

## Study Notes

# Cancer Control in Japan: A Critical Appraisal from the Right to Health Perspective<sup>1)</sup>

MUNESUE Tokuko

(Kanagawa University of Human Service)

The purpose of this report is to examine Japanese cancer control from the view of ensuring cancer patients' right to health. This paper starts by examining the historical development of Japanese cancer control. However, even though the Japanese government has launched various strategies to fight against cancer since 1984, the situation has not improved. Cancer patients, their families and cancer related groups started appealing for comprehensive policies and a high level of cancer care around 2001, and owing to their appeals, Japanese cancer control has gradually changed to be more sympathetic to patients. Secondly, it appraises the National Action Plan on Cancer Control for 2007-2011 to apply the indicators of the right to health, and propose from the right to health perspective that there should be developed accessibility to cancer care, acceptability of cancer care and participation of cancer patients and their families.

**Key words** : cancer control, cancer patients, the right to health, participation

## 1. Introduction

Since 1981, cancer has been the leading cause of death in Japan. Currently, more than 300,000 people die of cancer each year<sup>2)</sup>. It is considered that aging increases the risk of the on set of cancer and considering the progression of aging among the Japanese

population, an increasing number of deaths in the future can be foreseen.

Considering the situation, in fiscal year 1984, Japan launched a "10-year Strategy for Cancer Control" (until fiscal year 1993). After that, the "New 10-year Strategy to Overcome Cancer" (fiscal year 1994-2003) and the "3rd-term Comprehensive 10-year Strategy for Cancer Control" (fiscal year 2004-2013) were launched, showing continuous attention to cancer policies. The "Cancer Control Act" was approved in June of 2006 and implemented in April of 2007. Based on this law, in June of the same year, the "Basic Plan to Promote Cancer Control" was adopted by the Cabinet.

---

1) This paper was originally published in *Ritsumeikan Journal of Human Sciences*, No. 16, 105-115 (2008), and supported by the Health Welfare team, CEHSOC (Citizen and Community Empowerment in Health and Social Care), "Open Research Center" Project from MEXT. ("Establishment of Clinical Human Science-Human Environmental Research for Human Service" (2005-2009, main researcher Akira Mochizuki)). The project was carried out thanks to an economic contribution from the Health Co-operative Association of JCCU (Japanese Consumers' Cooperative Union).

2) "Vital statistics of year 2006" Japanese Ministry of Health, Labor and Welfare.

Currently, cancer is not only one of the most serious concerns for cancer patients, their families and related organizations, but also for the entire country of Japan. The government has been actively involved in the adoption of countermeasures. Research in natural sciences such as medicine and nursing is of course being undertaken, and a noticeable interest is also growing in research in social sciences that focus on gathering and conveying patients' voices, as well as social science research publications and dissertations.

The "Cancer Control Act" has been enacted and enforced, and although a very important law, there is very little research to analyze or verify this law from a legal point of view.

Therefore, besides classifying data related to Japanese cancer control trends, the author

would like to analyze and examine the Cancer Control Act and the Basic Plan to Promote Cancer Control programs from the perspective of ensuring cancer patients' right to health, based on interview research with cancer patients and related organizations. The present article is published as a "study note" and is the basis of future research the author intends to pursue. Therefore, I'd like to note that this article merely summarizes the trends of cancer control in Japan from the perspective of the right to health research, a field in which the author is involved.

## 2. Policy Debate on Cancer Control in Japan

Cancer control in Japan has followed the public development process presented in Chart 1.

**Chart 1**

1962	Creation of the National Cancer Center
1963	Subsidy for cancer research by Ministry of Health and Welfare started
1966	Subsidies provided for preparing and operating mobile group stomach examination services
1967	Cervical Cancer Examination Project
1982	Malignant neoplasm becomes the number one cause of death in Japan
1984	Law of Health and Medical Services for the Aged enacted: Cancer examination is carried out as part of the Health Care Program for the Aged.
1984	Comprehensive 10-Year Strategy for Cancer Control (~1993)
1994	New 10-Year Strategy for Defeating Cancer (~2003)
1998	General finances starts to include cancer examinations (Measures for the local allocation tax)
2004	The 3rd-term Comprehensive 10-year Strategy for Cancer Control (~2013)
2005	Health Frontier Strategy (~2014)
April 2005	Report of the association for the evaluation of the "Equalization of Medical Treatment for Cancer"
May 2005	Headquarters of Cancer Control in Ministry of Health, Labor and Welfare
August 2005	Action Plan 2005 for Promotion of Cancer Control
April 2006	Office for Cancer Control in Health Service Bureau, Ministry of Health Labor and Welfare
June 2006	Cancer Control Act approved
April 2007	Cancer Control Act implemented
June 2007	Basic Plan to Promote Cancer Control Programs approved

It can be said that full-scale cancer control in Japan started with the “Comprehensive 10-year Strategy for Cancer Control,” which was publicly developed between 1984 and 1993. The strategy focused on the following 5 issues: 1) Establishment of principal research topics<sup>3)</sup>, 2) Preparation of a system to train and actively use young researchers (Research Resident System), 3) Organization of joint international research and international symposiums, 4) Preparation to accept foreign researchers, and 5) Provision of a system that ensures a stable supply of high quality research materials required for cancer research (Research Source Bank). It is understandable at this point that the central theme was promoting cancer research.

Later in fiscal year 1994, the “New 10-year Strategy to Overcome Cancer” called for 1) Establishment of principal research topics<sup>4)</sup>, 2) Training and active use of young researchers, 3) Promotion of international collaboration<sup>5)</sup>, 4) Preparation of a research system for clinical application, and 5)

Improvements in social infrastructure, namely in public announcements and satisfactory promotions, promotion of an academic-industrial-government collaboration system, a support system for the provision of laboratory materials, and the preparation of fundamental research infrastructures that employ high-tech equipment.

Through these two strategies, part of the mechanism of a solution to cancer has been achieved, while the establishment of the technology for early detection and treatment standards of all the different types of cancer, and the improvement of treatment and diagnosis techniques were also realized. Actually, during this period of time, the mortality rate of cancers, including stomach cancer and uterine cancer decreased and the survival rate of stomach cancer and other types of cancers improved.

However, cancer was still the leading cause of death among Japanese and with the goal of reducing the incidence rate and mortality rate of cancer, the “The 3rd-term 10-year Strategy for Cancer Control” (hereinafter, “The 3rd-term Strategy”) was launched in fiscal year 2004. Until then, the two strategies paid major attention to the promotion of cancer research, but the 3rd-term Strategy was comprised of three pillars, the new “preparation of a social environment that supports the improvement of medical care for cancer” in addition to “the promotion of cancer control research” and “the promotion of cancer prevention”.

---

3) Considered as important research topics: 1) Human cancer onset and development genes (oncogene), 2) Human cancer caused by viruses, 3) Cancer onset, tumor promotion and inhibition, 4) Development of new early diagnostic techniques, 5) Development of cancer therapies based on new theories, 6) Immunoregulation control and genetic material regulation.

4) Here, researches related to 1) molecular cancer onset, 2) characteristics of metastasis, cellular infiltration or cancer cell, 3) cancer tipification and immunology, 4) cancer prevention, 5) development of new diagnostic techniques, 6) development of new treatment methods and 7) cancer patients' QOL.

5) Larger collaboration in terms of international cooperation and joint research with Europe and the Asia-Pacific countries were announced as aims.

Regarding, “the promotion of cancer prevention”, the National Cancer Center plotted out “12 Articles to Prevent Cancer” by then. In addition to that, development of anti-tobacco measures, improvement of eating habits and increase in the number of people undergoing cancer screening examinations were promoted based on “The Healthy Japan 21” project. On the basis of this improvement the 3rd-term Strategy provided for 1) The establishment of effective cancer prevention methods, 2) The promotion of education concerning cancer prevention, 3) The substantiality of preventive measures for infections that may cause cancer, and 4) The early diagnosis and early treatment of cancer.

Moreover, one of the pillars, “preparation of a social environment that supports the improvement of medical care for cancer” specifically referred to 1) Strengthening the functions of a core basis for cancer research and treatment, 2) Equalization of cancer care (that everyone in any part of the country be able to receive the same level of care from cancer physicians/specialists to bridge gaps in medical treatment and technology), 3) Improvement in the quality of life (QOL) of cancer patients, and 4) Promotion of international collaboration and exchange in line with involvement in the promotion of academy-industry-government collaboration. At this point, the cancer control policies of the government finally included matters from the patients’ point of view or with respect toward cancer patients, such as the “equalization” of cancer care and improvement in the quality of life (QOL) of cancer patients. In this sense,

the 3rd-term Strategy was the turning point in the shift to comprehensive cancer care policy in Japan.

“Equalization” of cancer care was also discussed in the 2004 “Health Frontier Strategy”. The same year, the “Committee for the Promotion of the Level of Cancer Care Equalization” was formed as a discussion group belonging to the Ministry of Health, Labor and Welfare.

The Health Frontier Strategy was proposed on May 19 at a policy affairs meeting by the chief secretary/policy chief of the ruling party and incorporated in the “2004 Basic Policy on Economic and Financial Administration and Restructuring” on June 4. The goal of the strategy was to extend the life expectancy of the Japanese population, in other words to achieve the promotion of healthy life measures and preventive care. Here, too, the goal to raise five-year survival ratios by 20% have been included in cancer control, in an attempt to realize more complete policies that lead to the equalization of medical care for cancer.

The “Committee for the Promotion of the Level of Cancer Care Equalization” was formed to analyze the primary factors that caused regional differences in cancer care, with the purpose of proposing specific policies to eliminate such differences. The committee conducted 5 interviews with involved parties and submitted an analysis of conditions in a report in April of 2005<sup>6)</sup>. The report identified

---

6) Report of the Evaluation committee on the promotion of cancer care equalization, “Towards the equalization of cancer care”

the following factors as causal factors of regional differences in cancer control: 1) Training of specialists, 2) Preparedness of organizations in charge of the early detection of cancer, 3) Role assignment in medical institutions and their network building capacity, 4) Cancer registry system, and 5) The provision and promotion of information. Since this report was prepared on the basis of opinions by patients' representatives, there are many descriptions that reflect the opinions of cancer patients. The opinions of cancer patients gradually became more important and were reflected in the process of policy establishment that led to the establishment of the "Office for Cancer Control".

The Office for Cancer Control was established within the Ministry of Health, Labor and Welfare in May 2005, with the Minister acting as the director general of the office. This was because cooperation across department boundaries was called for in order to respond to cancer in each stage and this led to the integral promotion of general cancer control. In August of the same year, the Office for Cancer Control announced its "Action Plan 2005 for Promotion of Cancer Control"<sup>7)</sup>. This action plan was made with the recognition that citizens and cancer patients had expectations in the improvement of cancer control development, but were not satisfied with actual medical services they could receive. In order to achieve its goals,

three actions were proposed: 1) To carry out an integral analysis of general cancer control from the viewpoint of citizens and reconstruct the "Basic Strategy for Cancer Control" to conduct major promotion of measures that address the needs of the population and patients, 2) To reduce patients and the general population's anxiety and discontent about cancer control and to promote the building of a "cancer information network" related to cancer control that would lead to the improvement and equalization of medical care levels everywhere, and 3) To establish an "examination framework" that would provide a shared information network that appropriately reflects the awareness and needs of the general population and patients, as well as the actual condition of medical care for cancer, in order to promote the standing of cancer control with patients and the population.

### 3. Cancer Patients and the Activities of Related Organizations

As seen in the flow of Japanese cancer control and pointed out there, the 3rd-term Strategy launched in 2004 began including the viewpoints of patients in cancer control. In 2005, the Action Plan 2005 for Promotion of Cancer Control clearly announced an attempt to establish "cancer control for the general population and patients". We should note the background in this shift of viewpoint includes the existence of patients who united and took action together due to their dissatisfaction toward the then current conditions of

---

7) Office for Cancer Control, about the future of anti-cancer policies "Action Plan 2005 for Promotion of Cancer Control", August 25, 2005.

Japanese cancer control.

Around 2001, almost all cancer patient organizations began appealing and petitioning the Minister of Health, Labor and Welfare and Diet members for anti-cancer drugs, which had already been a part of standard pharmaceutical treatment in Europe and America, to be approved and covered by the health insurance system. For example, in 2001, the “Petition for the Early Approval of New Medication” was submitted to the Diet. The petition was accepted by both chambers and passed to the Cabinet (Okuma, Kaihara, Hattori, 2006). Nevertheless, despite the petition activities of cancer patient organizations, the use of drugs unapproved and not covered by public health insurance was virtually impossible in Japan. Therefore, a system was made so that united and collaborative patient organizations could put in requests. For example, in February of 2002, four such organizations<sup>8)</sup> established the “Japan Cancer Patients Conference” to cooperate and act together<sup>9)</sup>.

The activities of organizations extended to every part of the country. On May 28 of 2005, 1,800 people, including patients, their families and related organizations from every region of Japan, gathered in Osaka to take part in the 1st National Convention of Cancer Patients<sup>10)</sup>.

---

8) Four groups: “Thinking of tomorrow’s medical care association”, “Living with cancer association”, “Seeking for the early approval of anti-cancer drugs” and the “Cancer navigation citizens network”.

9) Regarding Japanese cancer patients groups and organizations, refer to <http://nvc.halsnet.com/jhattori/JCPC/kai/kainituite.htm> (As of July of 2006)

The principal focus of the convention was “patients’ opinions and advocacy”. Patient representatives, medical staff, Ministry of Health Labor and Welfare employees and politicians participated in discussions as panelists, together with member of the mass media and involved people from all regions of Japan. They discussed topics related to how Japanese cancer control should be, in order for cancer patients to receive better medical care. The convention appealed to the then Minister of Health, Labor and Welfare, Mr. Otsuji, through the following statement, “Carrying out the right to make their own life-decisions based on correct information is the ‘hope for life’ that all cancer patients are looking for. For this hope, it is indispensable to establish a ‘cancer information center focusing on patients’ as soon as possible.” The demand for the “early establishment of a cancer information center” was fulfilled in October of 2006 with the establishment of the “Cancer Control Information Center”. Subsequently, cancer patient conventions have been held in Tokyo in 2006 and most recently in Hiroshima in 2007, to appeal for increased “palliative care”.

#### 4. The Cancer Control Act

Active involvement of cancer patients, their families and related organizations successfully influenced members of the Diet. In April of 2006, Congressman Motohisa Furukawa of the

---

10) Regarding the Convention of Cancer Patients, refer to: <http://www.daishukai.net/2007/main.html> (As of September of 2007)

Democratic Party and four other representatives presented a proposal for the Cancer Control Act to the House of Representatives. The following month in May, Congressman Ichiro Kamoshita of the Liberal Democratic Party and three other representatives submitted a counterproposal to the Democratic Party. On June 7, the ruling party and the Democratic Party concluded an agreement that was unanimously approved on June 9 by the House of Representatives and submitted the bill to the Upper House plenary session on June 13. Deliberation started the next day and the bill was approved by the Committee on Health, Labor and Welfare in the Upper House on June 15. At this time, Article 19 of the supplementary resolution was adopted by incidental vote<sup>11)</sup>. On June 16, the Upper House plenary session unanimously approved the act and the “Cancer Control Act” was enacted<sup>12)</sup>, taking effect on April 1, 2007.

---

11) Resolutions that refer to additional opinions, expectancies or expressions to laws and budgets that have been already passed. Although they do not have legal binding force, the government is supposed to consider them at the time of establishing policies and programs. About the Cancer Control Act, the Japanese association of cancer patients groups and organizations and the Living with cancer association were requested to organize the items to be incorporated in the additional resolution. The additional resolution incorporates with patients' viewpoint, including reflection of patients' intentions or wishes, provision of medical function information with patients' viewpoint, provision of the latest information in plain words in a correct and appropriate manner, expansion of second opinion services for outpatient and medical consultation offices, provision of high quality cancer care, provision of relaxation care and maintenance of cancer patients' quality of life, approval of new medication, insurance covered anti-cancer drugs, cancer registry, etc.

12) Refer to Kobayashi (2007) later for the establishing process of the Cancer Control Act.

The objective of the Cancer Control Act (hereinafter, the “Control Act”) states “...in light of the current situation it is clear that cancer is an important problem that concerns the life and health of the entire population. In order to realize more complete cancer control, basic concepts regarding cancer control must be established, the responsibilities of the national and regional governments, health insurance members, general population and medical experts clarified, and matters related to cancer control established, as well as integrally planned cancer control promotion.” (Article 1)

In terms of the basic ideology towards cancer control, three points are raised: “...to promote cancer research and... to popularize, use and develop the achievements of such research” (Article 2, Clause 1), “to make it possible for all cancer patients, no matter what area they reside in, to receive equal and appropriate cancer treatment based on scientific knowledge (Article 2, Clause 2) and “to prepare a system that provides appropriate treatment based on what condition cancer patients are in with respect to the patient's wishes” (Article 2, Clause 3).

Furthermore, the duties of all organizations and groups related to cancer control are specified in Articles 3 to 8. The national and local governments are obliged to establish and enforce cancer control (Article 3, Article 4). It was stipulated that the population in general is required to make every possible effort to acquire correct knowledge about cancer and be attentive to its prevention, by

actively undergoing necessary cancer examinations (Article 6).

In Articles 9 to 11, information about the “Basic Plan to Promote Cancer Control” programs. In Article 12 and following articles, information about the “Basic Policies” are established as follows: 1) promotion of cancer prevention and early detection (Articles 12 and 13), 2) promotion of the equalization of cancer treatment (Articles 14 and 17), 3) promotion of research (Article 18), and 4) Cancer Control Promotion Council (Articles 19 and 20).

The Control Act expresses the necessity for cancer control to reflect the opinions of cancer patients, including the intent of its principal ideologies of eliminating the regional gap (principle of equality), improving the maintenance of quality, respecting patients’ wishes, and selecting treatment methods (Article 2). Article 15 expressly mentions “the elimination of regional gaps” and establishes that it is both the national and regional public organizations’ obligation to ensure the maintenance of health facilities that offer quality specialized cancer control. Moreover, Article 16 deals with the improvement of quality maintenance by offering “palliative care” for patients to receive early and appropriate care in consideration of their conditions. Also, the article states the necessity to secure a collaborative system to provide cancer care at home as well as secure opportunities to receive training. Article 17 refers to the promotion of a system for collecting and

providing information, as well as counseling and support.

Furthermore, the Control Act made clear that the policy decision process requires the participation of all concerned parties. The central and prefectural governments have the responsibility of establishing plans to promote cancer control (Articles 9 and 11). Article 9, Clause 4 and Article 19 require that when the central government establishes a Basic Plan to Promote Cancer Control programs, it must seek the opinion of the Cancer Control Promotion Council<sup>13)</sup>. Article 20, Clause 2 stipulates that the Council should include representatives of cancer patients, family members and bereaved families. Thus, the participation of those directly involved is guaranteed under the law.

However, the Control Act did not stipulate about introduction of the “cancer registry”, which cancer patients’ groups had demanded. In the United States the “Cancer Registry Act” was enforced in 1992. Also “regional cancer registries” have already been established in 34 prefectures across Japan. However, due to issues like the protection of personal information and the cost of these systems, there are some opinions opposed to the introduction of a national registry system, so regulations regarding a “cancer registry” system were not included in the act. Yet, Article 17, Clause 1 of the Control Act says that both national and regional public

---

13) Established in the Ministry of Health, Labor and Welfare. There are twenty part-time committee members, appointed by the Minister.

institutions must prepare a system to collect and provide information, Clause 2 states that necessary measures to support efforts to understand and analyze how cancer is contracted and how it progresses must be undertaken. As a result, there is still room for improvement in the spread of a national registry system.

## 5. Basic Plan to Promote Cancer Control

In June of 2007 the Basic Plan to Promote Cancer Control (hereinafter, Basic Plan) was adopted in a cabinet meeting and established on the basis of Article 9, Clause 1 of the Control Act. The Basic Plan employs a long-term perspective covering the five fiscal years between 2007 and 2011 to attempt the integral and planned promotion of cancer control. It establishes the basic direction of cancer control and at the same time serves as a model for prefectures to prepare their own promotion of cancer control.

The Basic Plan, as a policy, works to enhance cancer control that considers the general population's point of view, including those of cancer patients. Then, through the fulfillment of its general goals, "reduce the number of cancer deaths", "alleviate the suffering of cancer patients and their families" and "maintain and improve the quality of life during treatment", the plan is conducted in a thoughtful and integral way for measures in each field, including "cancer medical services (primary focus)", "improvement of medical facilities", "providing information and

consultation supporting cancer care", a "cancer registry", "cancer prevention", "early detection" and "cancer research".

The areas of the program that receive the greatest attention are, 1) Promoting radiation therapy and chemotherapy and training specialist physicians or technicians in these areas, 2) Offering palliative care from the early stages of treatment, 3) Promoting a cancer registry.

In addition, the Basic Plan shows general objectives and measures for each field as well as detailed objectives to assist in the evaluation of the degree of accomplishment for these objectives. First, regarding general goals of the program, target values have been set for the "reduction of cancer related deaths", during the next 10 years to be "reduction of age-adjusted cancer mortality (younger than age 75) by 20%". Also, the goal is set to "alleviate the suffering of cancer patients and their families" and "maintain and improve the quality of life during treatment" with palliative care from the beginning of treatment, further fulfillment of cancer medical services, provision of treatment consultation support and information about cancer medicine.

In addition, as indicated below, individual goals and measures to work on have been set to assess achievements and accomplishments in each specialized area based on the understanding of the current condition.

Regarding "cancer medical services", the

following issues each had goals set: 1) Promotion of chemotherapy and radiotherapy, education of medical specialists, 2) Palliative care, 3) Home medical care, 4) Diagnosis and treatment guidelines, and 5) Others. The individual or specific targets of 1) are to prepare a system within 5 years in which all base hospitals will have the capacity to offer radiotherapy and outpatient chemotherapy, and at least all specialty hospitals and prefectural base hospitals, under a cancer treatment cooperation network, will install radiotherapy and chemotherapy departments. The goals also include shortening of the approval period for new anti-cancer pharmaceutical products to 2.5 years within 5 years. Regarding 2), the goals are that all physicians involved in cancer diagnosis and treatment should receive training to acquire basic knowledge of palliative care within 10 years, and all secondary care facilities should increase the number of physicians with palliative care knowledge and skills within 5 years, while medical organizations, including base hospitals, are able to provide palliative care teams. For 3), the goal, in consideration of patients' wishes, is to increase the number of patients who can receive treatment in their homes and communities in which they live. In regards to 4), the goal is to prepare and according to need update guidelines for diagnosis and treatment of all types of cancer, based on reliable scientific sources. Finally, 5) includes the improvement of medical doctors' communication skills, training healthcare workers who can offer psycho/physiological support to patients, and active involvement in the rehabilitation of cancer patients.

Regarding "improvement of medical facilities", it was decided that within 3 years, one base hospital should be set up in all secondary medical care zones in Japan, and within 5 years all base hospitals should establish a critical path community collaboration system covering five major cancers.

Regarding the "providing of information and consultation support in cancer care", secondary facilities throughout the country should be equipped with at least one consultation support center within 3 years. Within 5 years, all consultation support centers are expected to have a consultant who has received training at the Center for Cancer Control and Information Services. The plan also includes an increase in the number of pamphlets containing cancer information and the number of medical facilities to distribute them, and all cancer patients and their families should be able to obtain all information contained in printed materials for patients. Furthermore, information concerning the results of cancer diagnoses or treatment at base hospitals, cancer treatment specialists and clinical trial conditions should be improved and met.

Regarding a "cancer registry", the goal is to increase the number of medical facilities that practice cancer registration, and to administer the current condition of cancer registration at base hospitals. Within 5 years, all base hospitals should offer necessary training to workers in charge of cancer registries, gather data on the general

population's awareness and carry out further examinations and detection of possible problems of a cancer registry and find solutions for them.

In terms of "cancer prevention", the goals state all citizens should be well aware of the effects that tobacco has on health, the enforcement of appropriate measures to prevent passive smoking, the reduction of the smoking rate among under-age citizens to 0% within 3 years, and the spread of nonsmoking support programs and support for nonsmoking activities.

The goals of "early detection" include increasing the number of people undergoing cancer diagnostic examinations by 50% within 5 years and ensuring that in all cities, towns and villages throughout the country, cancer examinations are conducted under precision management and project evaluation, and cancer examination is conducted based on scientific grounds.

"Cancer research" aims to reduce the number of cancer deaths and to promote research that contributes to the practice of cancer control that alleviates the suffering of cancer patients and their families and improves the quality of life and treatment.

Finally, the Basic Plan raised seven critical topics for the promotion of total and planned cancer control. 1) Strengthening of organic collaboration and cooperation between all concerned parties, 2) Establishing a basic plan to promote cancer control programs at the

prefectural level, 3) Understanding the opinions of all concerned parties, 4) Efforts by citizens, including cancer patients, 5) Implementing necessary budget plans and budgeting in an efficient and focused manner, 6) Reviewing the condition of achieving goals and evaluating the effect of their application, 7) Reviewing the Basic Plan".

Although there are some items that require a more detailed examination, the preceding paragraphs provide a general overview of the contents of the Basic Plan. This article explains about "the right to health" as the focus for assessing the matters to be examined below, and briefly examines the Basic Plan from the viewpoint of ensuring the right to health. It is necessary to further analyze data resulting from interviews in order to conduct a more detailed evaluation.

## **6. Appraisal from the Perspective of Ensuring the Right to Health**

To put into practice cancer control that includes the viewpoints of the general population, including cancer patients, the Control Act was enacted in 2007 and the Basic Plan was established. From now on, it is important to observe the Control Act, and to monitor and evaluate the implementation of the Basic Plan. However, one of the evaluation standards or policies that we can mention is the right to health.

On an international level, the right to health is seen as an important, fundamental human

right, guaranteed to all people under international human rights treaties and various international documents, such as the International Covenant on Economic, Social, and Cultural Rights (hereinafter, ICESCR) (Munesue, 2005). Japan has also ratified several international human rights treaties that stipulate the right to health<sup>14)</sup>. Japan has an obligation to sincerely respect these treaties (Japanese Constitution Article 98, Clause2). Considering the relationship between international and domestic laws, in general, it is accepted that the covenants Japan has ratified are supposed to be predominant in its national laws. In other words, an infringement of the right to health in domestic law is a violation of international covenants. Furthermore, there is a theory that the right to health is not only directly related to international human rights treaties, but also an inherent part of the Japanese Constitution (Article 25) in which the right to health is guaranteed to all Japanese people.”<sup>15)</sup> (Inoue, 1991).

The right to health does not mean “the

right to be healthy”, but can be considered to be “a right to the enjoyment of a variety of facilities, goods, services, conditions, education and information necessary for the realization of the highest attainable standard of health” (Munesue, 2005, 2006). The right to health also means that one has the right to control ones own body and health, the freedom from torture or non-consensual medical treatment and the right to health protection systems that provide equal opportunities to enjoy the highest attainable level of health. The most important thing for the realization of the right to health is to ensure the participation of citizens in all decisions related to health at the community, national and international levels.

WHO and other organizations are creating the indicators to determine whether the health care policies of each country ensure the fulfillment of the right to health. The human rights committee on the ICESCR established the following as the right to health indicators: 1) Availability, 2) Accessibility, 3) Acceptability and 4) Quality. The interrelation between these four indicators is essential<sup>16)</sup>.

1) Availability refers to the number of health facilities and the amount of goods and services being sufficient for the population. For example, are there enough hospitals, clinics and related health facilities, and are there enough appropriately trained medical staff and other specialists at these facilities?

---

14) For example, what international covenants state regarding abolition of any form of racial discrimination (Ratified in 1995), International Covenant on Economic, Social and Cultural Rights (Ratified in 1979), Convention on the Elimination of All Forms of Discrimination against Women (Ratified in 1985), Convention on the Rights of Children (Ratified in 1994)

15) Inoue says “The right to health is, in the broad sense, based on the right to a peaceful existence and the right to live, and it includes a right to health in the narrow sense and furthermore, the right to a clean and healthy environment... It can be said this is based on the Japanese Constitution preamble, Article 13 and 25. Especially, the right to health in the narrow sense is directly stipulated in Article 25” (Inoue, p 86, 1991).

---

16) The right to the attainable standard of health: 11/08/2000/4, CESCR General Comment 14.

2) Accessibility indicates that all people, without discrimination, can make use of facilities, goods and services. The concept of access includes inability to access health facilities due to discrimination based on irrationality or physical reasons (are facilities reachable?), or economical reasons (are they affordable?), finally it also measures if access to information is available. 3) Acceptability deals with indicators that reflect whether personal information is protected, respect for medical ethics and adequate handling of cultural issues. 4) Quality refers to services being medically and scientifically appropriate and of good quality. To wit, can the population receive care services from qualified medical staff using standard techniques, and that use pharmaceuticals and medical equipment that are approved and within their expiry periods.

Nations are not just required to provide simple health care, but also to ensure that the health care provisions comply with the above indicators. Consequently, Japanese cancer control should also comply with these indicators and be evaluated. The following section will make a simple evaluation of the contents of the Basic Plan described above in light of the aforementioned the right to health indicators.

Regarding 1) Availability, “developing medical facilities” can be found in the Basic Plan. It refers to an adequate number of hospitals and other facilities that deliver cancer care, as well as sufficient equipment and staff to respond to patients needs. The same topic is related to 2) Accessibility. In

brief, the Basic Plan does not merely talk about quantities, but specifies the requirement for no uneven distribution at the community level and the need for all people to be able to receive necessary care in their communities of residence or homes. On this point, the Basic Plan refers to the promotion of the equalization of medical care for cancer and home care. Furthermore, simply having a sufficient number of local facilities where care can be received does not mean equal and good quality care. That means it is important for institutions to meet the requirements of 4) Quality. Regarding this point, the Basic Plan states that it is necessary to prepare training and diagnostic guidelines to obtain the necessary skills and technical training for doctors, nurses and other staff involved in cancer care. It also mentions the need of further cancer research promotion. Furthermore, in relation to 4) Quality, the Basic Plan considers that alleviating the suffering of cancer patients and their families, improving the quality of life and palliative care are important issues. In relation to number 2) Accessibility, it should be noted that from the beginning, cancer patient groups have called for policies that provide access to information on cancer care. The Basic Plan deals with this issue in specific topics and seeks to expand the possibility.

Although many points of the Basic Plan seem to meet the requirements of the right to health indicators, there are some unclear and insufficient components that we will discuss below. Regarding 2) Accessibility (affordability), the Basic Plan mentions the

reduction of the period required for the approval of new drugs and equipment for new therapies; but it is still unclear if the use of public health insurance to pay for them will immediately become available. Even if some drugs are covered by health insurance, there are actually patients who will need low-priced alternatives to these drugs due to economic reason, and are not able to select appropriate treatments. There are cases where patients accede to a treatment only after they have started to receive welfare benefits. The Basic Plan does not cover the situations of such patients, but problems related to economic access are directly related to the patient's freedom to select their preferred treatment and thus in violation of this freedom. From fiscal year 2006, terminal cancer patients aged 40-64 years have qualified for the benefits of long-term care insurance. Although there have been a number of problems related to the procedures for authorizing the receipt of long-term care services, if cancer patients can use existing policies that reduce their economic burden, it may provide a way to expand the variety of services they need. It is possible to expand the pension system and welfare aid system (livelihood protection) to ensure the patients income, but in the future it will be necessary to consider other approaches to provide adequate care to all patients, regardless of their different economic circumstances.

Regarding 3) Acceptability, as explained earlier, it is necessary to evaluate the condition regarding the protection of the personal information of patients. Although

the Basic Plan already addresses some matters regarding this point, it is necessary to carefully evaluate the introduction of a "cancer registry" system. Another issue related to acceptability that should be considered in the future is the use of complementary and alternative medicines and the freedom to select these medicines."

Finally, some considerations from the standpoint of the right to health can be found under the 4th item of the aforementioned points of the "critical topics for the promotion of total and planned cancer control" in the Basic Plan, "efforts of citizens, including cancer patients". The clause states "At least, the following efforts are expected from all citizens, including cancer patients", added with "c) Cancer patients and cancer patient groups have roles and responsibilities regarding cancer control. They should participate in the adoption of medical care policies and cooperate with medical workers and governmental organizations and act with responsibility and awareness to help reform cancer control"<sup>17)</sup>. The effect that the integration of the perspectives of citizens, cancer patients and cancer patient groups have had in the establishment of cancer policies has been noticeable, and it is no doubt that they will play a central role in the future development of cancer control in Japan. In that sense, it can be said that in spite of the large physical and economic burdens that patients and their families already carry, they

---

17) Basic Plan to Promote Cancer Control programs, June 2007, page 39.

continue to be forced to make real “efforts” to help cancer control development in Japan. However, from the perspective of ensuring the right to health, the participation of those directly involved (cancer patients and their families) in the establishment of medical care policies is an inherent right. As such, it can neither be taken away from them by others nor imposed on them. The government is responsible for ensuring the right that people have to participate. That is to say, it is not the patients but the government’s responsibility to ensure the participation of patients in the processes of establishment, determination, enforcement and evaluation of policies related to cancer, without imposing any burden on the patients. Similarly, we should not forget that the government carries the largest share of responsibility for the improvement of cancer control. Surely part of the responsibility also belongs to us, the citizens, considering that ensuring human rights is the government’s primary responsibility. In recent years, policies that are related to people’s health are changing the rights of citizens into responsibilities and obligations of those very same citizens. To this day, cancer patients, their families and related organizations have developed cancer control that includes the perspectives of the general population and cancer patients. In order to preserve this direction it is necessary to pay attention to this matter.

## 7. Conclusion

This article reviews the movement of cancer

control from the perspective of the right to health, but it does not go further than an initial discussion. Future research will address areas that have not been covered in this article, such as, information to be obtained from patients, families and related groups. We intend to make a more detailed analysis and evaluation of the Basic Act, the Basic Plan and how they are implemented based on interviews with people and from the perspective of the right to health.

I noted the involvement of cancer patients, their families and related groups has greatly contributed to the development of cancer control in Japan. We will conduct interviews and examine previous research to clarify the normative content of the rights of those directly involved (patients) to participate in decision making and the relationship between participation and the right to health.

In addition, this article introduced some internationally used the right to health indicators and applied them to the evaluation of cancer control in Japan. In the future, we intend to continue research in the field of evaluating policy indicators from the perspective of developing new policies based on the right to health viewpoint from Japan to the world.

## References

- Inoue, H. (1991) *Kenkoken to Iryohosyo*. Asakura, S. et al. *Koza Nihon no Hokeniryo Volume 2. Gendai Nihon no Iryohosho*. Rodo-Junposha Co. Ltd. 76-127. (in Japanese)

Kobayashi, H. (2007) Gentaishakukihonho no Igi to Ganiryō no Arikata : Rippokatei karamita Genjo to Kadai. *Rippo to Chosa*. 265, 55-69. (in Japanese)

Munesue (Shiino), T. (2005) The contemporary meaning of "the right to health" in international community: Referring to "general comment no.14" of the committee on the ICESCR. *Social Environmental Studies*, 10, 61-75. (in Japanese)

Munesue (Shiino), T. (2006) The present state and problems to ensure the right to health

in international human rights law. *Journal of Social Security Law*, 21, 166-181.

NHK-Japan Broadcasting Corporation Specials (2005) *Nihon no Ganiryō wo tou*. Shinchosha Publishing Co. Ltd. (in Japanese)

Ookuma, Y. Kaihara, T. and Hattori, Y. (written and Eds.) (2006) *Bringing Patient's Voice into Medical Care*. Igaku-Shoin Ltd. (in Japanese)

*Received September 28, 2007*

*Final acceptance December 11, 2007*