

Trends and Issues Relating to Hospice and Palliative Care in Japan

日本におけるホスピス・緩和ケアの現状と課題（総説）

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With the proportion of the elderly rising, the number of cancer patients and deaths continues to increase in Japan. While more than 320,000 people die of cancer every year, there are only 3,399 beds (2007) in palliative care units across Japan, and about 85% of cancer patients have little choice but to die in general hospitals. It is not common practice to prepare their own living will or advance directive in Japan, and even in the event of limited prognosis, if the patient's family asks for aggressive medical treatment, such treatment is often continued. As a result, terminal medical treatment accounts for a large proportion of overall medical expenditures, though medical costs are not a big problem for individual Japanese, who are protected under the universal health insurance system. As the rate of aging continues to rise over the next 30 years, an increase in terminal medical expenses cannot be avoided. For this reason, the government wants to promote home hospice care. However, because local governments are not ready to collaborate and visiting nurse service is not fully developed, home hospice care training has not yet been widely promoted. People in general feel anxious about dying at home, being concerned that they may become a burden on their families and that they may have trouble coping with sudden changes in their condition. As the number of elderly households continues to rise in the future, such anxieties are likely to escalate. In order to respect the patient's natural dying process, it is imperative to develop a medical system in which patients will be able to maintain consistent quality of life over the course of their treatment from the diagnosis of cancer to their death. This must include measures to strengthen the training system and to raise awareness about terminal care among the general public.

日本は、高齢化率の上昇に伴い、がん罹患数および死亡数ともに増加し続けている。がんによる死亡数は年間32万人を超えたが、緩和ケア病棟は全国に3,399病床（2007年）のため、がん患者の約85%は一般病院で最期を迎えることになる。日本ではリビングウィルや事前指示書などを作成する習慣が一般的ではないため、予後が限られた中でも家族が求めれば濃厚な医療が継続されることが多い。そのため医療費の中で終末期医療費が占める比率が高いが、国民皆保険制度に守られている日本人にとって医療費の負担が大きい問題とはなっていない。しかし、今後30年間は高齢化率が上昇し続けるため、終末期医療費の増加は避けられない状況にある。そのため国は在宅ホスピスケアを推進したいと考えているが、地方自治体の協力体制が不十分であることや、訪問看護システムが十分発達していないことから、在宅ホスピスケア研修が推進されない状況にある。また、一般の人々も家族への負担や急変時の対応などを懸念し、自宅で最期を迎えることに強い不安を抱いている。今後、高齢者世帯の増加とともに、一層不安は強くなると考えられる。自然なプロセスを辿って死を迎えることを尊重するために、がんと診断されてから死に至るまでその人の療養生活の質が一貫して保たれるような医療システムの構築と教育体制の強化、そして一般市民の終末期医療に関する認識が高まるような取り組みが必要である。

Key words: end-of-life care (終末期ケア)

hospice & palliative care (ホスピス・緩和ケア)

trends and issues (動向と課題)

I. Introduction

Following the enactment of the Cancer Control Act in April 2007, hospitals throughout Japan designated as cancer care hospitals have been playing a major role in promoting comprehensive measures to equalize cancer medical treatment. As nurses play a big role in efforts to improve the quality of cancer treatment, The Japanese Nursing Association is pushing forward with plans to train nurses to become highly specialized in nursing care for cancer patients and to place them in appropriate facilities and departments¹⁾. As the Cancer Control Act includes measures to promote palliative care and visiting nurse service, the quality of care will be substantially improved and patients' quality of life will be maintained through all stages of treatment, from prevention to the end of life.

Considering this background, this paper aims to ascertain the current state of hospice and palliative care in Japan and to discuss

future issues regarding such care, considering changes in demographics and the medical care system in Japan as well as literature on Japanese awareness of and attitudes toward terminal care.

II. The Current State of Hospice and Palliative Care in Japan

1. Trends in death and places of dying in Japan

The average life expectancy of Japanese has been increasing year by year. As of 2006, the life expectancy was 79.0 years for men and 85.81 years for women²⁾. Likewise, the proportion of the elderly, which exceeded 10% of the population as early as 1985, had increased to 20.1% by 2005³⁾. With this acceleration of the aging of the population has come an increase in the number of deaths, which surpassed one million people in 2003⁴⁾ (Fig. 1). According to the White Paper on Our Aging Society⁵⁾, persons aged 65 and over will reach 3.5 million in 2018, and continue rising to hit a peak in 2042. As the total population is expected to decline, the

proportion of the elderly will continue to rise, reaching some 40.5% in 2055.

Since 1950, causes of death have shifted from infectious diseases such as tuberculosis to lifestyle-related diseases. Major causes of death since 1950 include malignant neoplasm, heart disease and cerebrovascular disease. Deaths due to cerebrovascular disease have leveled off since reaching a peak in 1965, with the exception of a one-year spike increase in 1995 according to the International Classification of Disease. Deaths caused by heart disease, on the other hand, have been gradually increasing, almost tripling between 1950 and 2005, again with the lone exception of 1995, in which there was a decrease. Deaths by malignant neoplasm have also been increasing every year since becoming the leading cause of death in 1981, having grown five-fold from 1950 to 2005, and accounting for more than 30% of all deaths since the year 2000 (Fig. 2). A comparison of the mortality rates between men and women⁶⁾ shows similar rates for cerebrovascular and heart disease, while for malignant neoplasm the mortality rate is about 1.5 times higher for men than for women. By age group⁷⁾, these three major causes of death account for the largest percentage of deaths for people aged 55 and over, with malignant neoplasm the leading cause of death among all people aged 40 and over.

As for place of death⁸⁾, while 82.5% of people died at home in 1951, the percentage of hospital deaths has surpassed that of home deaths since around 1980, the respective figures being 80.5% and 12.4% as of 2004 (Fig. 3). With regard to malignant neoplasm, some 93.9% of deaths occurred in hospitals or care facilities, the figure for hospitals alone being 91.2%. Compared by gender, the percentage of home deaths was the same, but deaths in nursing homes or health care facilities for the elderly accounted for nearly three times as many deaths among women

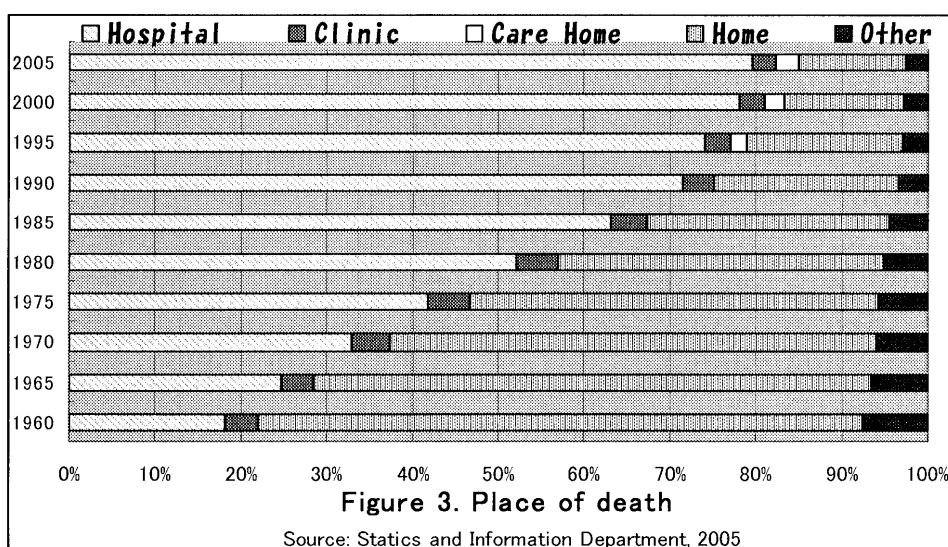
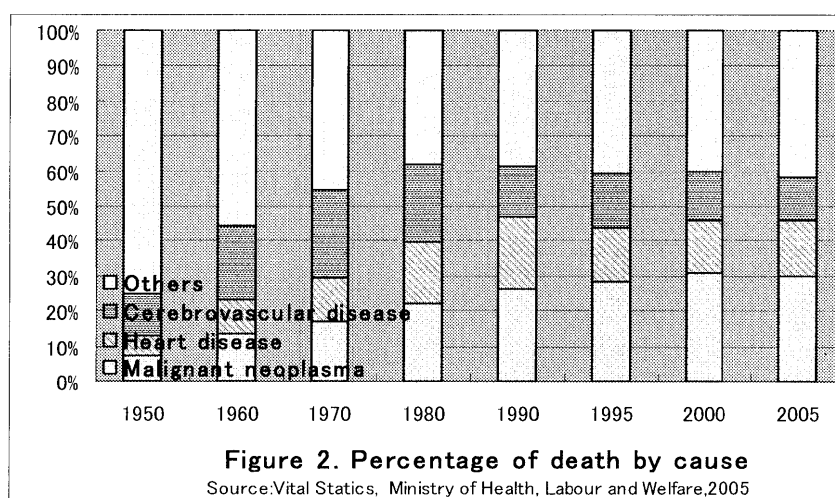
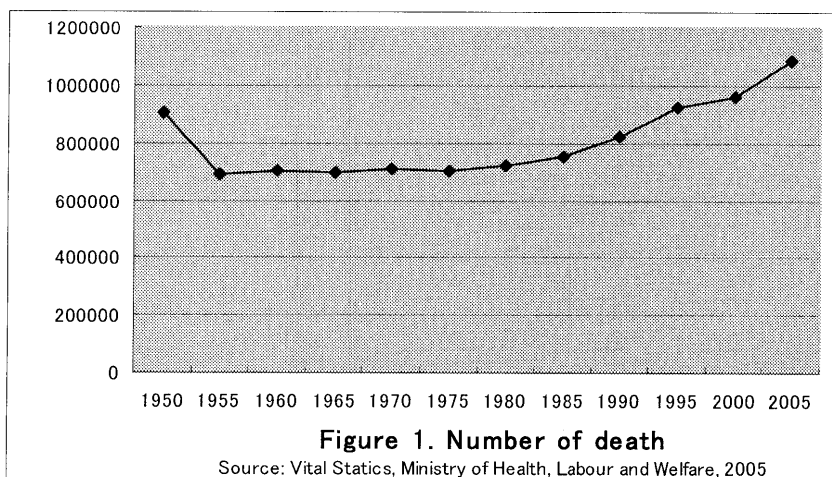
(4.4%) as among men (1.4%). Comparing different parts of the country, the area with the highest rate of home deaths had 16.4%, double the rate of the area with the lowest figure (8.2%). Looking at changes in the number of households⁹⁾, single-person households and husband-and-wife only households with at least one member 65 years old and over continued to increase, rising from 31.3% in 1986 to 51.9% in 2006.

Based on the above data, we assume that deaths will continue to increase in the coming ten years and that both the death ratio and the number of elderly-only-households will increase further. Since the aging of the population and an increase in population are major factors contributing to an increase in the incidence of cancer¹⁰⁾, we estimate that the number of Japanese cancer patients will definitely grow until 2020, when the population of the elderly will stop increasing. As for place of death, considering especially that more than 90% of cancer patients die in hospitals and that elderly-only households will increase in the future, it is unlikely that the proportion of home deaths will increase if the situation remains as is.

2. Trends in the medical care system and expenses in Japan

Health insurance in Japan can be categorized into two types: one for company employees and their families; and another for the general population including retirees and the self-employed along with their families (Table 1). Citizens have been obligated to join one or the other of these plans since the universal health care system was implemented in 1961. Under these insurance plans, individuals and companies or other organizations are each required to pay monthly premiums, and individuals receiving medical treatment must bear a certain percentage of the expenses, 30% since 2003.

As for medical expenses for the elderly,



the Law of Health and Medical Service System for the Aged came into force in 1983 to realize equitable burden-sharing in medical care for the elderly. Under this system, for any patient aged 70 and over, the cost of

medical treatment beyond that paid by the patient is covered in principle by public funds and contributions from health insurance. In response to the increase in medical expenditures for the elderly, the

Table 1. History of medical care system

1961	Start of the universal health insurance plan
1963	Enactment of the Welfare Law for the Aged
1973	Partial revision of the Welfare Law for the Aged: No individual payment of medical expenses for people aged 70 or over
1982	Enactment of the Law of Health and Medical Service System for the Aged
1990	Revision of the medical treatment fee system: Establishment of a new fixed medical treatment fee system for palliative care units
1994	Authorization of palliative care units transferred from Ministry of Health to prefectural governments
1998	Revision of the medical treatment fee system: The fixed medical treatment fee for palliative care units increased
2000	Enactment of the Public Nursing Care Insurance
2002	Revision of the amount of individual payment under the Law of Health and Medical Service system for the Aged Revision of the medical treatment fee system: Additional payment for palliative care and antidecubitus care
2005	Revision of the Public Nursing Care Insurance Law
2006	Expansion of the coverage by the nursing care insurance Revision of the medical treatment fee system: Addition of home medical care support clinics

percentage that persons with sufficient income, aged 70 and over, must pay was raised in 2006 from the former 10% to the current 30%, and the percentage of payment for persons between the ages of 70 and 74, with the exception of persons with sufficient income, is to be raised evenly across the board from 10% to 20% in 2008. Visiting nurse service for the bed-ridden elderly after discharge from hospital was started under the Law of Health and Medical Service System for the Aged. This law was revised in 1992 to include visiting nurse service for the elderly as a whole, and from 1994 visiting nurse service for non-elderly persons also became possible. In addition, a visiting nurse service covered by nursing care insurance was started in 2000.

The enactment in 2000 of the Law of Elderly Care Health Insurance reorganized the systems provided under the Old-Age Person's Welfare Law and the Law of Health and Medical Service System for the Aged, aiming to make available comprehensive

care service covering medical care, health care and welfare according to the needs of senior citizens. Under Elderly Care Health Insurance, a certain premium is paid by insured persons aged 40 and over, and persons aged 65 and over who require nursing care are in turn eligible in principle to receive insurance payments, depending on the degree of care required. Persons between the ages of 40 and 64 are also eligible for insurance payments if they have specific age-related illnesses. In 2006, the program was expanded to include terminal cancer patients aged 40 and over and dying patients being cared for at elderly care facilities or at home by facilities registered as home medical care support clinics, as well as covering the cost of day care medical services.

Medical treatment fees paid to medical institutions are stipulated by the Medical Service Law, which prescribes fundamentals of the medical delivery system. Basically, fees are based on the actual cost of treatment, but can differ depending on the nursing system

and other factors. From 2002, additional fees are paid for palliative care and antidecubitus care. Comprehensive disease-specific medical treatment is scheduled to be introduced widely in the future, but at present, fees for such treatment are applied only to palliative care units approved by municipalities. The fixed medical treatment fee system for palliative care units was created newly in 1990 to be applied to patients diagnosed with malignant tumors or HIV with a prognosis of six months or less. The number of approved palliative care facilities in 1990 was five institutions, with a total of 141 beds. The numbers have gradually increased since 1994, when authorization was transferred from the Ministry of Health, Labor and Welfare to prefectural governments, and as of October 1, 2007 there were 177 institutions with a total of 3,399 beds¹¹⁾ (Fig. 4). Palliative care units tend to be concentrated in relatively urban areas: Tokyo; Kanagawa and Chiba Prefectures in the Kanto area; Hyogo and Osaka Prefectures in the Kansai area, and Fukuoka Prefecture on the island of Kyushu. Given that over 320,000 patients die of malignant tumors every year, and that 85%

of these patients die in hospitals, most cancer patients die in general wards. In view of this situation, in 2002 eligibility for the additional palliative care payments was extended to palliative care teams comprising a full-time physician, a full-time psychiatrist, and a certified nurse.

National medical care expenditures¹²⁾, the estimated total costs required for treatment of sicknesses and injuries at medical institutions, have increased steadily, from 238.8 billion yen in 1955 to over 30 trillion yen in 1999, reaching 32.1111 trillion yen in 2004. By age group, the percentage of national medical care expenditures spent on people aged 65 or over surpassed the percentage for those under 65 in 2004, when it reached 51.1%. The total cost of nursing care also has been increasing every year, from 3.6 trillion yen in 2000 to 6.8 trillion yen in 2005.

While revisions have been made in the medical system in response to increases in medical expenses, hospital stays tend to be long in Japan, and outpatient visits frequent (Table 2). Although the Public Nursing Care Insurance system was started in 2000, home healthcare accounts for only about 0.5% of

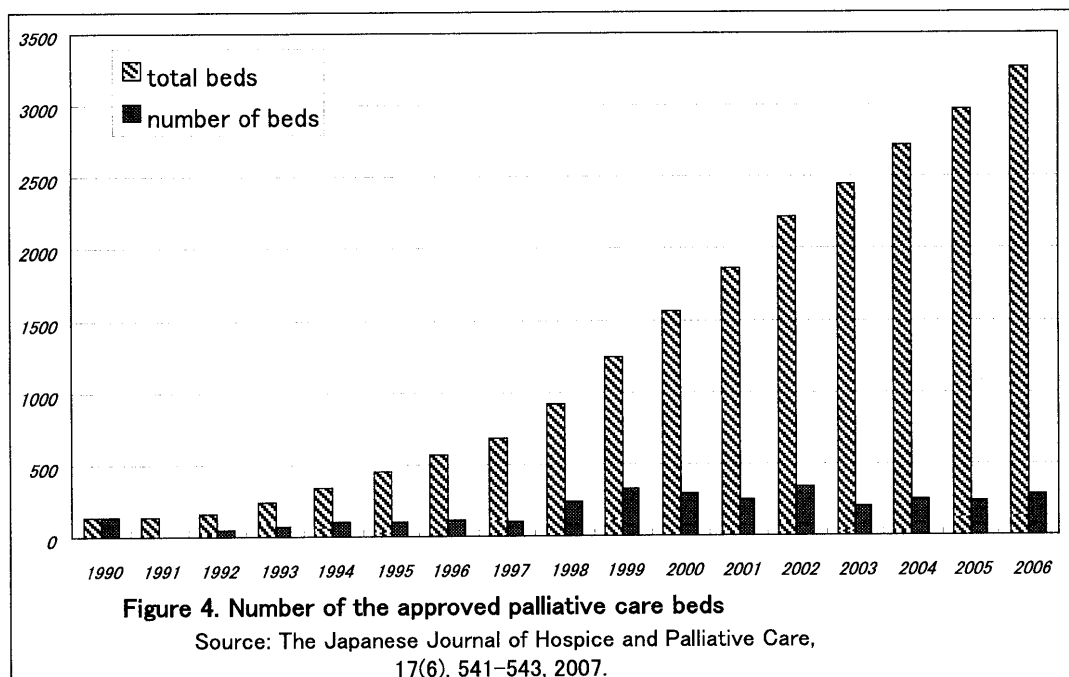


Table 2. Cross-national comparison of hospital stay and visit

	Source: Ministry of Finance		※data of 1996			
	Japan	USA	UK	Germany	France	Sweden
Number of beds (in 10 thousand, 2000)	164.7	98.4	24.3	74.9	48.6	3.2
Number of beds per 1000 people (2000)	13.0	3.6	4.1	9.1	8.2	3.6
Average length of hospital stay (1999)	30.8	7.0	※9.8	12.0	10.6	6.7
Number of outpatients visits per year (2000)	14.4	8.9	4.9	※6.5	6.9	2.9

national medical care expenditures. Measures to deal with these circumstances hold the key to curbing medical expenditures. Asahi Shimbun¹³⁾ conducted a survey of 151 prefectural government-approved palliative care units which are members of Hospice Palliative Care Japan, receiving responses from 100 of these. According to its report, only five hospitals had certified nurse specialists in cancer nursing with advanced knowledge of cancer. Among the rest of the hospitals, 36 had certified nurses in hospice and palliative care capable of providing necessary care to terminal cancer patients, and 12 had certified nurses in cancer pain control, but 57 had neither of these. As for the specialties of their physicians, internists accounted for the largest number (33), followed by surgeons (29), and the remainder divided into some 20 other specialties including psychiatry, radiology and anesthesiology. The report concludes that the focus of care varies widely depending on the hospital. In order to provide quality of life to cancer patients during treatment, it is necessary to establish standards for assessing the quality of home hospice care and palliative care units and teams, which will ensure a high level of service and treatment.

3. National awareness of hospice and palliative care

According to an awareness survey

conducted on the general public by the Panel for Investigating End-of-life Care¹⁴⁾, 76.9% of those surveyed responded that they would like to know the name of the diagnosis and prognosis of their disease, and 92.0% answered that they would like to receive an explanation directly from their doctor. If informed that they were dying, 74.0% of those surveyed responded that it would be better if life-sustaining treatment were discontinued. In the case of a family member dying, the figure fell to 62.5%. Both percentages were higher than in the 1998 survey. If they were in a vegetative state, 79.6% answered that they would want life-sustaining treatment withheld, the corresponding figure for family members being 64.9%. Concerning the concept of a living will, 59.1% of those surveyed agreed with the concept, and 25.2% agreed with the concept but thought there is no need to have it in writing, both percentages up from the 1998 survey. However, asked about the way to express one's will, the response, "a law should be enacted" decreased from 48.7% in 1988 to 37.2%, while "the doctor can decide a treatment policy after consulting with the family and respecting their wishes" increased from 45.6% in 1998 to 60.3%. As for the place of care at the end of life, 48.3% of those surveyed responded that they want to have home care and be admitted to a medical institution or palliative care unit when

necessary, and 10.5% responded that they want to have home care to the end. Asked about the possibility of having home care to the end, only 8.3% responded that they thought it could be realized, while 65.5% responded that it would be difficult to be realized. Reasons given for this difficulty included the burden on the family (78.4%), concerns about dealing with sudden changes in condition (57.3%), and others such as the inadequacy of the medical system.

Noguchi et al.¹⁵⁾ reported the results of a survey of small and medium-sized general hospitals conducted nationwide. The survey was sent to hospitals having 50–300 beds. According to the report, terminally-ill patients accounted for 9.1% of all inpatients, and 45.9% of the terminally-ill patients with a presumed life expectancy of six months or less were informed of their diagnosis, along with 95.8% of the patients' families. Preference for life-sustaining treatment was confirmed with 15.2% of the patients and 86.8% of the patients' families. 26.6% of the patients and 90.8% of the patients' families were notified of remaining life expectancy.

According to an awareness survey conducted on medical professionals across Japan by the Panel Investigating End-of-life Care¹⁶⁾, doctors' most common responses to the question about particular difficulties in dealing with incurable, dying patients suffering from pain were "explaining the name of the diagnosis and state of the disease" (59.7%), and "insufficient home healthcare system" (53.9%), while nurses cited "symptom relief" (63.5%), and "lack of facilities for end-of-life care" (56.8%). Concerning WHO cancer pain relief, 42.7% of the doctors and 20.1% of the nurses responded that they had "a certain degree of knowledge" or "a good knowledge" of it, as opposed to 25.9% of the doctors and 43.7% of the nurses who answered that they had "no knowledge". Asked if they could explain to patients the effectiveness and

adverse effects of morphine, 88.4% of the doctors and 80.5% of the nurses responded "yes" or "to some extent". About the possibility of having care at home to the end, 51.6% of the doctors and 47.5% of the nurses believed "it is difficult to be realized". The reasons cited by the two groups were "the burden on the family" and "concerns about dealing with sudden changes in condition". 75.3% of the doctors and 75.2% of the nurses responded that they "agree with the concept of a living will", both percentages up from the 1998 survey. About the best way to express one's will in writing in a living will, 47.7% of the doctors and 43.6% of the nurses answered that "a law should be enacted", both percentages down from the 1998 survey.

From the above data, it is clear that Japanese people make different treatment decisions for themselves and for their families, and that they are more likely to worry about being a burden on their families. This indicates a need to create a medical system which supports families in making treatment decisions and reduces the burden on families. Medical professionals lack the knowledge and communication skills needed for the practice of palliative care. As to correcting these problems, guideline for decision-making in End-of-Life Care¹⁷⁾ had been worked out in 2007, which indicated the need for better symptom management, providing more thorough information, and paying greater attention to the will of the patients and their family. In fiscal 2004, the Ministry of Health, Labor and Welfare initiated a project to promote visiting nurse service, which includes home hospice care training and exchange program with nurses working in the home care setting and nurses working in the hospital. The cost of this project is to be split half-and-half between the Ministry and local governments, but not many local governments have taken the initiative in carrying out the project because of financial

difficulties. Furthermore, nurses working at visiting nurse stations cannot take time out of their schedule to participate in the training, because not many stations are well-staffed. The education of medical professionals needs to be further strengthened.

III. Issues Surrounding Hospice and Palliative Care in Japan

In response to an increase in cancer incidence and mortality, the Japanese government has been developing anti-cancer measures. In accordance with the formulation of the Cancer Control Act and the Basic Plan to Promote Cancer Control Programs, as well as the "3rd-term Comprehensive 10-year Strategy for Cancer Control," designated cancer care hospitals have been developed for the purpose of promoting "equalization" of medical care for cancer¹⁸⁾. Also, palliative care units and palliative care teams have been steadily increased and care for terminally ill cancer patients improved. However, there is a wide gap between the quality and quantity of hospice and palliative care available in general wards and that available in palliative care units. Furthermore, there are many problems with the palliative care currently provided by home care. Although home medical care support clinics were newly established in 2007 to strengthen local medical care systems, they do not seem to be functioning adequately enough to provide the proper palliative care for cancer patients staying at home. The fundamental challenging issue of hospice and palliative care in Japan is the shortage and uneven distribution of its quality and quantity.

1. The need for medical professionals to be trained in palliative care

Considering that palliative care needs to be provided consistently from the earliest stage of treatment, beginning with diagnosis and

continuing throughout hospital treatment and home medical care¹⁹⁾, its importance must be recognized and the necessary knowledge and skills must be acquired not only by doctors and nurses specializing in the field, but by all doctors and nurses involved in cancer treatment²⁰⁾. It would be optimal to introduce palliative care at the stage of general medical education and to promote its dissemination among doctors engaged in home medical care, who should receive more training and education in the field.

For postgraduate education of nurses in palliative care a number of programs exist, and there has been an increase in the number of certified nurse specialists and certified nurses by the Japanese Nursing Association in cancer nursing (in the respective areas of hospice and palliative care, cancer pain control, chemotherapy and breast cancer care), and these have begun to play an increasingly active role in hospitals. Yet, the number of certified nurse specialists and certified nurses active in home care remains extremely small. In the field of visiting nurse service, it is urgent to improve the palliative care abilities of all visiting nurses since they are directly involved in the nursing care of cancer patients and their families. The Japanese Ministry of Health, Labor and Welfare has been promoting palliative care education for visiting nurses, providing a budget specifically for that purpose. But, this crusade will not be effective unless the Ministry is successful in gaining the understanding and cooperation of local governments, which must also subsidize the training. Another consideration is the loss of income to visiting nurse stations due to the participation of visiting nurses in the training, especially given the small size of most of these stations.

In addition, an issue that needs to be addressed is the education of social workers and pharmacists as palliative care team

members.

2. The need to strengthen partnerships between hospital and home care staff

In order to reduce the gap in the quality of palliative care between palliative care units and general wards, palliative care duty nurses sometimes visit general wards to give advice. Also, palliative care teams have been organized in some general hospitals in an attempt to improve the level of palliative care throughout the hospital, and these efforts are covered by the same reimbursement scheme that applies to other medical services. Yet, there are still many problems with the palliative care provided by visiting nurse service.

(1) Development and promotion of a system of partnership between hospital and home care staff to coordinate discharge from hospital

There are many risks involved in discharging cancer patients from hospital to receive palliative care at home. Serious problems have occurred due to insufficient preparation for release from hospital or inadequate coordination between the doctors and visiting nurses responsible for home care. As a result, the mass media have reported an increase in the number of patients dying at home immediately following discharge from hospital²¹⁾. The issue of proper coordination for hospital discharge is not limited to cancer patients, and many hospitals consider it necessary to focus their efforts on developing a system to deal with the problem. More hospitals have begun implementing measures such as assigning nurses to be in charge of coordination for hospital discharge in order to manage difficult cases, and creating strategies to predict and manage the risks accompanying the shift from hospital to home by developing screening or assessment sheets to prepare for hospital discharge²²⁾. At the same time,

hospitals have begun holding conferences on preparation for hospital discharge, with increasing participation by doctors and visiting nurses involved in home medical care.

(2) Consultation support system to apply palliative care expertise to home care

Some doctors and visiting nurses responsible for palliative care in the home still do not have sufficient knowledge and skill, they need support from doctors and nurses specializing in palliative care. Also, the types of analgesics available locally are limited due to various circumstances, and the shortages sometimes need to be supplemented with the assistance of a hospital. Therefore, palliative care needs to be improved from the early stages of treatment and be provided consistently from the time of diagnosis, continuing throughout the period of treatment and home medical care. It is further necessary to promote local partnerships between palliative care teams, hospice/palliative care units and home medical care support clinics, centered on designated cancer care hospitals²³⁾. Participating in conferences on hospital discharge, holding joint training sessions, sharing feed-back on the condition of patients post-discharge, and other activities to foster communication and help build closer relations should facilitate mutual support and cooperation.

3. Support for cancer patients and their families living in the local community

With the aim of curbing rising medical costs for hospitalization, and in response to past surveys reporting people's preference for home care, the Ministry of Health, Labor and Welfare has undertaken a policy of promoting palliative care at home for terminal cancer patients. As part of the "Survey on the End-of-Life Care (2004)"²⁴⁾, patients were asked where they would prefer

to stay while receiving end-of-life care. While expressing a strong desire to receive home medical care, respondents showed a reluctance to stay at home to the end of life. The reasons given were "Home care will be a burden on my family," and "I have concerns about how to handle a sudden change in my condition." It has thus been stipulated that home medical care support clinics and visiting nurse stations should provide 24-hour service to respond to concerns of families, and that further support for families should be available from cancer care support centers established at designated cancer care hospitals²⁵⁾. Since nurses are expected to play a key role at these cancer care support centers, they should receive training in the communication skills necessary to provide appropriate consultation/support services.

4. Raising awareness of palliative care in society and promoting its dissemination

With increasing use of palliative care wards, "palliative care" has begun to take on more positive connotations. Generally speaking, however, the term still has negative associations in many cases. No matter how effective cancer treatment may have become thanks to the progress of medical science, patients and their families are still overwhelmed by a diagnosis of cancer or by being asked for informed consent. The approach of the Ministry of Health, Labor and Welfare, which forms the basis of both the Cancer Control Act and the Basic Plan to Promote Cancer Control Programs, is to emphasize the need for a positive, proactive and self-reliant stance to cope with cancer. The Ministry says it aims to create a society in which the entire public, including cancer patients, endeavor to learn about, face, and cope with the reality of cancer.²⁶⁾ There is, however, still a gap between these expectations and the awareness of people in society. In order to foster a positive attitude

towards cancer, more information on cancer treatment and palliative care should be provided for the general public. The mission of information support section at designated cancer care hospitals is to take the lead in providing society with the information it needs to fill this gap.

IV. Conclusion

As already mentioned above, the fundamental issues of hospice and palliative care in Japan are believed to be the shortage and uneven distribution of its quality and quantity relating to the place where cancer patients receive medical service and the area where they live. In order to improve the present unfair conditions in the palliative care people receive, the Cancer Control Act calls for measures to enable citizens to share equally in appropriate palliative care, summed up in the word "equalization". "Equalization" means that all the people concerned receive equal profits or benefits²⁷⁾. Medical professionals and the general public are called upon to commit themselves to working together toward the realization of this goal.

References

- 1) Formulate a Plan of Japanese Nursing Association to the Enactment of the Cancer Control Act. Japanese Nursing Association News, 485, 4, 2007.
- 2) Journal of Health and Welfare Statistics. 54(9), 68, Health and Welfare Statistics Association, 2007.
- 3) A National Census. Ministry of Internal Affairs and Communications, 2005. [cited, 30/Nov./07'] Available from: <http://www.stat.go.jp/data/kokusei/2005/kihon1/00/zuhyou/a00411.xls>
- 4) Demographic Development. Ministry of Health, Labour and Welfare, 2006. [cited,

- 30/Nov./07'] Available from :
<http://www.mhlw.go.jp/toukei/saikin/hw/jinkou/kakutei06/hyo2-1.html>
- 5) Annual Report on the Aging Society. 2, Cabinet Office, 2007.
- 6) Op. cit. 2), 384.
- 7) Op. cit. 2), 49.
- 8) Regarding Place of Death. Ministry of Health, Labour and Welfare, 2005.
[cited, 30/Nov./07'] Available from :
<http://www.mhlw.go.jp/toukei/saikin/hw/jinkou/tokusyuu/sinno05/index.html>
- 9) Op. cit. 2), 39.
- 10) Tannock, F. I. et al. : The Basic Science of Oncology, Fourth Edition, The McGraw-Hill Companies, 2005. Taniguchi, N. et al. translator, The Third Japanese Edition, Medical Sciences International, 2006.
- 11) A List of Institutions Approved for Hospice and Palliative Care in Japan. The Japanese Journal of Hospice and Palliative Care, 17(6), 541, 2007.
- 12) Op. cit. 2), 219-223.
- 13) Asahi Shimbun. The Morning Edition, 2, 18/Dec./05'.
- 14) An Awareness Survey Conducted on the General Public by the Panel for Investigating End-of-life Care. Health Policy Bureau, Ministry of Health, Labour and Welfare, 2004.
- 15) Noguchi, W. et al. The Present State of "Death with Dignity" in Japan. Journal of the National Institute of Public Health, 55(3), 208-212, 2006.
- 16) Op. cit. 14)
- 17) Guideline for decision-making in End-of-life Care. [cited, 7/May/08'] Available from:
<http://www.mhlw.go.jp/Shingi/2007/05/dl/s0521-11a.pdf>
- 18) Preparation for Proficient Hospitals on Cancer Treatment. Health Bureau, Ministry of Health, Labour and Welfare, 2006.
- 19) The Enactment of the Cancer Control Act. Ministry of Health, Labour and Welfare, 8, 2007.
- 20) Op. cit. 14)
- 21) Abandoned Cancer Patients. AERA, 14/May/07', 32-34, Asahi Shimbun, 2007.
- 22) An Interim Report about a Project to Improve Health for Aged: The System Supported from Preparation for Discharge to Home Care. Institute for Health Economics and Policy, 2007.
- 23) Op. cit. 19), 16.
- 24) Op. cit. 14)
- 25) Op. cit. 19), 26.
- 26) Op. cit. 19), 3.
- 27) Koujien. Sixth Edition, 772, Iwanami Shoten, 2008.