MEETING REPORT

Roundtable Discussion at the UICC World Cancer Congress: Looking Toward the Realization of Universal Health Coverage for Cancer in Asia

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Abstract

The Japan National Committee for the Union for International Cancer Control (UICC) and UICC-Asia Regional Office (ARO) organized a Roundtable Discussion as part of the official program of the UICC World Cancer Congress 2014 in Melbourne, Australia. The theme for the Roundtable Discussion was "Looking Toward the Realization of Universal Health Care 'UHC' for Cancer in Asia" and it was held on December 5, 2014. The meeting was held based on the recognition that although each country may take a different path towards the realization of UHC, one point that is common to all is that cancer is projected to be the most difficult disease to address under the goals of UHC and that there is, therefore, an urgent and pressing need to come to a common understanding and awareness with regard to UHC concepts that are a priority component of a post-MDG development agenda. The presenters and participants addressed the issue of UHC for cancer in Asia from their various perspectives in academia and international organizations. Discussions covered the challenges to UHC in Asia, collaborative approaches by international organizations, the need for uniform and relevant data, ways to create an Asia Cancer Barometer that could be applied to all countries in Asia. The session concluded with the recognition that research on UHC in Asia should continue to be used as a tool for cancer cooperation in Asia and that the achievement of UHC would require research and input not only from the medical community, but from a broad sector of society in a multidisciplinary approach. Discussions on this issue will continue towards the Asia-Pacific Cancer Conference in Indonesia in August 2015.

Keywords: UICC-WCC - UICC-ARO - universal health coverage - Asia Cancer Barometer

Asian Pac J Cancer Prev, **16 (1)**, 1-8

Introduction

The Union for International Cancer Control (UICC) is a membership organization with the vision to unite the cancer community to reduce the global cancer burden, to promote greater equity, and to integrate cancer control into the world health and development agenda. Founded in 1933 and based in Geneva, UICC's growing membership of over 770 organizations across 155 countries, features the world's major cancer societies, ministries of health, research institutes and patient groups. Together with its members, key partners, the World Health Organization, World Economic Forum and others, UICC is tackling the growing cancer crisis on a global scale. As part of the official program of the UICC World Cancer Congress 2014 in Melbourne, Australia, on December 5, 2014, the Japan National Committee for UICC and UICC-Asia Regional Office (ARO) organized a roundtable discussion to address the topic "Looking Toward the Realization of UHC for Cancer in Asia."

The goals of universal health coverage (UHC) are to ensure that all people have access to high-quality health services, to protect all people from public health risks, and to protect all people from financial hardship due to out-of-pocket costs for health services and loss of income when a person or a family member falls ill. Although each country may take a different path towards the realization of UHC, one point that is common to all is that cancer is projected to be the most difficult disease to address under the goals of UHC. There is, therefore, an urgent and pressing need for cancer specialists to come to a common understanding and awareness with regard to UHC concepts that are a priority component of a post-MDG development agenda.

As it undergoes a process of dynamic economic

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development, the Asian region is experiencing significant changes in social structures, although a full picture may be difficult to discern. However, efforts to share the experiences of Asian countries as they introduce and implement UHC strategies focused on cancer are likely to provide a valuable framework for future cancer care policies that will serve as a reference for other regions, including Africa.

UICC-ARO has engaged in discussions to date concerning the medical economy, which have confirmed the necessity of newly creating and analyzing data that covers the situation relating to cancer across Asia as a whole. Such data compilation and analysis would help to clarify the values that underpin economic concerns and constraints (doctor-patient relations, public expectations of health services, relations with families and relatives of patients, etc.) and would also assist in the achievement of "well-being"—the ultimate goal of UHC.

This Roundtable Discussion was held to discuss a policy research framework for cancer UHC strategies in Asia, taking advantage of the valuable opportunity provided by the gathering of global cancer experts at the UICC World Cancer Congress in Melbourne. The discussion was co-chaired by Hideyuki Akaza (RCAST, The University of Tokyo), Jae Kyung Roh (Yonsei Cancer Center, Yonsei University Medical School) and Xishan Hao (Chinese Anti-Cancer Association (CACA)).

Objectives

Share information about the current status of countries in Asia, which are at various stages—from introduction to full operation—of UHC strategies for cancer. Examine research frameworks and aim to devise new structures for cooperation on cancer in Asia based around the goal of UHC. Utilize the forum of the UICC-WCC to call for further technical advice and financial and policy assistance for the compilation of UHC policies and related structures.

1. Present Status of UHC Strategy on Cancer in Asia; a Global Perspective

Way to Realize UHC on Cancer

Hideyuki Akaza (RCAST) introduced his co-chairs, Jae Kyung Roh (Yonsei Cancer Center) and Xishan Hao (CACA). He began by noting that the goal of universal health coverage (UHC) is to ensure that all people obtain the health services they need without suffering financial hardship when paying for them. It is also important to reduce disparity and ensure that efforts are realized both internationally and intra-nationally. An ultimate goal of UHC is to reduce the ratio of mortality to incidence by cancer type, bringing low income countries in line with the situation with high income countries.

Various factors influence the realization of UHC, in addition to clinical decisions. In terms of cancer treatment decisions, other factors include: science, politics, economics, philosophy, religion, education and lifestyles. Health expenditure per person is very high in the United States, but lower in countries like Japan and the countries of Europe. This depends on the kind of health insurance is applied and discussion is required on the kind of system that is best-suited to achieving UHC.

At the 2013 Asian Oncology Summit in Bangkok, Thailand a consensus statement on resource-stratified guidelines for prostate cancer was adopted by a multidisciplinary panel from Asia-Pacific countries, stratified according to the extent of resource availability based on a four-tier system of basic, limited, enhanced and maximum resources to enable applicability to Asian countries with differing levels of healthcare resources (William et al., 2013). This kind of guideline could be one way of achieving UHC international or intra-nationally.

In terms of UICC-ARO activities, various meetings were implemented during fiscal 2013, including a UICC session at the Asia Pacific Cancer Control Leaders' Summit in Tianjin (October 31, 2013) and the Japan-Korea-China Trilateral Cross-boundary Cancer Studies Joint Seminar in Seoul (February 21, 2014). In fiscal 2014 the UICC-ARO is sponsoring this roundtable discussion as a part of the official program of the UICC World Cancer Congress to address the issue of UHC and cancer/NCDs. In addition to this roundtable discussion, a further UICC-ARO session is planned for the UICC World Cancer Congress, entitled "Economic Burden of Cancer in Asian Countries: How should we face the current situation?"

UHC research trends

Shinjiro Nozaki (WHO) made a presentation entitled "Advancing NCDs in Universal Health Coverage and the Possible Role of WHO Kobe Centre (WKC)." With regard to forward movement of action on NCDs, in 2011 the UN General Assembly Political Declaration for Prevention and Control of NCDs defined voluntary targets for NCDs. The WHO is also leading a global coordination mechanism for NCDs and is interacting with many stakeholders, including UICC and the NCD Alliance. The WHO also assists in the development of national multi-sectoral plans. There is a global need for NCD linkages, due to the aging of populations, urbanization, life course approaches and also control of risk factors through health promotion. This need exists in all countries, whether they be high or low income.

UHC is defined as ensuring that all people can use the promotive, preventive, curative, rehabilitative and palliative health services they need, of sufficient quality to be effective, while also ensuring that the use of these services does not expose the user to financial hardship. This definition of UHC embodies three related objectives: equity in access to health services - those who need the services should get them, not only those who can pay for them; that the quality of health services is good enough to improve the health of those receiving services; and financial-risk protection - ensuring that the cost of using care does not put people at risk of financial hardship.

All member states of the WHO have endorsed actions on UHC. The UN itself is developing sustainable development goals for post 2014. This requires rethinking and reorienting of health systems, to include: Emphasis on prevention and health promotion, quality of services; Community engagement and person-centered approaches; Defining services: rehabilitation, palliative care;

Integration within health system and across sectors; Priority for most vulnerable groups (children and the elderly); and Health financing and social safety nets; policy coherence.

Major agenda items for UHC include health service delivery, follow up for the MDGs, healthcare financing, human resources for health and innovation for affordable and accessible medicines and health technologies.

In June 2013 the government of Japan released its strategy on Global Health Diplomacy, which focuses attention on UHC. Japan's experiences of UHC from the 1960s onwards can be usefully transferred to other countries, including such matters as comprehensive health services for citizens, universal health insurance system, long-term care insurance, medical expenditure control system, unified health regulation, medical education, nursing education, inter-professional education and innovation for NCDs.

The aging of society is a key issue for Japan and the aging society will create new health needs and opportunities for early prevention and health promotion. Aging is not only a problem for Japan, but for the entire region, where the aging process has already begun. Japan and other Asian countries will face a declining birth rate with an increasingly elderly population. This changing demographic situation will create new health needs, including financing strategies and incentives, NCD prevention/control, and community models of care and support. It is against this backdrop that Japan has announced a new "Nippon Initiative on UHC."

The WHO Kobe Centre (WKC) was created in 1995 as part of WHO headquarters. It is global center of excellence for cross-cutting research into health, social, economic, and political factors in health and development. WKC leads WHO work on urbanization and health and research applied to NCD prevention and control. Other efforts include initiatives to promote innovation for aging populations. WKC is now shifting to a focus on UHC, aging and innovation.

In November 2014, a consultation on "Achieving UHC and Future Research Directions for the WHO Center for Health Development" took place at WKC. It was proposed in that consultation that WKC should act as a think tank within the WHO with convening power. In the future the WKC will focus on UHC, innovation and aging, looking in particular at case models. WKC seeks to engage in linkage with the Japanese government's Nippon Initiative on UHC and further enhance collaboration with Japanese and international academia (Figure 1). WKC seeks also collaborate further with other stakeholders, including UICC and UICC-ARO.

How can we frame UHC within the UICC?

Eduardo Cazap (UICC) noted that the phrase "global UHC" presents challenges relating to all aspects of its terminology: "Global" "Universal" and "Health Coverage." Today, one of each ten dollars that the world produces goes to health, and the results in some cases are not very good https://www2.deloitte.com/content/dam/Deloitte/global/Documents/Life-Sciences-Health-Care/dttl-lshc-2014-global-health-care-sector-report.pdf (Last access January 12, 2015). With regard to UICC, the point of focus is the World Cancer Declaration. One of the points of the declaration is "Proper Access to Care." For access to care, a system that responds to the needs of the patients is required (http://www.uicc.org/world-cancer-declaration). A further issue is that UHC is based in diagnosis and treatment in the majority of cases. If cancer control is to be analyzed from primary prevention and research, secondary prevention, palliation, morphine access and end-of-life, although many systems are providing coverage for diagnosis and treatment, they do not provide for secondary

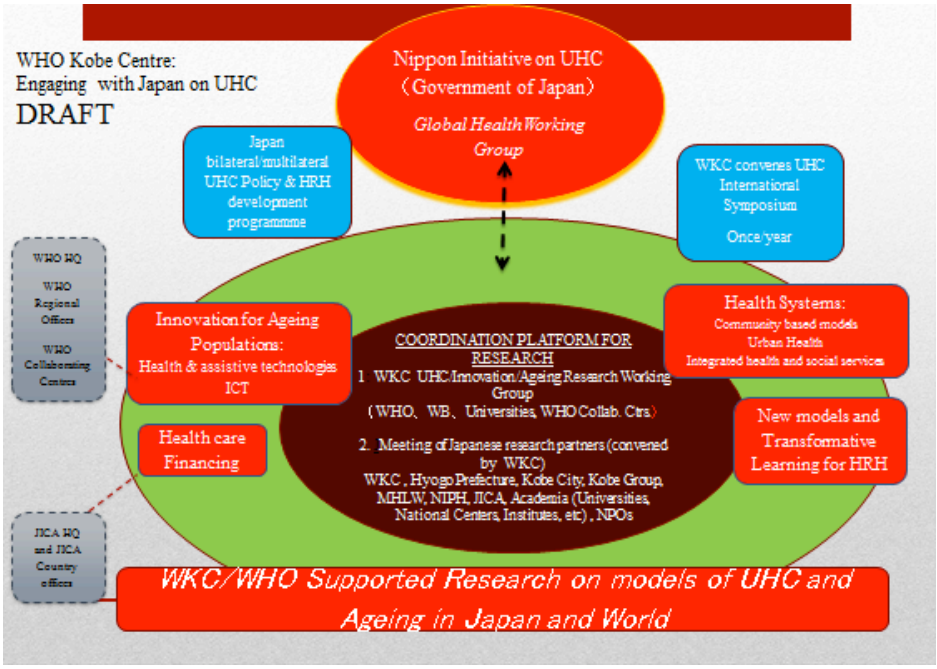

Figure 1. Activities of the WHO Kobe Centre with regard to Universal Health Coverage

prevention and palliation, etc. UHC therefore has a political component and this component should perhaps be included in the promotion of actions on NCDs (UN Global Health and Foreign Policy resolution: UHC 2012 67th G.A.). One of the key initiatives of the UICC has been to promote primary and secondary prevention for the major diseases and palliative care. However, there was no strategy for diagnosis and treatment. The question is: what is the common denominator for all diseases in order to have the same benefits in diagnosis and treatment, if diagnosis and treatment methodologies are different? If all the diseases together are included under UHC, the majority of diseases, including cancer, would benefit. One of the WHO's top priorities is UHC and the WHO is part of the UN system, which is composed of national governments (Vega, 2013 also Ref: http://www.who.int/bulletin/volumes/91/8/13-125450/en/).

In many countries one of the key issues that require attention is fragmentation of healthcare systems and in some cases double coverage, which incurs additional cost and impacts efficiency of actions on NCDs (eg Goss et al.,. 2013). For the UICC and the world it will be necessary to promote UHC for cancer together with all other diseases in order to overcome political obstacles. It will also be necessary to have a top-down strategy from the WHO and UICC and other international organizations that work in conjunction with bottom-up initiatives including NGOs that push local governments to have a coordinated approach.

What does UHC mean in terms of global health?

Edward Trimble (National Cancer Institute) noted that in terms of global health, UHC means access for all people to prevention, screening, treatment, and symptom management for cancer and other NCDs. Dr. Cazap had mentioned that coverage for prevention, screening and symptom management is particularly important.

There are a number of issues, however, that require attention. Firstly, what services are covered by UHC, and are all types of cancer are included? As UHC is introduced by some countries, not all cancers are covered. Other issues that require attention are whether there are out-of-pocket expenses and whether co-payments are required. Also, the issue of whether there is access to appropriate specialists needs to be asked and whether the care provided is of sufficiently high quality. Another issue is whether UHC gives the patient access to academic clinical trials. There are effective examples in France and the UK where publicly funded clinical trials networks are well integrated with the healthcare system.

Anecdotal reports suggest that not all cancers are covered, requests for co-payments are made, and there are expectations that the patient will pay for supplies, medications and pathology, etc. It is also sometimes the case that cancer specialists are not available and sometimes cancer medications are not available when needed, or cancer care is not of sufficiently high quality. When rolling out UHC in Asia it will be important to ensure that UHC is paying for good cancer care and providing value for money.

2. What data are required to create country profiles on the current status of UHC for cancer in Asia? Development of basic data

Human resources and economic considerations relating to cancer in Asia

Xishan Hao (CACA) noted that according to the International Agency for Research on Cancer (IARC), in 2012 there were 14 million new cancer cases in the world, 48% of which were in Asia. In addition, there were 8.2 million deaths from cancer around the world, 55% of which were in Asia. These figures demonstrate that there are more cancer deaths than incidence in Asia. In 2012 all countries committed to achieving a 25% reduction in premature mortality from non-communicable diseases (NCDs) by 2025 (the 25 × 25 target). This is a very ambitious target. Economic concerns are closely related to cancer control and over the past 25 to 30 years the economy has grown dramatically in Asia. There are still many resource-limited countries in Asia, however, and the threat of cancer continues to grow. Stomach cancer is one of the serious cancers faced in Asia and in China it is the second most prevalent cancer, rising to the most prevalent in rural areas. Although Dr. Cazap had noted that around the world 10% of funds are channeled to healthcare, in China this figure is only five percent. Public attitudes to cancer control are also very important, as evidenced by a study implemented by Dr. David Hill some years ago, in which people were asked whether they agreed with the statement that "Cancer=Death." In China a total of 42% of respondents agreed with the statement, whereas in the United States this figure was only 10%, thus demonstrating how public perceptions can play important roles in shapingattitudes to cancer.

The issue of UHC is very important for Asia and it is essential to work together towards the achievement of this common goal.

What kinds of data do we need to frame issues of Asian cancer in UHC?

Takashi Fukuda (National Institute of Public Health) noted that as Dr. Akaza had mentioned, the goal of UHC is to ensure that all people obtain the health services they need without suffering financial hardship when paying for them. Key factors to achieve UHC include strong, efficient, well-run health systems, affordability, ease of access and sufficient capacity of well-trained, motivated health workers.

In terms of the kinds of data that are required, it is firstly important to acquire an understanding of the current status relating to cancer, before turning attention to future policy. In order to gain an understanding of the current status, data relating to the burden of disease is required. Burden of disease includes data on incidence and prevalence, as well as mortality. The WHO and other organizations also use Disability Adjusted Life Years (DALY) to assess the burden of disease. Other beneficial data include the results of studies on the cost of illness, including direct and indirect costs. An additional aspect that relates to reducing the burden of disease is data on

activities of cancer survivors.

Secondly, data are required on coverage under social security schemes. It is important to gain a picture of what kinds of treatment of covered, including high cost drugs, surgery and radiotherapy. In the case of Japan, while all drugs are covered, some kinds of advanced surgery, including laparoscopic and robotic surgery are not covered, nor are advanced forms of radiotherapy, such as proton beam therapy. It is also important to gain a picture about prevention measures, including smoking cessation, screening and vaccination. Such preventive measures may not be covered by health insurance, but may be partially covered by public funds.

Thirdly, it is important to gain a picture of access to healthcare. The issue of access includes such matters as the distribution of healthcare resources, such as healthcare professionals and healthcare facilities, as well as assessing the inequity of healthcare consumption, arising from geographical or income differences.

Finally, data on expenditure for cancer treatment would also provide an interesting picture of the status in different countries. However, it is necessary to define what constitutes healthcare expenditure. The Organisation for Economic Co-operation and Development (OECD) has formulated a System of Health Account (SHA), which has also been adopted by the WHO and could be a useful and applicable indicator.

In terms of formulating future policy, it is important to consider cost effectiveness and financial impact. In order to analyze cost effectiveness, it is first necessary to assess the unit cost of treatment or prevention, and also examine the outcomes of clinical trials and observational data. No healthcare system can afford to cover all procedures that are developed and therefore affordability and priority setting are essential factors when assessing the financial impact amid budgetary limitations. Cost effectiveness considerations involve examination of thresholds and how much can be spent and for what benefit.

In health technology assessments, assessment and appraisal are treated separately, with assessment involving analyses of efficacy, safety and cost-effectiveness, and appraisal being applied to interpret results and considering other factors, including ethical and social factors. It is this dual process of assessment and appraisal that leads through to a final decision on reimbursement and pricing (Figure 2).

In terms of possible data sources, the first source is vital statistics such as mortality. Other sources are cancer registries and claims databases. In the case of Japan a claims database has been compiled since 2009, which contains all claims made since that date nationwide, accounting for 1.4 billion claims each year. This may be a good source to gain a picture of the status of cancer patients. Cohort studies that demonstrate screening and follow up methods and well as health behavior could also be a beneficial source of information.

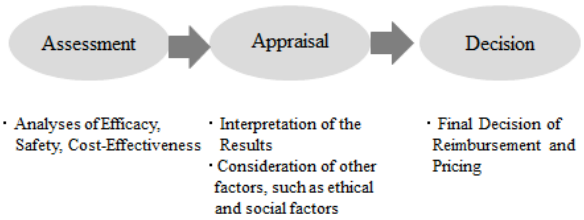

Figure 2. Assessment ,Appraisal and Decision-making - From the National Institute of Public Health, Japan

3. Research tools to identify conditions for realizing UHC for cancer in Asia: Proposing a multidisciplinary approach

UHC and interdisciplinary research: The significance of Cross-boundary Cancer Studies

Jae Kyung Roh (Yonsei Cancer Center) noted that Asia has a huge population with diverse ethnicity, different cultural backgrounds and diverse economic conditions. Cancer prevalence is diverse among Asian countries, but cancer has become the major health agenda even in economically emerging countries. Clinical practice guidelines for cancer prevention and control are not yet fully established. Appropriate guidelines are urgently required for Asian cancer control, but uniform cancer guidelines would not be appropriate, given the various stages of development of society and healthcare systems. On February 21 and 22, 2014, the First Japan-Korea Bilateral Joint Seminar on Cross-boundary Cancer Studies Toward the Cancer Cure in Asia was held at Yonsei University, Korea. The seminar was sponsored by the National Research Foundation of Korea and the Japanese Society for the Promotion of Science and was attended by 21 participants from Korea, 15 participants from Japan and four participants from China. The seminar was held against the backdrop of the increasing incident of cancer in the Asia-Pacific region and the importance of interdisciplinary research efforts between Asian countries. It provided a common working platform to bring together both medical and non-medical fields. It represented a significant first step towards international and interdisciplinary efforts to be extended to China and the wider Asian region. Interdisciplinary discussions on cancer from medical, pharmaceutical, anthropological and social points of view sought to create a new knowledge network on existing networks in diverse fields.

Creating an Asia Cancer Barometer: What indicators are available to us and how can we utilize them?

Shigeto Sonoda (University of Tokyo) noted that he is a sociologist with a strong interest in comparing Asia by using datasets covering all Asian countries. He noted his great interest to hear about the concept of fragmentation noted by Dr. Cazap and his opinion that UHC should be approached by both top-down and bottom-up initiatives. The needs of people are diverse and the amount of need may also differ from person to person. In order to measure the degree of need, some form of empirical data is required. A meeting such as this roundtable discussion is very timely, as the concept of *Asianization* of Asia is currently being developed by experts in various fields. Many people talk about Asia, but the scope and concept of Asia are different from person to person. The concept of the *Asianization* of Asia is that

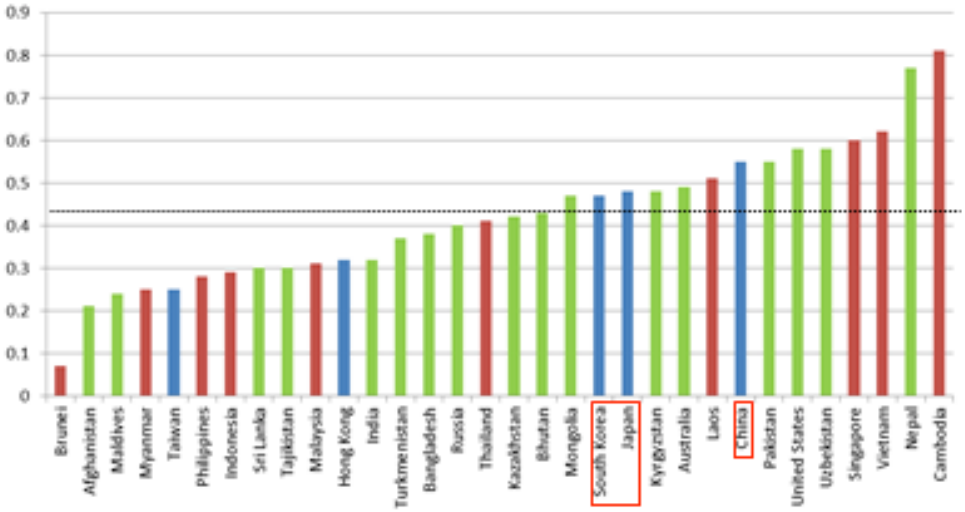

Figure 3. Health as a Great Concern in Asian Countries

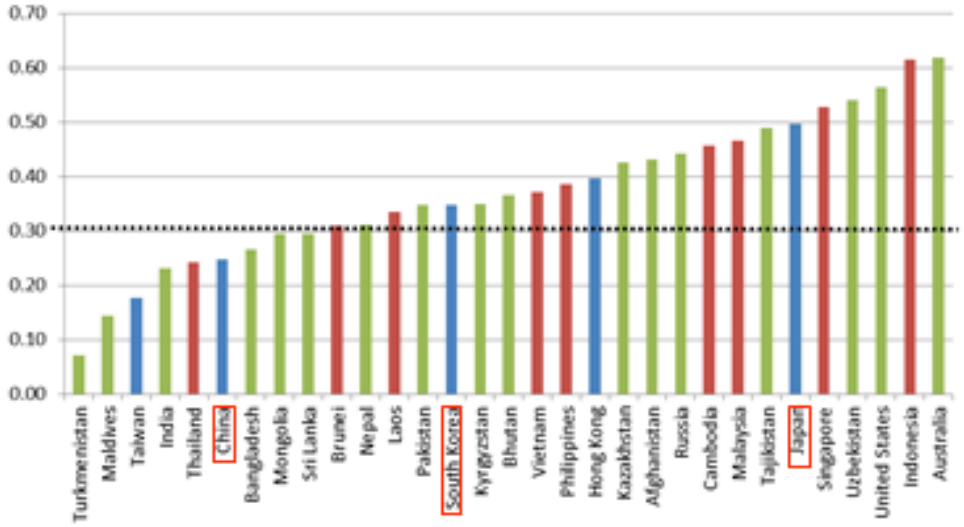

Figure 4. Relative Expectations of Governmental Expenditure for Public Health

Asia is coming to be viewed and to be understood as a whole. In order to understand Asia from a scientific point of view it is important to gather data. Unless all countries share a common understanding about the necessity of data collection it would not be possible to gain a full picture about Asia. There is a dynamic relationship between the understanding of Asia and the collection of data. There are some data archives that have been accumulated to date, mostly among political scientists. For example, the Asia Barometer project began in 2003, instigated by Prof. Takashi Inoguchi, formerly of the University of Tokyo (Inoguchi and Fujii, 2008). The project covered 27 countries throughout Asia. Other studies include the East Asia Social Survey (EASS) and ASEAN Barometer. The findings of these kinds of data collection activities have been interesting.

For example, as part of the Asia Barometer project, 32 potential concerns for the people of Asia were listed and respondents were asked to select their five most significant concerns. The results show the great diversity among Asia. In the case of "Health as a Great Concern" there is great diversity among the countries surveyed (Figure 3).

While the responses from Korea, Japan and China can be discerned to be similar concerning the issue of health, the picture is very different in countries such as Brunei, Nepal and Cambodia. In addition, with regard to the relative expectation of governmental expenditure for public health (Figure 4), it can be seen that there are considerable differences even between Japan, Korea and China. Similarly diverse results can be seen with regard to the relative trust in the public health system.

Relatively speaking, in Asian countries the public health system is trusted to a greater degree than other institutions such as the government or the military. While there may be reasons as to why these differences should arise, these can only be addressed once data is collected. This demonstrates the tremendous importance of collecting data in a uniform manner.

In terms of an Asia Cancer Barometer, there are some potential variables that could be used. The EASS and ASEAN Barometer already includes variables such as health conditions, health checkups and exercises, social trust, care management, medical insurance, socio-economic conditions and lifestyles and social values. However, the data that currently exists has been compiled by political scientists and further data collection activities will be required from other angles in order to compile an Asia Cancer Barometer.

It will be important to seek to elucidate the social dimensions of cancer study in Asia for fruitful inter/cross-national interdisciplinary cancer research for UHC. In order to promote the compilation of an Asia Cancer Barometer and create new directions for cross-boundary research it will be important in the future to create a "common archive" and "exchange ideas" among Asia to gain new findings.

4. Discussion

Dr. Doug Pyle (American Society of Clinical Oncology (ASCO)) noted that the Roundtable Discussion had provided an excellent opportunity to share ideas on a critical and timely topic, given that UHC is being discussed at international levels. He noted that the presentations gave a sense of the challenges for pursuing advocacy for UHC in Asia and engaging in research on the current status of UHC. In a research project one of the key first steps is to define terms and UHC presents unique challenges for defining terms. However, the presentations have shown some promising initiatives to overcome these challenges and share information and engage in collaborations across Asia. Dr. Pyle noted that equity, quality and managing financial risk, as raised in the presentations, are very important for ASCO. Dr. Trimble had also stressed the importance of quality. As healthcare expands one of the key issues is to maintain or enhance quality. Quality is something that is not necessarily given the attention it deserves. In the past few years ASCO has launched a major meeting on cancer quality and its delivery. ASCO is developing a platform called CancerLinQ™ that will link together all the electronic records in the United States to aggregate the cancer care data and see what the outcomes are. Dr. Cazap had raised the key issue of fragmentation and how that impacts UHC. It is important to identify the most essential standards of care that would qualify for healthcare coverage. ASCO is working with UICC and others to advise the WHO on its list of essential medicines as it relates to cancer therapies. When discussing the importance of implementing or researching UHC in Asia it is important to remember that aspects of UHC may be different in Asia to other parts of the world. Also, as raised by Dr. Sonoda, a key point is to recognize the role of public perceptions and factor these perceptions into analysis.

Dr. Akaza noted that when discussing UHC there is a tendency to focus on the concept itself, but what is also important is how to realize UHC in Asia.

Prof. Kitagawa noted that most of the interest in UHC is focused on diagnosis and treatment and patient care. However, the most important aspect of healthcare is the primary prevention of cancer. Elementary school education should have very distinct importance in terms of primary prevention, as it offers an opportunity to imprint upon children ideas and concepts that would help to prevent cancer later in life. Elementary school education is an area that has been poorly served to date and considerations are currently underway in Japan about how to provide such education. Elementary-level education is something that could be implemented in every country regardless of cost in any country in Asia.

Dr. Noda noted that he had been able to gain various kinds of beneficial information from the presentations. The goals of UHC can be shown very easily, but they are very hard to accomplish. He asked how the tactics for achieving UHC would differ in the various countries of Asia and what efforts would be most effective. He also noted that while data collection would be beneficial it would not necessarily lead to the achievement of UHC. He asked what the "low-hanging fruit" was perceived to be on the path towards achieving UHC in all Asian countries.

Dr. Akaza responded that the research efforts had been started in Japan, Korea and China as a first step, but would need to be developed further in order to be applicable to other countries in Asia.

Dr. Sonoda noted that as a methodologist he would want to find out what healthcare professionals are actually talking about in terms of the practical application of UHC. In order to connect research findings to practical application of UHC it is essential to incorporate practical questions in strategic questionnaires about the current status. Unless these practical aspects are addressed it is unlikely that academic research findings alone would translate into application of UHC.

Dr. Roh responded to Dr. Noda's question by noting that the cross-boundary studies had begun with Japan, Korea and China from the time of the Asia-Pacific Cancer Conference (APCC). The three countries had discussed how to improve the situation relating to cancer control across Asia as a whole. Asia is extremely diverse and as a first step the aim is to identify models in the three countries that could be applicable to other countries in Asia. There will be a discussion on such models at the upcoming Asia-Pacific Cancer Conference in Indonesia in 2015.

Dr. Cazap noted that UHC is a critical issue for all countries around the world and the efforts implemented and data collected by Japan, Korea and China are extremely promising. He suggested that the results of research so far could be presented to the Board of Directors of UICC and could be expanded to other regions as an example of the work of UICC-ARO.

Dr. Hao noted that the situations even in Japan, Korea and China are still very different. The UICC World Cancer Congress was held in China in 2010 and the government has since worked to promote cancer control measures and learn from the experiences of other countries.

Dr. Nozaki noted that NCDs are very important for achieving UHC. The WKC will be implementing new research activities for innovation, aging and UHC and wishes to cooperate with other organizations in this endeavor.

Dr. Kakizoe noted that according to the WHO definition, UHC should not incur financial hardship and suffering. Cancer control programs are generally composed of four pillars: prevention, screening, treatment and palliative care. As far as treatment is concerned, some of the treatment modalities are very expensive and it is therefore very important to consider the medical economy. In terms of UHC in Asia, prevention and screening should be a focus for all countries. Dr. Trimble had noted that not all cancers may be covered under UHC and for some

countries this may be a reasonable approach by which to start the process towards UHC, expanding coverage to include other forms of cancer should economic constraints permit.

Dr. Tajima noted that discussion of UHC in Asia is very interesting but very complicated, because of the heterogeneity of Asia. When UICC-ARO was established the view was that Asia could become a model area for progress on UHC strategy around the world. He noted the importance of sharing local information about health coverage strategies in order to work towards UHC across Asia.

Dr. Roh thanked all participants for their valuable comments and opinions. He noted that UHC will not be easy to achieve and discussions will continue at the upcoming Asia-Pacific Cancer Conference (APCC) on August 20-22, 2015. He noted that he would discuss with the APCC president about how to gain the participation of other medical and non-medical personnel from other Asian countries in the discussions. He concluded by noting that research on UHC in Asia should continue to be used as a tool for cancer cooperation in Asia and that the achievement of UHC would require research and input not only from the medical community, but from a broad sector of society in a multidisciplinary approach.

References

Akaza H (2013). Challenges and outlook for the UICC-Asian Regional Office. *Asian Pac J Cancer Prev*, **14**, 4935-37.

Akaza H, Kawahara N, Roh JK, et al (2013). Japanese Cancer Association Meeting UICC International Session - What is cost-effectiveness in cancer treatment? *Asian Pac J Cancer Prev*, **15**, 1-8.

Goss PE, Lee BL, Badovinac-Crnjevic T, et al (2013). Planning cancer control in Latin America and the Caribbean. *Lancet Oncol*, **14**, 391-436.

Inoguchi T, Fujii S (2008) The AsiaBarometer: Its Aim, Its Scope and Its Development. In M. Moeller, et.al. eds., Barometers of Quality of Life Around the Globe, Springer, 187-232.

Murray C, Vos T, Lozano R, et al (2010). Disability-adjusted life years (DALYs) for 291 diseases and injuries in 21 regions, 1990–2010: a systematic analysis for the Global Burden of Disease Study 2010. *Lancet*, **380**, 2197-223.

OECD, Eurostat, WHO (2011), A System of Health Accounts, OECD Publishing. doi: 10.1787/9789264116016-en

Vega J (2013). Universal health coverage: the post-2015 development agenda. *Lancet*, **381**, 179-80.

Watanabe T (2002). Growing Asia, Stagnant Asia. Kodansha Press Lrd, Tokyo (in Japanese).

Williams S, Chiong E, Lojanapiwat B, Umbas R, Akaza H; Asian Oncology Summit (2013). Management of prostate cancer in Asia: resource-stratified guidelines from the Asian Oncology Summit 2013. *Lancet Oncol*, **14**, e524-34.