WHITE PAPER on CANCER CONTROL

Looking Back 15 Years of Japan's Cancer

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がん対策総合機構
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Executive Summary: Looking Back on "15 Years of Cancer Control"

1) 15 Years of Cancer Control—Steady Progress and Favorable Results

- In the 15 years since the "Cancer Control Act" was enacted in 2006, measures to improve treatment settings and relieve or resolve physical and social pain for cancer patients have been steadily strengthened and have yielded many favorable results in Japan.

- The age-adjusted mortality rate under age 75[1] has declined from 92.4 (in 2005) to 70.0 (in 2019),[2] and the rates of persons receiving cancer screening for various cancer types have increased; for instance, the rate of women receiving lung cancer screening has increased from 23.0% to 45.6%.[3]

- As health care delivery systems to eliminate disparities in cancer care have been developed, the number of medical institutions designated as "core cancer hospitals" now exceeds 400 nationwide. Measures against pediatric cancer have also been strengthened, and 15 medical institutions located throughout Japan have been designated as "core hospitals for pediatric cancer" since 2012.

- With the expansion of care delivery systems, including establishment of "palliative care teams" in the core cancer hospitals throughout Japan,[4] according to a survey, the "difficulty" that physicians and other health care providers face when providing palliative care has consistently reduced.[5]

- Steady progress has also been made in "Patient and Public Involvement (PPI)"[6] toward policymaking relating to cancer. The Cancer Control Act ensures opportunities for patients and their family members to participate in the Anti-cancer Measures Promotion Council Meeting of

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[1] 人口構成が基準人口と同じであった場合に実現されたであろう死亡率。異なる集団や時点などを比較するために用いる（参考：https://ganjoho.jp/reg_stat/statistics/qa_words/word/nenreityouseisibouritu.html）

[2] 国立がん研究センター がん情報サービス Web サイト「都道府県別 75 歳未満年齢調整死亡率」より（https://ganjoho.jp/reg_stat/statistics/stat/age-adjusted.html）

[3] 胃がん、肺がん、大腸がん、乳がん、子宮頸がん等、いずれのがん種も検診受診率は改善している。国立がん研究センター がん情報サービス Web サイト「全国の受診率（2010 年、2013 年、2016 年、2019 年）」より（https://ganjoho.jp/reg_stat/statistics/stat/screening/screening.html）

[4] 「緩和ケア診療加算届出受理施設の累計数は、日本ホスピス緩和ケア協会の調べによると、2002 年の 22 施設から 2012 年は 168 施設、2016 年には 231 施設にまで増加した」（中澤葉宇子ほか「緩和ケアチームのこの 10 年」『ホスピス・緩和ケア白書 2018』青海社）

[5] 国立がん研究センターWeb サイト「がん診療に携わる医師の緩和ケア知識・困難感を調査」等より（https://www.ncc.go.jp/jp/information/pr_release/2017/1102/index.html）

[6] 患者・市民参画の対象となる人々の範囲については様々な考え方があり得るが、例えば NHS England は「『Patients and Public』という言葉には、介護者や家族を含め、サービスを利用している、あるいは将来利用する可能性のあるすべての人が含まれる。医療・介護サービスの利用者はときに『経験豊かな専門家』と呼ばれる。NHS イングランドは、彼らの経験から為される貢献を高く評価している」と"Patient and Public Participation Policy"に明記している（https://www.england.nhs.uk/wp-content/uploads/2017/04/ppp-policy.pdf）。

the Ministry of Health, Labour and Welfare. Some prefectures also elect committee members for their Anti-cancer Measures Promotion Council Meeting from the public.[7]

2) 15 Years of Cancer Control—Next Challenges

- Despite such positive progress and results of cancer control in Japan, on the other hand, the next challenges that require more efforts are becoming clear.
- Currently, Japan's 5-year survival rates of some cancer types, such as adult lymphoid and myeloid malignant diseases, fall behind some countries, including the U.S.. Further progress, including treatment development, is particularly expected for these cancer types.
- Although efforts to eliminate disparities in cancer care have yielded some favorable results, inter-prefectural disparities, including the age-adjusted mortality rate under age 75, definitely exist; further efforts are required to eliminate such "cancer disparities" among prefectures.[8]
- In an international comparison study on palliative care,[9] Japan ranks 14th internationally in the palliative and healthcare environment category and 16th in the quality of care category, which falls behind some Asian countries, such as Taiwan and Singapore. Extra efforts to broaden the delivery system of palliative care and improve its quality, including the usage environment of analgesic drugs, are expected.
- As for "Patient and Public Involvement (PPI)" toward policymaking, although the opportunities have steadily been expanding, when it is compared to some countries such as the U.K., for instance, the transparency relating to the selection system of committee members from patients and their family members remains low. The system to enhance empowerment,[10] such as training of patient representative committee members who participate in the policy meeting, is also weak.
- Regarding the "Basic Plan to Promote Cancer Control Programs" as an administrative plan, while the revisions have been made from the first term (FY 2007-2011) to the third term (FY 2017-2022), the nature of the basic plan has altered from an "objective setting-oriented" plan

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[7] 特定非営利活動法人がん政策サミットの調査によれば、2017 年時点において、少なくとも 40 の都道府県において、がん対策に係る会議体に患者・市民委員が参加している（参考：http://cpsum.org/pdf/Pref_Karte_2017.pdf)。

[8] 例えば、75 歳未満年齢調整死亡率の最も低い長野県は 58.9（2019 年)、最も高い青森県は 90.8（同）となっている。(参考：https://ganjoho.jp/reg_stat/statistics/data/dl/index.html#pref_mortality)

[9] "THE 2015 QUALITY OF DEATH INDEX RANKING PALLIATIVE CARE ACROSS THE WORLD　KEY FINDINGS INFOGRAPHIC" Economist Intelligence Unit study, commissioned by the Lien Foundation

[10] エンパワーメント（Empowerment）とは患者代表委員に対して、①政策提言などの社会的スキルを獲得させ、②その権利を行使できるような環境条件を整備し、③権利行使のために必要な手段や情報を提供することで、社会を活性化させることである。

(e.g., 20% reduction of the age-adjusted mortality rate under age 75)[11] to a "philosophy-oriented" plan where policy goals are not set numerically, which makes it difficult to evaluate results. In this basic plan, "prevention" and "coexistence with cancer" are emphasized, and "radical cure" is not stated as a policy goal.[12]

- Furthermore, for both "first term (FY 2007-2011)" and "second term (FY 2012-2016)" Basic Plan to Promote Cancer Control Programs, the national government did not make evaluations and reports on the input (injected resources), output (activity performance) and outcome (results)[13] after the end of these terms. Efforts toward policy research by academics who study these fields including university researchers were also limited. The way to review the plan, including assessing the cost-effectiveness, needs work.

3) Proposal: 5 Suggestions for the Next 15 Years

- Based on the above favorable results and remaining challenges from the last 15 years of cancer control in Japan, we would like to propose to proceed the efforts below to persons in both the government and private sector involved with cancer control in this white paper.

(1) In the next "Basic Plan to Promote Cancer Control Programs," it is desirable to set numerical goals to enable evaluation and validation of outcomes (results) of measures, including 5-year survival rates. From the viewpoint of international comparison, it is particularly desirable that the enhancement of efforts to improve the status of cancer types with survival rates falling behind is stated as a goal. Each prefectural "Basic Plan to Promote Cancer Control Programs" is also expected to have numerical goals, aiming to establish a system enabling evaluation of the outcomes (results) as policies.

(2) Since it has become evident that there are disparities in prevalence rate among prefectures, as well as differences in the organizational system concerning the cancer control planning, Japan needs to develop measures for further improvement in the policymaking functions of each prefecture, using the efforts made by the Centers for Disease Control and Prevention (CDC) in the

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[11] 「目標設定型健康増進政策は『目標による管理(management by objectives)』という経営管理手法を用いているため目標管理型健康政策と言われることもあるが、ヘルスプロモーションは従来の健康管理的発想を脱却してボトムアップ型の健康づくりをめざすものであるので、本稿ではあえて『管理』という言葉を用いず目標設定型という用語を採用している。」(本橋豊ほか「目標設定型健康増進政策の国際比較」『日本衛生学雑誌』2002 年 57 巻 2 号 p. 498-504)

[12] 例えば、第三期基本計画においては「共生」の文言が 9 箇所登場するのに対して、「根治」の文言の記載は一箇所にとどまっていることは、基本法制定以前、緩和ケアの提供やがん医療の均てん化に十分な政策的措置が講じられなかった反省から、「共生」に力点の置かれた計画となっていることを示唆している。

[13] 日本国内においては様々な訳が為されているが、日本政府では、例えば、インプットは「予算」、アウトプットは「活動実績」、アウトカムは「活動実績がもたらす状況の変化、人の行動変容、その他成果」とそれぞれの用語につき、説明が付されるケースが見られる（参考：https://www.kantei.go.jp/jp/singi/it2/ebpm/dai5/sankou1.pdf）

U.S. as a reference, for instance. At the same time, it is considered that the prefectures where numerical values of the age-adjusted mortality rate under age 75, etc. fall behind the other prefectures particularly need extra measures to enhance cancer control. The national government is therefore expected to advance consideration on intensive financial support to such prefectures.

(3) With respect to patient involvement in the "cancer control" policymaking process at the national and prefectural levels, using the efforts in other countries including the U.K. as references, the following suggestions are strongly recommended: (1) aim for a system that ensures better transparency, fairness, and other relevant qualities on standards and procedures relating to the appointment of patient representative committee members, and (2) enrich systems relating to training/information provided to patient and family representative committee members from the viewpoint of enhancing the empowerment of patient representatives.

(4) To improve the molarity rate, etc. of cancer patients, research and development of drugs and treatment development, as well as early detection of cancer and individual behavior changes, are extremely important. Since the Basic Plan to Promote Cancer Control Programs is positioned above the "10-year Strategy of Cancer Research" and other relevant plans,[14] it is desirable to state the next challenges and policy directions of research and development and treatment development more specifically.[15] From these viewpoints to formulate the "Fourth Term of the Basic Plan to Promote Cancer Control Programs," it is strongly expected to resume consideration in the "Cancer Research Expert Panel" held from FY 2011 to 2012 under the Anti-cancer Measures Promotion Council Meeting and to newly establish a platform for patient support organization members to exchange opinions about challenges around cancer research ("Research Advocates Expert Committee" [provisional name]),[16] for instances.

(5) Some Social challenges, including "pursuing the balance between treatment and work" that happens on cancer patients, are also common in patients with diseases other than cancer. Taking advantage of the establishment of so-called, the "Cerebrovascular and Cardiovascular Disease Control Act" and other relevant matters, further collaborative policymaking with other disease

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[14] 前述の通り、「根治」を重視したがん対策が結果として「がん難民」を生んでしまったことへの反省が、「がん対策基本法」制定の背景にあったことから、同法に基づくがん対策推進基本計画は患者の QOL の改善や、患者の生活に関わる社会的課題の解決を重視し、一方で研究・治療開発への言及は乏しく、この領域は下位計画である「がん研究 10 か年戦略」等に委ねられる傾向が見られる。

[15] オバマ大統領（当時）が「米国をがんの治癒する国にしよう」と述べ、Precision Medicine Initiative 等の政策を推し進めたことは、中央政府のがん対策における今後の役割を考える上で示唆的である。（https://www.mixonline.jp/tabid55.html?artid=53629）

[16] 例えば、米国の国立がん研究所（National Cancer Institute, NCI）は、「NCI リサーチ・アドボケート協議会」（the NCI Council of Research Advocates, NCRA）を運営しており、米国連邦政府における唯一のアドボケートのリーダーを集めた諮問委員会として、① がん研究を取り巻く諸問題に関する意見交換、② 国立がん研究所長官への助言、等を行っている。ただし、NCRA の委員への就任は、がん研究や政策に関する専門知識を有していることが要件となっている。（参考：「臨床研究等における患者・市民参画に関する動向調査報告書」平成 31 年、EY 新日本有限責任監査法人）

areas and implementation of policies beyond the barriers of disease types are expected in order to advance the policy responses to psychological and social challenges where patients with chronic diseases other than cancer/lifestyle-related diseases and those involved with such patients face in common.