UICC-ARO
UICC ASIA REGIONAL OFFICE

UICC International Session

81st Annual Meeting of the Japanese Cancer Association

The core elements in sustainability of UHC for cancer in Asia?

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Place: **Hotel PACIFICO Yokohama, Japan and online**

Co-Chairs
The session was co-chaired by: Tetsuo Noda, Chairperson of the Executive Committee of the Japan National Committee of the Union for International Cancer Control (UICC-Japan); Jeff Dunn, CEO of the Prostate Cancer Foundation of Australia and President-elect of UICC; and Kazuo Tajima, Mie University.

Concept
The post-Cold War international order is currently facing an existential crisis, with the world on the brink of fragmentation, and the threat from Covid-19 remains ever-present. Even in such unprecedentedly critical times, humanity cannot avoid the scourge of cancer. In this period of global upheaval we must ask ourselves once more: What does cancer mean for the sustainable society we are aiming to achieve? In post-Covid healthcare what societal elements will form the basis for realizing sustainability? UICC-ARO has to date organized and supported Cross-Boundary Cancer Studies, a multidisciplinary educational program that perceives cancer as a social challenge. With the support of UICC-Japan, UICC-ARO has worked together with UICC headquarters to consider the role that Japan can take in Universal Health Coverage (UHC) for cancer care, particularly in the Asian region, and formulate policy proposals. Global health is also a priority for Japan's foreign and economic security policy as it is expected to result in the "global development of a virtuous cycle of growth and distribution." In contrast to communicable diseases, responses to cancer care require an extended time horizon, which is precisely why cancer care is such a critical challenge in today's world where we are seeking to realize sustainability. This session will discuss the way forward for sustainable cancer care that is relevant to and rooted in the characteristics of the Asian region.

Welcome Remarks
Tetsuo Noda, Chairperson, Executive Committee of UICC-Japan (Co-Chair)
This session is organized by UICC-Japan, UICC-ARO and JCA. UICC is the oldest and largest cancer fighting organizations, globally, established in 1933. It has more than 1,200 members across 173 countries. It has official relations with various UN agencies. UICC-Japan was established to raise a fund for UICC in 1962 and currently comprises 30 members and these members are actively working to tackle cancer. UICC-Japan is contributing to the promotion of anti-cancer movement in Japan and Asia, as an official partners of UICC. The UICC Asia Regional Office (UICC-ARO) also promotes collaborative efforts and this session has been co-arranged by UICC-ARO.

UICC-ARO was established by UICC-Japan in 2006. In 2013, Prof. Hideyuki Akaza, a director of UICC-ARO clarified the roles of UICC-ARO and since then UICC-ARO has organized a variety of meetings for UHC and cancer control in the World Cancer Congress and annual meetings of major academic societies such as JSCO and JCA. UICC-ARO also supports the lecture series on Cross-boundary Cancer Studies by the University of Tokyo. UICC-ARO also works to facilitate government-academic-industry dialogues in Japan.

Prof. Jeff Dunn (President-elect, UICC) and Dr. Kazuo Tajima (Mie University) have been invited to act as co-chairs for this session, which will feature presentations from eminent researchers and practitioners.

Opening Remarks

Jeff Dunn, CEO of the Prostate Cancer Foundation of Australia and President-elect of UICC (Co-Chair)

On the occasion of the JCA Annual Meeting, and importantly this UICC Session, I would like to acknowledge Dr. Noda and each of the delegates for participating in what is an important session. Never before has the topic of UHC been more important. The core elements for sustainable UHC have never been more important, and as we come out of the COVID-19 pandemic we need to keep a laser-sharp focus on how we treat cancer, how we prevent it and detect it early, and make sure that we have world-class research to ensure the best possible outcomes. We must ensure that all of us benefit from the gains in technology, clinical practice, awareness in epidemiology. We must all share these developments equally to make sure that into the future we do control cancer and have a world free from cancer. By your participation in this session you are actively contributing to that hope, and I thank you for it.

Kazuo Tajima, Mie University (Co-Chair)

Dr. Dunn's work in cancer control spans 30 years, in which time he has dedicated his career to the development of strategies that underpin cancer survival and improve awareness of the disease with a special focus on the social and behavioral aspects of cancer and has over 200 publications, including peer-reviewed manuscripts, chapters, books and reports.

In 2014 he was appointed an Officer in the Order of Australia for distinguished service to medical administration through leadership of cancer control organizations and promotion of innovative and integrated cancer care programs.

Presentation 1

UHC: What it is, why it is important, what does it mean for cancer control?

Jeff Dunn

CEO of the Prostate Cancer Foundation of Australia and President-elect of UICC

UHC means that all people can get quality health services, where and when they need them, without suffering financial hardship. It has three key dimensions: 1) Access to health services; 2) Financial risk protection, i.e., access not determined by ability to pay, and people should not fall into debt paying for treatment and care; and 3) Quality of services should be good enough to improve the health of the people who receive them. UHC is also grounded in the principle of equity, namely 'Health for All' and 'Leave no one behind.'

UHC is a political choice and commitment. It is not a new idea or approach. "Health for All" is embedded in the WHO Constitution in 1948 and was central to the Alma Ata Declaration on Primary Health Care (1978). Implementing UHC has been placed on health agenda of many countries and is included in the Sustainable Development Goals (SDG 3.8)

In September 2019, a UN High Level Meeting saw the adoption of the Political Declaration "UHC: Moving together to build a healthier world." This is a High-level political framework for action, negotiated by UN member states over four months in New York. It proposes a rights-based approach, based on people-centred services, and calls for investment in health (all countries encouraged to spend an additional 1% of GDP on health).

UHC is important because huge inequities in access to health services and a huge problem of out-of-pocket spending is leading to impoverishment. At least half of the world's population still lack full coverage with essential health services. The incidence of catastrophic spending increased continuously between 2000 and

2017. Between 2015 and 2017, the proportion of the population with OOPs exceeding 10% of their household budget rose from 12.7% of the population (940 million) to 13.2% (996 million) (WHO/World Bank 2021 Global Monitoring Report).

The global COVID-19 pandemic points towards a significant worsening of financial protection globally, due to a higher incidence of catastrophic spending and worsening impoverishment due to out-of-pocket health spending, unemployment, shrinking savings etc. Survival rates for cancer are vastly different across countries and even within countries (e.g., paediatric cancer survival rates- 80% and above in some HICs, lower than 20% in some LICs).

UHC requires investing in the health system. UHC is premised on building an efficient health system that provides equitable access to affordable, high quality health care (e.g., services, health workers, medicines, technologies etc.), and also spans the continuum of health from prevention and health promotion to treatment, curative, palliative and rehabilitation. UHC can be measured/monitored by the proportion of a population covered by essential quality health services, or the proportion of the population covered by prepaid health fund, or the proportion of health services included in the UHC package.

Catastrophic health spending can be a problem in many countries. Is mainly found in LMICs but also some HICs. In LMIC countries, where GDP spending on health is low (less than 5%), out of pocket payment can accounts for 37-50% of health spending. Cancer has been documented to be a major cause of high out of pocket spending. A longitudinal study in the USA (9.5 million new cases of cancer from 2000-2012), found at two years post diagnosis,42.4% had depleted their entire life's assets. An ACTION study in Southeast Asia found that 12 months after diagnosis, 29% had died, 48% experienced financial catastrophe with only 23% still alive with no financial distress.

In terms of implementing UHC, it does not necessarily mean free coverage for all possible health interventions, regardless of the cost. It includes interventions for individuals and for entire populations, such as health promotion, prevention, screening, and access to treatment. It encompasses all components of the health system: health service delivery systems, the health workforce, health facilities and communications networks, health technologies, information systems, quality assurance mechanisms, and governance and legislation. UHC is not only about ensuring a minimum package of health services, but also about ensuring a progressive expansion of coverage of health services and financial protection as more resources become available. There is no one size fits all. But every country can do something to advance UHC.

In terms of progress in implementing UHC, a study in the Lancet on UHC coverage in 111 countries, found that seven of the twelve countries for which they had trend data have increased their UHC index over time. These increases were achieved mostly by improving both financial protection and service coverage. The study found that UHC indicators are significantly and positively associated with GDP per capita, and most are correlated with the share of health spending channelled through social health insurance and government schemes.

With regard to financing UHC, no country has attained UHC on the basis of voluntary contributions alone or on out-of-pocket payments. Financing UHC requires raising revenue (income tax, taxes on consumption (excise tax), 'sin tax,' taxes on business or on trade, payroll tax, compulsory health insurance etc., also 'external' revenue such as ODA); pooling funds (pools pre-paid funds, spreads the risks of costs of care across a group); and purchasing. Domestic public financing is fundamental to achieving UHC. However, private sector and civil society are critical stakeholders in achieving UHC.

In terms of addressing cancer within UHC, globally, cancer is the second leading cause of mortality, morbidity

and disability, with an estimated 19.3 million new cases and 10 million deaths in 2020. It is estimated that 90% of high-income countries can provide access to the essential treatment modalities (surgery, radiotherapy, and essential medicines) for cancer patients, compared to 30% of LMICs. There is a need for a comprehensive response to cancer control underpinned by strong data- critical importance of cancer registries. It is essential to include NCDs (of which cancer is on) in the essential UHC package. A 15% reduction in premature mortality could be achieved by 2030 by implementing the WHO Best Buys.

In terms of cancer and UHC in the Asia region, a number of countries in Asia can serve as case studies in how quality cancer care can be made more widely available in coordination with a UHC benefit package and strategy.

In Indonesia, with regard to cancer care, the national health insurance scheme aims to provide diagnosis and treatment for all cancer types. This package includes financial protection to access chemotherapy, radiotherapy and surgery with a cancer diagnosis in district and national facilities. Cancer prevention and screening remain important gaps that are not covered with the exception of the national cervical cancer screening program.

In the Philippines, The journey to UHC began with a 'Medicare' health insurance in 1971. In 1995, the National Health Insurance Act paved the way for the creation of the Philippine Health Insurance Corporation and was enacted to provide social health insurance coverage for all Filipinos. While coverage had increased to 82% by 2009, conditions that resulted in prolonged hospitalization and care still posed major financial hardship. In response to civil society pressure, the 'Z benefits' package was introduced which covered care for breast, prostate, cervical and childhood cancer (Acute Lymphocytic Leukemia) and from 2015, colon and rectum cancers.

In Thailand, since 2002, everyone in Thailand has access to health coverage, through Universal Health-care Coverage Scheme that covers 75% of the population, a Civil Servant Medical Benefit Scheme (7%) and a social security scheme for private sector employees (covering around 17% of the population). The goal of Thailand's healthcare reforms was to expand and improve health services as well as lower financial risks and catastrophic spending. The health insurance system in Thailand pays for all cancer care. Those with government insurance can go to any hospital, while those covered by the UCS and social security schemes first consult at primary care facilities and, if diagnosed, they are referred to an oncologist and regional cancer center for treatment.

In conclusion, given the rising burden of NCDs, the cost of inaction on NCDs and cancer far outweighs the costs of action to improve prevention, early detection, treatment, and care for population health. Therefore, inclusion of cancer control is essential to achieving UHC.

Discussion

Noda: You spoke about the importance of a focus on LMICs and in the final part of your presentation you referred to three Asian countries. The Philippines belongs to the LMIC group. Do you think that we have enough information about the medical systems with regard to funding and UHC in LMICs in Asia?

Dunn: We really do need to work individually with countries, as there is no one-size-fits-all. There are some situations in high-income countries (like the U.S.) where treatment can cause financial catastrophe. We must recognize individual country differences and work with countries to bring about the best possible outcomes, based on the resources available.

Noda: You didn't mention much about COVID-19. When we think about UHC for NCDs, we always have to

think about COVID-19 and infectious diseases. Could you share your thoughts on the interrelationship on UHC for NCDs like cancer, and UHC for infectious diseases like COVID-19?

Dunn: COVID-19 has had a major impact on cancer control. In Australia, COVID-19 has impacted testing and treatment and there are concerns that this may impact early detection activities. We certainly need to treat COVID-19, but the job for NCD experts is to maintain a focus on NCDs and cancer in particular.

Presentation 2
Cancer in low- and middle-income countries in the context of global health
Hajime Inoue
World Bank
In terms of the mapping of disease burden in East Asia, the great majority of the disease burden is accounted for by NCDs, and for some NCDs the burden is increasing, including for a number of cancers.

Every year 10 million people around the world die of cancer and more than half of those deaths are in Asia (5.8 million), and the figure is rapidly increasing, due in part to the rapid aging of Asian populations. Cancer cases will continue to increase, and the WHO estimates that the approximately 20 million cases in 2020 will increase to over 30 million by 2040. Cancer is increasing more rapidly in low human development index (HDI) countries, and it is estimated that in low HDI countries new cases will increase by almost 100%.

Treatment disparity is also larger than for other diseases, given that cancer treatment requires skilled specialists, heavy equipment for diagnosis and treatment, intensive care units, non-generic medicine, and cross-disciplinary work. The availability of comprehensive cancer treatments is also an issue as availability is less than 20% in low-income countries, in contrast to approximately 90% in high-income countries.

In covering UHC cancer faces specific difficulties in achieving comprehensive coverage for treatment. This is because cancer treatment requires strong social and health systems. Some of the factors that are required, or need to be borne in mind include: health literacy, socio-cultural factors, data to inform policies, screening, early diagnosis and effective care, transportation, health worker capacity, supply chains, financial affordability, and health insurance coverage. These requirements are demanding and not easy to fulfil.

One example of work towards ensuring success is the WHO and IAEA project to set technical specifications of radiotherapy equipment for cancer treatment.

A comprehensive approach to mitigating disease burden is critical, and covers everything from screening, prevention, early diagnosis, treatment, and palliative care. In terms of prevention, between 30 to 50% of cancers are preventable by healthy lifestyle choices.

There are globally more than 2.2 million infection-attributable cancer cases globally, which accounts for approximately 20% of all cancer cases. These cases are easily treatable, even in LMIC settings, and could be considered to be “low-hanging fruit” in terms of initiatives to improve prevention. The East Asian region is most prone to infection-attributable cancers and therefore more attention is required in this region.

There are more than 400,000 cancer cases estimated to be attributable to alcohol in Asia, and this is another area that requires action in the region. There are an estimated 800 million smokers in middle income countries, which is the category in which most countries in Asia are classified.

In summary, cancer cases and deaths are increasing disproportionately in MLICs. Treatment disparities between HICs and LMICs are significantly large in cancer. Cancer treatment is a challenge as it requires

stronger social and health systems. There is a need for broader scope than treatment, including prevention, which is particularly important in East Asia where risks associated with infection and smoking are higher.

Discussion

Tajima: I am working in a local area of Japan, where most people are over 65. You introduced approaches for prevention of NCDs, but what you did not mention is the importance of exercise.

Inoue: Actually, exercise is also important and generally speaking lifestyles that could affect various types of diseases need to be given attention. Cancer is more strongly linked to infection and alcohol, rather than exercise, which is more strongly linked to diseases such as cardiovascular diseases, which is why I did not refer to it specifically in my presentation.

Noda: You noted that for LMICs a package of treatment, diagnosis of prevention is required. Do you think that we have a common package that may be applicable to many types of LMICs in Asia, or is it necessary to adjust packages to each country's situation?

Inoue: I agree with the previous comment by Prof. Dunn, that no system fits all and we must adjust to each country's national plan. Generally speaking, it is important to combine all elements and approaches, but the actual mixture differs from country to country. This is first and foremost a decision that needs to be made by the authorities in each country based on their own particular situation.

Presentation 3

Affordable access to care in low- and middle-income Asian countries: Some lessons from recent experience

Ajay Mahal & Marie Ishida

Nossal Institute for Global Health, The University of Melbourne

In terms of understanding the term "affordable access," for the purposes of this presentation it is defined as follows. "People obtain the health services they need without financial hardship and without compromising quality."

There has been remarkable expansion in population health insurance coverage in Asian LMICs. The share of population supported by government health insurance has increased markedly in recent years, and some countries have achieved almost 100% coverage in terms of the proposition of population covered by health insurance.

For example, in Malaysia public sector hospitals and outpatients offer a wide range of services for free to all Malaysians and private insurance is available to those who can afford it. In India, government-funded hospital insurance and social insurance has expanded from negligible levels in 2005 to cover almost 70% of the population at present.

One of the key lessons from this increase in health insurance coverage is that high levels of government subsidies are required to expand coverage to informal sector workers, whether through public insurance, or tax-financed public services. This is because the high share of informal work means that income-based premiums have not been easy to implement. It is difficult to separate poor from non-poor informal workers for the purpose of premiums.

In terms of the generosity of coverage provided, in almost all cases the share of out-of-pocket expenditure in national health spending has declined since 2000. The achievement has been most marked in Thailand, where out-of-pocket expenditure is now around 10%.

However, the share of out-of-pocket expenditure is still high, standing at above 30% in most countries. There is still some way to go before it can be said that coverage is sufficiently generous. One of the causes of this is the issue of incomplete coverage. High shares of out-of-pocket spending suggest that coverage is incomplete and focused on hospital care. It also points to government funding constraints. For example, where as health spending accounts for approximately 10% of GDP in Japan and Australia, spending as a percentage of GDP is significantly less in other Asian countries.

Another issue to consider is the inefficiency of resource use. The high share of out-of-pocket spending illustrates fragmented funding, which in turn limits ability to negotiate price and quality with healthcare providers. Inefficiency in resource use also lowers the focus on preventive care among users and providers alike.

Another key point to consider relates to equity. Out-of-pocket spending may reflect an inability of some population sub-groups to access health insurance benefits, for example a lack of awareness about eligibility. Another important group that often does not enroll in the health insurance system is the so-called "missing middle" (near-poor) who do not enroll voluntarily. In some cases out-of-pocket spending may reflect a decision on the part of the patient to seek care instead of going without care.

Policy lessons about affordable access and talking out-of-pocket expenditure include using resources efficiently and fairly. This includes focusing on prevention (tobacco taxes, vaccination, etc.), investing in coverage of primary care, effective use of payment mechanisms to promote referral linkages across healthcare providers, and easing of administrative procedures for enrolment, combined with awareness campaigns.

Discussion

Inoue: With regard to the out-of-pocket expenditure data, there is a risk of over generalization. For diseases other than cancer it is correct that health insurance coverage is increasing and improvements have been achieved in recent years. Cancer is special in that it requires specialist and expensive care. The reality in middle income countries in Asia is that cancer treatment is not covered, or only partially covered. There are also few or no facilities for comprehensive care in MICs in Asia and a lack of specialists capable of providing specialist treatment. We really need to bear in mind that cancer is very difficult to generalize.

Mahal: There is no doubt that without paying attention to the supply side there is little meaning to any benefits package. However, at a fundamental level with regard to the issues relating to the supply side, simply expanding coverage and throwing money at the problem is not going to be sufficient to improve the situation. The supply side needs attention, otherwise inefficiencies are only going to be exacerbated.

Noda: This is a very important point.

Presentation 4

Core elements in sustainability of UHC for cancer in Asia

Murallitharan M. Munisamy

National Cancer Society of Malaysia

UHC is an unreachable situation, because it is an ever-evolving dynamic process. Malaysia theoretically has UHC since independence, but there are high amounts of out-of-pocket expenditure, which is due to the fact that the health coverage system is largely inadequate. The quality of care and the supply side is being unrealistically deployed. Countries should continually question themselves about how they can do better in providing UHC. This is why UHC should be an ever-evolving goal. The three dimensions of UHC are population, services and direct costs.

In a post-COVID world the UHC box for cancer has already shrunk significantly. Financial and human resources have been diverted to communicable diseases to prepare to mitigate future outbreaks. There has been little or no development of resources in order to “catch up” on cancer initiatives that have been impacted during the three years of COVID-19. The challenge is to keep the UHC box for cancer at least the same size, or even to expand it further.

For every kind of segment within the cancer control continuum there needs to be a continuous review process that looks at aspects of prevention, screening, diagnosis, treatment and survivorship. It is important to continue to ask basic questions like: who is covered? What is covered? Who is paying for coverage? How can we do better?

In terms of sustainable elements for UHC, it is essential to gain input from various stakeholders. In the case of Malaysia this has included ministry officials, primary care management, hospital management, voluntary insurance associations, national banks, health system experts and economists. These stakeholders are asked for their opinions on various pressing issues.

In terms of challenges for UHC on the supply side and demand side in Malaysia, on the supply side common challenges to medical goods and medical services including managing innovation and entry, medical and non-medical inflationary pressures, and medicalization and defensive medicine. Also on the supply side are indirect medical-related expenditures, which exist in a largely unregulated market, including supplements, etc. There is also a growing need for more and expanded psychosocial support.

On the demand side, in the public sector one of the challenges is a reducing tax base as more and more people are moving to employment in the gig economy, and therefore not paying into health insurance systems. Another issue, and one that is common to Asian countries is that there is an increasing aging population that is growing sicker as they age. There is also competition for funds with other national priorities. Governments are also moving to contain costs amidst economic uncertainty, whereas patients are seeking ever more sophisticated treatment.

Returning to the “UHC Box” it is important to envision sustainability in the future, and whether sustainability will increase, be maintained, or decrease.

In terms of increased sustainability in the population axis of the UHC box, proposed measures are to introduce preventive health care and implement cross-functional measures that address the social determinants of health. If maintenance of sustainability is the goal, this will require non-citizen enrolment into the healthcare system, innovative insurance models, the removal of discriminatory barriers, and innovative financing. Gate-keeping measures are only likely to result in decreased sustainability.

In terms of costs in the UHC Box, in order to increase sustainability, proposed measures are to implement voluntary licensing, strengthen not-for-profit delivery models, and ensure robust mixed purchasing models. To maintain sustainability the proposed measures are to strengthen cost-effective delivery and seek alternative/complementary funding. The introduction of cost-control and cost-containment measures will result in decreased sustainability.

In terms of services in the UHC, to increase sustainability proposed measures are to build in applicability measures into development models, provide public financing for R&D of medical technologies, provide downstream innovation, and task-shifting to allied HCPs. To maintain sustainability the proposed measures are to ensure transparent prioritization initiatives, and engage in strategic purchasing or pooled procurement.

Rationing of services will merely lead to decreased sustainability.

I would like to talk about the BEAUTY and HEALTH Project, which is a transnational collaboration between Malaysia and Japan to build a sustainable health promotion system in Malaysia based on digital technology. The aim is to make sure that people who are living longer are not as sick.

Another challenge is to bridge the NCD and communicable disease space. For example, the National Cancer Society of Malaysia assisted the government of Malaysia to vaccinate more than 155,000 bed-bound cancer patients with COVID-19 vaccines, mobilizing a volunteer force of more than 700 people.

Discussion

Norie Kawahara (University of Tokyo): As Dr. Noda mentioned, we have been implementing Cross-Boundary Cancer Studies for more than 20 years at the University of Tokyo with the support of UICC-ARO. This year there has been a course focusing UHC in Malaysia. Dr. Akaza once said that cancer is a mirror of society. UHC for cancer is complex and cannot be solved by medicine alone. As UICC members, NCSM and Asia Cancer Forum have maintained a good relationship and we are now working together on the BEAUTY Project with the support of Astellas. We are thinking about what is important for sustainability and how to collaborate with the world outside medicine. I believe that the UICC network based on trust has the potential to overcome various difficulties.

Murallitharan: None of us can act alone, and we have learned from COVID-19 that transnational cooperation across many sectors will actually help the drive for cancer care and help to reduce costs. Many companies that ran PCR tests now have an excess capacity, and working together with multinationals we have managed to reduce HPV testing costs across Malaysia by about 40%.

Presentation 5

Policy on the international development of health care

Ryosei Mizuguchi

Ministry of Economy, Trade and Industry (METI) Japan

The Asia Health and Wellbeing Initiative (AHWIN) was launched by the Japanese government in 2008. Under this basic policy, the Japanese government is promoting initiatives through mutually beneficial approaches, including the entry of the Japanese private sector into the Asian region. In terms of intergovernmental cooperation various MOUs have been concluded under AHWIN. Products and services included include medical/elderly care, healthcare services (prevention/health maintenance), and services supporting healthy life.

METI is promoting the international expansion of medical care, while taking into account AHWIN. METI is considering both outbound and inbound measures. In terms of outbound promotion, METI, in cooperation with related ministries and agencies, is promoting the export of medical equipment and services as “business” (i.e., aiming to obtain appropriate revenue and compensation from the partner country, rather than just international contribution and cooperation). It is important to contribute to both UHC and also to the achievement of SDGs.

In terms of METI policy for supporting international expansion, through support for demonstration surveys, the project supports development of local human resources, and establishment of local standard medical treatment methods through creation of academic guidelines and inclusion in insurance coverage. In the future METI will further promote business, including the use of digital technology, to capture new growth markets. Examples include projects implemented jointly with major Japanese companies such as Olympus and Fujifilm.

In the case of the Olympus-led project the aim was to resolve issued by developing local human resources

and establishing standard medical practices. The Fujifilm project sought to promote the superiority of Japanese liver cancer surveillance and diagnosis in Thailand.

Another Fujifilm-led project launched health checkup centers in India and other emerging countries in Southeast Asia, the Middle East and Africa. “NURA,” a health checkup center focusing on cancer screening was opened in Bangalore in February 2021, in Gurugram in July 2022, and in Mumbai in September 2022. A total of 10 cancer screening tests are offered.

In terms of medical inbound (medical travel) initiatives. These refer to the acceptance of foreign patients by Japanese medical institutions, who travel to Japan for the purpose of receiving medical care at Japanese medical institutions. Providing advance Japanese medical care to medical travelers contributes to the international community and improves the utilization of medical resources for Japanese medical institutions. The medical inbound system also includes a medical visa guarantor agency to facilitate the travel and medical care of patients from overseas.

Medical Excellence Japan (MEJ) was established in 2011 with the support of METI. MEJ promotes the globalization of Japan’s medical services as a public and private partnership under the philosophy of mutually beneficial international cooperation. In recent years MEJ has been focused on a project called MEX, which aims to establish medical centers in each region that will serve as MEJ counterparts in a mutually beneficial relationship. One such initiative is the establishment of “Medical Excellence Vietnam” (MEV), consisting of industry-academia-physicians to establish a relationship with local opinion leaders.

Following the advance initiatives currently underway in India and Vietnam, the MEX initiative will be accelerated with other countries based on AHWIN, and also the African Health Initiative. A true solution will require academia-industry-government collaborations in all countries in the future. The Japanese government will continue to support such initiatives going forward.

Discussion

Noda: METI is implementing various projects overseas, so could you tell us how approaches are being made to contacts overseas. Is it the case that METI officials are contacting counterparts directly, or are you working in partnership with the private sector to approach other countries.

Mizuguchi: METI officials reach out directly to hospitals and companies in other Asian countries, and METI also works with Japanese hospitals, companies and academic institutions to interact with counterparts and stakeholders in Asia. There is a website that explains the situation of the AHWIN-related projects and also the status of the MEJ/MEX projects.

Tajima: We can recognize from each speaker’s presentation that there are still issues relating to the establishment and development of UHC for cancer. In terms of the development of UHC, a question that we would like to discuss more fully at a later date concerns the unique and essential strategy for cancer in comparison to other NCDs.

Noda: Given that the next UN High-Level Meeting is scheduled to take place in September 2023, in the runup to that meeting it would be extremely beneficial for all speakers and stakeholders present here today to stay in touch via mail, etc., to confirm the key points that need to be taken forward to the UN meeting. I suggest that we continue to monitor the situation and identify points that we can propose to UICC President-elect Dunn to raise at the UN next year.