugs came out, my life changed"—their clinical significance extends across patients' entire daily lives. However, out-of-pocket costs of around ¥20,000 per month constitute a major barrier to long-term continuation of treatment. Cases have been reported in which monthly burdens accumulate without ever reaching the threshold for the High-Cost Medical Expense Benefit system, forcing patients to discontinue medication for financial reasons. In particular, the access disparity between patients who can receive supplementary benefits from large-company employee insurance and those enrolled in National Health Insurance or working as non-regular employees must be taken seriously as a form of health inequity based on income and employment status.

Correcting access disparities for new therapeutic agents, including CGRP-related antibody drugs, requires simultaneous responses along several policy axes. The first is resolving the structural inequity of cost burdens. The current High-Cost Medical Expense Benefit system applies uniformly to all insurers, but for chronic diseases in which out-of-pocket costs on the order of ¥10,000–20,000 per month continue over the long term, it constitutes a de facto barrier. Explicit positioning of burden-reduction measures that make use of existing institutional frameworks is required—such as lowering the out-of-pocket ceiling for patients with chronic migraine, or creating a new add-on fee structure dedicated to the continuous management of chronic migraine.

The second is rationalizing the indication criteria for already approved drugs. Rimegepant and atogepant have become available in Japan in succession as oral gepants. In addition, the intravenous CGRP antibody eptinezumab was under application for approval as of November 2025, and prompt approval together with swift development of optimal use promotion guidelines continues to be required. Furthermore, the current step-up requirement (prescribing restrictions premised on failure of existing preventive drugs) needs to be taken up as an agenda item at Chuikyo for review in light of the international trend, exemplified by the AHS's 2024 positioning of CGRP-related drugs as first-line therapy.

The third is the systematic collection and use of real-world data. Now that more than four years have passed since CGRP-related antibody drugs came into use in Japan, data on long-term efficacy, safety, and impact on medical expenditure are accumulating. Under collaboration among stakeholders including the Japanese Headache Society, the Ministry of Health, Labour and Welfare, and pharmaceutical companies, an evaluation system using registry data should be developed, and a mechanism should be built to

reflect the results in continuous review of drug pricing and indication criteria.

The fourth is public recognition and promotion of the patient financial assistance programs offered by individual pharmaceutical companies. At present many patients are unaware that these programs exist, and in some cases even prescribing physicians are not able to explain them adequately. Consolidating and disseminating this information through official websites of the Japanese Headache Society and similar channels is an effective and realistic short-term action.

In designing these access support arrangements, it must always be borne in mind that simple reductions in drug prices could impede the recovery of investment in innovation and invite future drug loss. Reducing cost burdens and maintaining incentives for new drug development are not mutually exclusive; they are goals that can be pursued simultaneously through three pillars: rationalization of indication criteria, use of patient assistance programs, and value assessment based on real-world data.

Recommendation 8: Establishing an Implementation Structure for Migraine Measures in Government and a Legal Basis for Them

The Ministry of Health, Labour and Welfare currently has no department dedicated to migraine equivalent to its Cancer Control Division or Infectious Disease Control Division. Buried within the broad category of “pain,” with no lead department designated to drive continuous policy promotion, this administrative vacuum structurally impedes the translation of migraine measures into policy. In the expert interviews, the view was expressed that establishing a legal basis—such as a potential “Basic Act on Chronic Headache” or a potential “Basic Act on Chronic Pain”—would be effective in breaking this deadlock. However, the form such legislation takes requires careful consideration. If migraine were subsumed within a broader framework such as a “Basic Act on Chronic Pain,” there is a risk that migraine would be buried within “pain” in its broad sense and its specific issues would not be adequately positioned, reproducing within the legal system the same vacuum that exists in the current administrative structure. Migraine causes serious interference with patients’ lives even before it becomes chronic (15 or more headache days per month), and early intervention can prevent chronification and refractoriness and reduce medical expenditure. Its pathology, the age and sex distribution of those affected, its treatment framework, and the timing of the interventions required differ greatly from other disease groups discussed collectively as chronic pain. So that these characteristics specific to migraine and the health-economic significance of early intervention are explicitly positioned regardless of the form legislation takes, relevant academic societies, patient organizations, and members of the Diet should work together and actively engage in the debate over legislation.

Specifically, what is required is the establishment within the Ministry of Health, Labour and Welfare of a department or coordinating function with cross-cutting jurisdiction over chronic headache and chronic pain including migraine; explicit positioning of chronic headache in national health promotion plans such as “Health Japan 21 (Third Term)”; and, in the Diet, the launch of a suprapartisan study group of legislators

addressing the issues specific to migraine and chronic headache, together with its continued activity. Existing frameworks targeting chronic pain also exist, but within them it is important that the issues specific to migraine be positioned as an independent agenda item so that they are not buried within broad-based chronic pain measures. In approaching policymakers and legislators, presenting international comparisons drawing on precedent institutional examples from the G7 and OECD countries carries persuasive force.

Chapter 4 Conclusion

The challenges surrounding migraine—its concentration among women and the working-age population, productivity loss, low awareness and low rates of seeking care, and the need for pediatric guidelines—have long been pointed out by the Japanese Headache Society, government, patient organizations, and others. Building on this accumulated work and adding a structural analysis of clinical inertia and the perspective of patient participation, these recommendations present responses to challenges that have hitherto been raised individually as a single, mutually interconnected set of policies.

Migraine has long been trivialized as "only a headache." Yet as these recommendations show, migraine—which involves 8.4 million patients along with their families, workplaces, and schools—is truly "a disease of everyday life." Many of the important issues facing contemporary Japan, such as the advancement of women, measures to address the declining birthrate, improved labor productivity, and reducing school non-attendance, are deeply connected to migraine measures. Because migraine is more common in women and concentrated in the generation bearing the burdens of work, child-rearing, and caregiving, it is also deeply connected to the promotion of women's active participation and to measures addressing the declining birthrate. At the same time, there are also a considerable number of male patients, and it is a disease that impairs quality of life across all generations, from childhood and adolescence to old age. Society as a whole must advance both measures that take into account circumstances specific to women and measures that treat migraine as a national disease affecting people regardless of gender or generation.

What emerged through the expert interviews and the ethnographic survey was the robust structure of clinical inertia formed by the overlapping "rational choices" of patients, physicians, and the healthcare system. Patients resign themselves to "a pain one must live with"; physicians outside the specialty choose a rational reticence of "responding only to what the patient asks for"; and the system contains no incentive to correct that stagnation. Breaking this chain requires comprehensive policy intervention that goes beyond awareness-raising to span the education system, the medical fee schedule, legal frameworks, and industrial policy.

The words of a patient who engaged proactively with migraine treatment indicate the destination that policy should aim for. A headache borne as "uncontrollable pain" is transformed—through encountering a headache specialist, self-understanding gained via a headache diary, and trial and error grounded in a trusting relationship—into "an inconvenience that can be predicted, managed, and coped with." What makes that transformation possible is not the existence of excellent drugs alone. It is putting in place, as a matter of institutional design, the pathways by which patients can encounter appropriate care.

We hope that these recommendations will deepen a shared understanding of the issues among all those involved in migraine care and policy—policymakers, healthcare professionals, patients, and industry—and will help lead to concrete action. We would be gratified if these recommendations contribute, even in small measure, to advancing migraine care and policy in Japan.

Reference Materials

1. Dong L, Dong W, Jin Y, Jiang Y, Li Z, Yu D. The global burden of migraine: a 30-year trend review and future projections by age, sex, country, and region. Pain Ther. 2025;14(1):297-315. doi:10.1007/s40122-024-00690-7
2. Wijeratne T, Oh J, Kim S, Yim Y, Kim MS, Shin JI, et al. Global, regional, and national burden of headache disorders, 1990-2021, with forecasts to 2050: a Global Burden of Disease study 2021. Cell Rep Med. 2025;6(10):102348. doi:10.1016/j.xcrm.2025.102348
3. Sakai F, Igarashi H. Prevalence of migraine in Japan: a nationwide survey. Cephalalgia. 1997;17(1):15-22. doi:10.1046/j.1468-2982.1997.1701015.x
4. Sakai F, Hirata K, Igarashi H, Takeshima T, Nakayama T, Sano H, et al. A study to investigate the prevalence of headache disorders and migraine among people registered in a health insurance association in Japan. J Headache Pain. 2022;23(1):70. doi:10.1186/s10194-022-01439-3
5. Lancaster University. 86 million workdays lost to migraine in the UK every year [Internet]. EurekAlert!; 2018 Apr 27 [cited 2026 May 27]. Available from: https://www.eurekalert.org/news-releases/862212
6. Fujitsu Limited. What is the "FUJITSU Headache Project"? Headache education through which 80% of employees deepened their understanding of headache [Internet]. note; 2024 Feb 16 [cited 2026 May 27]. Japanese. Available from: https://note.com/fujitsu_pr/n/n692108c36c45
7. Azuma Y. Background to the launch of a headache project (73,000 people) in the occupational health setting. Journal of the Japanese Headache Society. 2024;50(3):575-578. Japanese. doi:10.50860/jjho.50.3_575
8. Takeshima T, Wan Q, Zhang Y, Komori M, Stretton S, Rajan N, et al. Prevalence, burden, and clinical management of migraine in China, Japan, and South Korea: a comprehensive review of the literature. J Headache Pain. 2019;20(1):111. doi:10.1186/s10194-019-1062-4
9. Hirata K, Ueda K, Komori M, Zagar AJ, Selzler KJ, Nelson AM, et al. Comprehensive population-based survey of migraine in Japan: results of the ObserVational Survey of the Epidemiology, tReatment, and Care Of MigrainE (OVERCOME [Japan]) study. Curr Med Res Opin. 2021;37(11):1945-1955. doi:10.1080/03007995.2021.1971179
10. Larsson B, Sigurdson JF, Sund AM. Long-term follow-up of a community sample of adolescents with frequent headaches. J Headache Pain. 2018;19(1):79. doi:10.1186/s10194-018-0908-5
11. Bjørk MH, Borkenhagen S, Oteiza F, Dueland AN, Sørgaard FE, Saether EM, et al. Comparative retention and effectiveness of migraine preventive treatments: a nationwide registry-based cohort study. Eur J Neurol. 2024;31(1):e16062. doi:10.1111/ene.16062
12. Diener HC, Ashina M, Durand-Zaleski I, Kurth T, Lantéri-Minet M, Lipton RB, et al. Health technology assessment for the acute and preventive treatment of migraine: a position statement of the International Headache Society. Cephalalgia. 2021;41(3):279-293. doi:10.1177/0333102421989247
13. Lanteri-Minet M, Leroux E, Katsarava Z, Lipton RB, Sakai F, Matharu M, et al. Characterizing barriers to care in migraine: multicountry results from the Chronic Migraine Epidemiology and Outcomes - International (CaMEO-I) study. J Headache Pain. 2024;25(1):134. doi:10.1186/s10194-024-01834-y

14. Puledda F, Sacco S, Diener HC, Ashina M, Al-Khazali HM, Ashina S, et al. International Headache Society global practice recommendations for the acute pharmacological treatment of migraine. Cephalalgia. 2024;44(8):03331024241252666. doi:10.1177/03331024241252666
15. Igarashi H. Needs for and effects of CGRP-related antibody drugs and ditans among young people. Journal of the Japanese Headache Society. 2025;52(1):10-13. Japanese. doi:10.50860/jjho.52.1_10
16. Takizawa T, Ihara K, Watanabe N, Takemura R, Takahashi N, Miyazaki N, et al. CGRP-monoclonal antibodies in Japan: insights from an online survey of physician members of the Japanese Headache Society. J Headache Pain. 2024;25(1):39. doi:10.1186/s10194-024-01737-y
17. Takizawa T, Kitano T, Togo K, Yoshikawa R, Iijima M. Clinical practice for migraine treatment and characteristics of medical facilities and physicians treating migraine: insights from a retrospective cohort study using a Japanese claims database. PLoS One. 2024;19(12):e0315610. doi:10.1371/journal.pone.0315610
18. Suzuki S, Ishii R, Danno D, Takizawa T, Hamakawa M, Tanizawa Y, et al. Patient-doctor communication in migraine: results from the OVERCOME (Japan) 2nd study. Neurol Ther. 2025;14(6):2695-2721. doi:10.1007/s40120-025-00839-2
19. Ministry of Economy, Trade and Industry. Report on the fact-finding survey concerning the promotion of working women's health [Internet]. Tokyo: Ministry of Economy, Trade and Industry; 2018 Mar [cited 2026 May 27]. Japanese. Available from: https://www.meti.go.jp/policy/mono_info_service/healthcare/downloadfiles/H29kenkoujumyou-report-houkokusho-josei.pdf

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Declaration of generative AI and AI-assisted technologies in the writing process

During the preparation of these policy recommendations, the authors used Claude (Anthropic, San Francisco, CA, USA) throughout the writing process, including the organization and analysis of qualitative data obtained from the expert interviews and the ethnographic survey, the examination of the document structure, the preparation of drafts, the translation of the text into English, and the improvement of the readability and language of the manuscript. All analytical interpretations, policy judgments, and conclusions presented herein were made by the authors. After using this tool, the authors reviewed and edited all content, verified the accuracy of the facts and references cited, and take full responsibility for the content of the publication.

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