A Nationwide Survey on Cancer in Japan

20 Years Since the Enactment of the Basic Act on Cancer Control

Health and Global Policy Institute (HGPI)

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1. Introduction

Twenty years have passed since the enactment of the Basic Act on Cancer Control in 2006, during which Japan's cancer control policy has undergone systematic evolution. Under the First Basic Plan to Promote Cancer Control Programs (from 2007), foundational infrastructure for cancer care was strengthened through the development of designated cancer care hospitals, enhancement of palliative care systems, and expansion of cancer registries. The Second Plan (from 2012) introduced new pillars including pediatric cancer control, cancer education, and employment support for patients. The Third Plan (from 2018) advanced initiatives under the three pillars of "cancer prevention," "cancer treatment," and "living with cancer," with major progress in cancer genomic medicine as well as measures for rare and refractory cancers. The current Fourth Plan (from 2023) sets forth the overarching goal of "promoting cancer control that leaves no one behind and striving to overcome cancer together with all citizens." It introduces new policy priorities including balancing equitable access to cancer care and the centralization of highly specialized services, age-specific and life-stage-sensitive cancer policies, patient and public engagement, and digitalization. Over the past two decades, Japan has made substantial progress in strengthening its healthcare delivery system, accompanied by improvements in five-year relative survival rates.

Alongside these policy developments, innovation in medical technology has accelerated rapidly. Advances in precision medicine and genomic medicine are ushering in an era in which optimal treatment can increasingly be tailored to the characteristics of each individual patient. The application of these advanced technologies now extends beyond treatment to prevention, screening, and support for decision-making for patients and people affected by cancer. At the same time, the increasing sophistication of medical technologies inevitably leads to rising healthcare expenditures. In Japan, where universal health insurance is built on the principle of equitable access, a central policy challenge is how to balance equitable access to increasingly advanced cancer care with the financial sustainability of the healthcare system. Debates surrounding the scope of insurance coverage for cancer genomic medicine, patient cost-sharing, the role of mixed billing and private insurance, and the appropriate balance between functional differentiation and centralization within the healthcare delivery system toward 2040 are all closely interconnected. Questions of acceptability, equity, and sustainability therefore lie at the heart of current policy discussions.

Against this backdrop, several major policy developments are expected in the coming years. In November 2025, Japan formulates the Basic Plan for Genomic Medicine Policies. In 2026, the government will conduct the interim evaluation of the Fourth Basic Plan to Promote Cancer Control Programs, while discussions toward the Fifth Plan (beginning in 2028) are expected to intensify. In a society where one in two people is expected to experience cancer during their lifetime, these issues are no longer relevant only to patients and people affected by cancer; they concern society as a whole. At the same time, perceptions of these issues vary considerably depending on cancer type, personal experience with cancer, and socioeconomic background. Understanding how citizens perceive these increasingly complex issues, and what they expect from future policy, is therefore essential for shaping the next phase of cancer control policy in Japan.

Health and Global Policy Institute (HGPI) has long engaged in policy advocacy related to cancer precision medicine, genomic medicine, and regional disparities in cancer care, while also facilitating dialogue among patients, citizens, policymakers, and other stakeholders. Through these activities, the need for broader social consensus grounded in the perspectives of practitioners and people affected by cancer has become increasingly clear, particularly regarding the acceptability, equity, and financial sustainability of cancer-related policies and systems. However, many previous studies have focused either on specific medical technologies or on the needs of patients and people affected by cancer, and relatively little research has examined how the public as a whole perceives existing systems and emerging medical technologies in cancer care.

To address this gap, the present study conducted a nationwide survey of 10,000 citizens across Japan. The survey explored a wide range of topics, including knowledge and experience related to cancer, participation in cancer screening, views on the centralization of healthcare functions, perceptions of cancer genomic medicine, attitudes toward advanced treatments, and perspectives on healthcare financing systems. By examining public awareness, opinions, and expectations across these diverse issues, the study aims to provide a broader picture of social attitudes that previous research has not fully captured. Through the wide dissemination of these findings, we hope to stimulate public discussion and contribute to the continued evolution of cancer control policy in Japan in a

manner that reflects citizens' perspectives and advances the goal of truly inclusive cancer care that leaves no one behind.

2. Executive Summary

This nationwide survey of 10,000 respondents examined public knowledge and experience related to cancer, participation in cancer screening, views on the healthcare system, and attitudes toward advanced cancer treatments. The principal findings are summarized below.

[Respondent Characteristics and Cross-Cutting Trends]

Younger respondents were more likely to select "Do not know / Prefer not to answer," suggesting lower levels of engagement with policy discussions related to cancer care. For example, regarding the future direction of public health insurance (Q29), the proportion selecting "Neither agree nor disagree" was 29.6% among respondents aged 70 years and older, compared with 50.5% among those in their 20s. By gender, men were slightly more likely to express support for policy measures, whereas women were somewhat more likely to select "Do not know." Differences were also observed by residential area. Residents of rural towns, villages, and mountainous areas showed higher levels of opposition to the centralization of healthcare functions (24.6%) than residents of government-designated major cities (20.7%), reflecting concerns about disparities in access to care.

[The Impact of Cancer Experience on Knowledge, Attitudes, and Behaviors]

One of the most notable findings of this survey was the extent to which personal or family experience with cancer shaped respondents' knowledge, attitudes, and behaviors across nearly all domains examined. Respondents with either personal or family experience of cancer (3,832 individuals, approximately 38% of the sample) demonstrated substantially higher levels of knowledge regarding cancer care, greater engagement with policy issues, and higher rates of participation in cancer screening than those without such experience. In addition, the proportion selecting "Do not know / Prefer not to answer" on specific policy issues differed markedly according to cancer experience. These findings suggest that experiencing cancer may not only influence support for particular policies, but may also encourage individuals to form opinions on cancer-related policy issues more broadly.

[Gaps in Public Knowledge Regarding Cancer Treatment]

Among major cancer treatment modalities, the proportion of respondents reporting familiarity ("know well" or "know to some extent") was 65.6% for surgery, 58.5% for radiation therapy, and 58.4% for drug therapy. In contrast, only 34.5% were aware that cancer care often involves multidisciplinary treatment teams composed of specialists from multiple clinical departments. Awareness that palliative care can be introduced from the early stages of treatment was even lower, at 24.8%.

[Public Attitudes Toward the Centralization of Healthcare Functions]

Approximately half of respondents (47%) expressed support for the centralization of healthcare functions. However, more than 30% (32%) selected "Do not know / Prefer not to answer," indicating that public opinion on this issue remains in the process of formation. Among those opposed to centralization (22%), the most frequently cited concerns were the physical burden associated with traveling long distances for treatment (60%) and financial burden (47%). These findings indicate that the physical and economic costs associated with travel are major concerns for patients. A key policy challenge moving forward will be how to improve the quality of care while maintaining equitable access for patients.

[Participation in Cancer Screening]

Across screening programs for gastric, colorectal, lung, breast, and cervical cancer, only approximately 27-35% of eligible respondents reported undergoing screening regularly, while roughly 30% indicated that they had never undergone screening. The Fourth Basic Plan to Promote Cancer Control Programs established a target screening rate of 60% for these cancers. The present findings therefore demonstrate a substantial gap between current screening participation and national policy goals.

[Interest in Cancer Genomic Medicine and Limited Public Awareness]

Only 5.2% of respondents reported being familiar with cancer genomic medicine, including its content and implications, while nearly 60% stated that they had never heard of it. However, after reading the explanatory information provided during the survey, 55.8% indicated that they understood the concept, and 56.2% supported allowing comprehensive gene panel testing to be covered by public insurance at earlier stages of treatment. At the same time, 32.1% selected “Do not know / Prefer not to answer” regarding earlier insurance coverage. These findings suggest that low awareness may stem less from lack of interest than from limited opportunities to access understandable information, highlighting the importance of effective public communication strategies that promote genuine understanding rather than simple name recognition.

[Public Attitudes Toward Healthcare Costs and Insurance Systems]

Awareness of the high-cost medical expense benefit system (“know well” or “know to some extent”) was 51.0%. When asked about measures to sustain the system, the most commonly supported option was raising the maximum out-of-pocket payment limit for high-income individuals (41.0%), followed by introducing additional cost-sharing for extremely expensive treatments (21.7%) and excluding treatments with insufficient evidence of effectiveness from coverage (19.7%). Support for uniform increases in taxes or insurance premiums was comparatively low. Meanwhile, 26.2% selected “Do not know / Prefer not to answer,” suggesting that many citizens do not feel sufficiently informed to make judgments regarding healthcare financing policy. Regarding the scope of public insurance coverage, respondents favoring the introduction of prioritization or limits on coverage (41.8%) substantially outnumbered those supporting expansion of coverage even if accompanied by increased public burden (20.6%). Younger respondents were particularly likely to withhold judgment; among respondents in their 20s, 50.5% selected “Neither agree nor disagree.”

Based on these findings, we propose the following policy recommendations:

1. **Strengthen public communication and develop multilayered information dissemination strategies**

   In light of substantial disparities in public knowledge regarding cancer care, the Ministry of Health, Labour and Welfare, local governments, designated cancer care hospitals, and professional medical organizations should collaborate to strengthen public communication. The Fifth Basic Plan to Promote Cancer Control Programs should incorporate indicators evaluating the citation and secondary use of publicly produced educational materials, while also establishing “push-based” systems that ensure patients receive reliable information and support immediately after diagnosis.

2. **Centralize cancer screening data and improve screening participation**

   The national government should take the lead in establishing standardized operational guidelines and data formats to enable integrated management of screening data across workplace-based and municipal screening programs. Continuous reminders should be ensured during life transitions such as retirement or relocation. Screening participation rates stratified by household income, as well as non-participation rates among low-income populations, should be adopted as key performance indicators (KPIs), with reduction of screening disparities established as an explicit policy objective.

3. **Promote public understanding of cancer genomic medicine**

   Designated core hospitals for cancer genomic medicine and related institutions should develop standardized educational materials and establish systems to disseminate them broadly through designated cancer care hospitals and local government consultation services. In addition, explanation and informed decision-making processes at the time of diagnosis and treatment planning should be standardized. Policy evaluation should place greater emphasis not only on awareness rates, but also on meaningful public understanding.

4. **Balance the centralization of healthcare functions with stronger patient support systems**

   Efforts to centralize specialized cancer care should be accompanied by integrated measures to support patients, including improved transportation infrastructure, public financial support for travel and accommodation costs, and stronger coordination with primary care providers. Consideration should be given to establishing a cross-generational and wide-area public support system that subsidizes transportation costs for patients traveling long distances for cancer treatment regardless of age or cancer type. Such systems should be designed in accordance with regional circumstances through discussions involving Prefectural Cancer Care Coordination Councils and related regional platforms.

5. **Build social consensus toward a sustainable healthcare system**

   To facilitate meaningful national discussion regarding healthcare financing, efforts should be made to improve public understanding of the healthcare insurance system, including the high-cost medical expense benefit system. Information should be communicated progressively in ways appropriate to different generations and levels of familiarity. In addition, opportunities for citizens to participate in discussions regarding Regional Medical Care Visions should be expanded in order to foster broader social consensus on the future sustainability of the healthcare system.

3. Cancer Experience and Help-Seeking Behavior

This chapter reports on respondents' own experience with cancer, the presence or absence of cancer experience among family members, and help-seeking behavior at the time of a cancer diagnosis. Cancer experience is assumed to broadly influence subsequent information-seeking related to treatment, interest in the healthcare system, and individual attitudes toward healthcare policy. In this survey, approximately 9% of respondents reported having personal experience with cancer, and about 35% reported having a family member within second-degree relatives with cancer experience. Overall, approximately 38% had cancer experience either personally or within their family.

3.1 Personal Experience with Cancer (Q4, Q5)

Table 3-1. Personal Experience with Cancer (Q4)

Response option	Number of responses (%)
Currently undergoing cancer treatment	196 (2%)
Previously treated for cancer (including remission/follow-up)	676 (6.8%)
No experience with cancer	8,406 (84.1%)
No response	722 (7.2%)

A total of 8.8% of respondents (n=872) reported that they were either currently undergoing treatment or had previously received treatment for cancer. According to estimates by the National Cancer Center Japan, the overall five-year relative survival rate for cancer patients in Japan is approximately 68% (for those diagnosed in 2014–2015), and the number of cancer survivors who continue to live long-term in society after treatment has been increasing year by year. In this survey as well, about 10% of respondents were cancer survivors, suggesting the continued importance of developing a social foundation that supports people living with cancer and promotes coexistence with the disease.

Table 3-2. Years Since Most Recent Cancer Diagnosis (Q5, n=872)

Response option	Number of responses (%)
Less than 1 year	68 (7.8%)
1 to <3 years	159 (18.2%)
3 to <5 years	198 (22.7%)
5 to <10 years	182 (20.9%)
10 years or more	252 (28.9%)
Unknown / no response	13 (1.5%)

Among cancer survivors (n=872), approximately half (49.8%) had been diagnosed five or more years earlier. Long-term survivors of 10 years or more accounted for 28.9%, indicating that living with cancer often extends over a long period. At the same time, 26.0% had been diagnosed within the past three years, indicating that a certain proportion were currently navigating cancer care.

[Key findings from cross-tabulation: personal cancer experience]

- By age group, the proportion of respondents with cancer experience (currently undergoing treatment or previously treated) increased with age: 5.2% in their 20s, 6.3% in their 30s, compared to 8.2% in their 60s and 10.5% among those aged 70 and above.

3.2 Family Experience with Cancer (Q6)

Table 3-3. Cancer Experience Among Family Members (within second-degree relatives) (Q6)

Response option	Number of responses (%)
Yes	3,450 (34.5%)
No	5,650 (56.5%)
Unknown / no response	900 (9%)

More than one in three respondents had a family member within second-degree relatives with cancer experience, indicating that cancer is a highly familiar disease.

[Key findings from cross-tabulation: family cancer experience]

- By age group, the proportion of respondents with a family member who had cancer was 11.8% in their 20s, increasing to 45.0% in their 60s and 48.0% among those aged 70 and above. The proportion of individuals with either personal or family cancer experience reached approximately 58% among those aged 70 and above, confirming that contact with cancer increases with age.
- Overall, approximately 38% of all respondents had cancer experience either personally or within their family.

3.3 Consultation Sources at the Time of Cancer Diagnosis (Q7)

Table 3-4. Consultation Sources at the Time of Cancer Diagnosis (Q7, multiple responses allowed)

Consultation source	Number of responses (%)
Attending physician	2,048 (53.4%)
Family/relatives	1,238 (32.3%)
Did not consult anyone	768 (20.0%)
Searched for information on the internet	462 (12.1%)
Nurses	302 (7.9%)
Friends/acquaintances	280 (7.3%)
Consultation support centers at designated cancer care hospitals	211 (5.5%)
Patient groups and patient support organizations	61 (1.6%)

Note: Q7 respondents include those who answered “have cancer experience” in Q4 or “have a family member with cancer experience” in Q6.

The most common consultation source at the time of diagnosis (for oneself or a family member) was the “attending physician” (53.4%), followed by “family/relatives” (32.3%), indicating reliance on both medical professionals and close personal networks. Meanwhile, 20.0% reported that they “did not consult anyone,” suggesting that a certain proportion did not seek advice despite receiving a cancer diagnosis. Possible reasons include not perceiving the need for consultation, uncertainty about what to discuss, lack of knowledge about where to seek help, psychological barriers to consultation, or reluctance to burden others. This pattern varied significantly depending on cancer experience. Among respondents without personal experience but with affected relatives, 22.0% reported not consulting anyone, whereas among those currently undergoing treatment only 7.1% reported the same.

Regarding cancer consultation and support centers at designated cancer care hospitals, 5.5% of all Q7 respondents selected this option. However, when stratified by cancer experience, 14.3% of those currently undergoing treatment and 8.3% of those with past cancer experience reported using these centers. These centers serve as public access points providing information on treatment and survivorship, guidance on second opinions, employment support, and information on financial assistance schemes. However, their relatively low utilization suggests that awareness of these services may be insufficient. Similarly, the use of patient groups and patient support organizations was extremely low at 1.6%, reaching only 8.2% even among those currently undergoing

treatment.

[Key findings from cross-tabulation: consultation at diagnosis]

- By age group, the proportion of those who "did not consult anyone" was highest among younger respondents, at 27.5% in their 20s and 24.2% in their 30s, compared to 17.3% in their 60s and 17.8% among those aged 70 and above. This suggests that younger individuals are less likely to engage in help-seeking behavior, possibly due to lower awareness of support resources such as cancer consultation and support centers at designated cancer care hospitals.

4. Knowledge of Cancer Treatment

This chapter reports on public awareness of the three main cancer treatment modalities (surgery, drug therapy, and radiation therapy), awareness of the involvement of multiple specialists in cancer care, and awareness of the provision of palliative care from the early stages of treatment. While cancer care has become increasingly advanced and complex, the extent to which basic knowledge about cancer treatment is widely disseminated in society is a critical issue directly linked to achieving better care, including patients' active participation in treatment and the quality of informed consent. The survey results revealed marked differences in knowledge levels by age group, with consistently lower awareness observed among younger respondents.

4.1 Awareness of the Three Main Treatment Modalities (Q8)

Table 4-1. Awareness of the Three Main Treatment Modalities (Q8)

Treatment	Awareness			Heard of name only	Not aware at all
	Well understood	Somewhat understood	Subtotal		
Surgery	22.2%	43.4%	65.6%	18.6%	10.0%
Radiation therapy	15.8%	42.7%	58.5%	24.7%	10.8%
Drug therapy	15.7%	42.7%	58.4%	23.7%	12.0%

Awareness of surgery ("well understood" + "somewhat understood") was the highest at 65.6%, followed by radiation therapy (58.5%) and drug therapy (58.4%). There were no substantial differences in overall awareness among the three modalities, and more than half of respondents had at least heard of each treatment.

However, when limited to "well understood," the proportions were much lower: 22.2% for surgery, 15.8% for radiation therapy, and 15.7% for drug therapy. This indicates that only a limited proportion of respondents have a deeper understanding of treatment details, indications, and side effects. In particular, for drug therapy, treatment options have expanded significantly in recent years with the advent of molecular targeted therapies and immune checkpoint inhibitors, but these advances may not be widely recognized. Similarly, despite being regarded as a relatively less physically burdensome option, radiation therapy remains less well understood compared to surgery.

[Key findings from cross-tabulation: awareness of the three main treatment modalities]

- By age group, awareness increased with age. The proportion who reported "well understood" for surgery was 17.2% among those in their 20s, compared to 29.8% among those aged 70 and above, a gap of approximately 12 percentage points.
- By cancer experience, awareness was substantially higher among those currently undergoing treatment, with 47.4% reporting "well understood" for surgery, more than double the overall average, indicating that personal experience strongly promotes knowledge acquisition.
- Gender differences were small, although women's awareness of surgery (67.6%) slightly exceeded that of men (63.4%).

4.2 Awareness of Multidisciplinary Care Involving Multiple Specialists (Q9)

Table 4-2. Awareness of Multidisciplinary Care Involving Multiple Specialists (Q9)

Response option	Number of responses (%)
Well understood	520 (5.2%)
Somewhat understood	2,930 (29.3%)
Not very aware	3,530 (35.3%)
Not aware at all	2,330 (23.3%)
No response	690 (6.9%)

With the increasing sophistication and complexity of cancer care, systems have been established at designated cancer care hospitals and other facilities in which specialists from multiple departments—such as surgery, medical oncology, radiation oncology, and pathology—collaborate to determine treatment strategies, rather than relying solely on a single attending physician. In recent years, the development of medical oncology, which oversees drug therapy, has further advanced, leading to evolving forms of cross-disciplinary collaboration.

In this survey, only 5.2% of respondents reported that they "well understood" the existence of such multidisciplinary care, and even when including "somewhat understood," the proportion reached only 34.5%. Approximately 60% responded that they were "not very aware" or "not aware at all."

It should be noted that this question specifically asked about awareness of the existence of multidisciplinary care systems. Lack of awareness of the existence of such systems may be a factor underlying patients' hesitation to seek opinions from specialists other than their primary physician or to utilize second opinions, and remains an issue requiring further examination. At designated cancer care hospitals, cancer boards—where specialists from multiple departments and professions jointly discuss treatment strategies—are incorporated into institutional guidelines. These mechanisms are intended to support patients in arriving at optimal treatment decisions.

[Key findings from cross-tabulation: awareness of multidisciplinary care]

- By age group, awareness ("well understood" + "somewhat understood") was about 40% among those aged 60 and above, compared to 23.8% in their 20s and 27.5% in their 30s, indicating lower awareness among younger populations. This suggests that younger individuals, who have fewer opportunities to encounter cancer, may have limited exposure to the concept of team-based care.

- Differences by cancer experience were substantial. Awareness was 69.9% among those currently undergoing treatment, 54.7% among those with past cancer experience, and 47.7% among those with family experience, compared to only 29.0% among those with no personal or family experience. This represents a gap of approximately 41 percentage points between those currently undergoing treatment and those with no experience. Even between those with only family experience (47.7%) and those with no experience (29.0%), there was a gap of about 19 points, suggesting that awareness of multidisciplinary care is often acquired through the cancer experience of close others.

4.3 Awareness of Early Implementation of Palliative Care (Q10)

Table 4-3. Awareness of Early Implementation of Palliative Care (Q10)

Response option	Number of responses (%)
Well understood	440 (4.4%)
Somewhat understood	2,040 (20.4%)
Not very aware	3,560 (35.6%)

Not aware at all	3,390 (33.9%)
No response	580 (5.8%)

Awareness that palliative care is provided from the early stages of treatment was 24.8% ("well understood" + "somewhat understood"). When combined, "not very aware" (35.6%) and "not aware at all" (33.9%) accounted for approximately 70%, suggesting that sufficient information about early palliative care has not reached the general public. International evidence has accumulated showing that early integration of palliative care contributes to improved quality of life (QOL) and reduced psychological distress among patients. In Japan, since the launch of the Third Basic Plan to Promote Cancer Control Programs in 2018, "promotion of palliative care from the time of diagnosis" has been positioned as a key policy measure. This has been carried forward in the Fourth Basic Plan to Promote Cancer Control Programs launched in 2023 as part of the "cancer treatment" domain. Institutionally, designated cancer care hospitals are required to establish palliative care teams under national guidelines. Despite such system-level developments, the findings of this survey indicate that public awareness of the reality that palliative care is provided from the early stages of treatment remains limited.

According to the Cabinet Office's "Public Opinion Survey on Cancer Control" (July 2023), 49.7% of respondents agreed that palliative care should be provided "from the time of cancer diagnosis," indicating that normative views on the appropriate timing are relatively positive. However, this survey suggests a gap between such normative beliefs and awareness of actual practice.

Several additional points emerge from these findings. First, palliative care is inherently provided by healthcare professionals in response to patients' symptoms and distress, and prior knowledge of the concept of "palliative care from diagnosis" does not necessarily align with the actual quality or extent of care received. From this perspective, low awareness may reflect not only a public knowledge gap but also the importance of communication practices on the provider side, including information provision, symptom assessment, and elicitation of patient concerns. Second, limited public awareness may lead to misunderstandings among patients and families, highlighting the need to ensure that accurate information about the role of palliative care alongside treatment is delivered at appropriate times. Third, while awareness-raising efforts have been continuously undertaken by patient organizations, healthcare institutions, academic societies, and government bodies, the results suggest that there remains room to reconsider approaches, target audiences, and messaging. In addition to public outreach, ensuring opportunities for healthcare providers to communicate appropriate information directly to patients and families in clinical settings may be critical for effectiveness.

[Key findings from cross-tabulation: awareness of early implementation of palliative care]

- By age group, awareness was highest among those aged 70 and above (26.3%), but the difference from those in their 20s (24.2%) was small. However, the proportion of "no response" was relatively high among those in their 20s (12.0%), suggesting lower overall engagement with the topic.

- By cancer experience, substantial differences were observed. Awareness was 62.2% among those currently undergoing treatment, 39.5% among those with past cancer experience, and 31.1% among those with family experience, compared to 22.2% among those with no personal or family experience. This represents a gap of approximately 40 percentage points between those currently undergoing treatment and those with no experience. Notably, there was a 22.7-point gap between those currently undergoing treatment (62.2%) and those with past experience (39.5%). No other item showed such a large gap between patients currently undergoing treatment and those who had completed treatment within the group with personal cancer experience, suggesting that opportunities to encounter information on palliative care may be concentrated during the treatment period.

- Gender differences were minimal, with awareness at 24.2% among women and 25.3% among men.

5. Attitudes Toward the Centralization of Healthcare Functions in Cancer Care

This chapter reports on attitudes toward the centralization of healthcare functions in cancer care. Amid ongoing policy discussions on restructuring the cancer care delivery system, the survey examined levels of support and opposition to centralization, specific reasons for opposition, and conditions under which patients would accept traveling long distances for care. Attitudes toward centralization varied by age group and residential area, with concerns about the burden of travel particularly pronounced among rural residents and older populations.

5.1 Support for or Opposition to Centralization (Q11)

Table 5-1. Support for or Opposition to Centralization (Q11)

Response option	Number of responses (%)
Strongly support	767 (7.7%)
Somewhat support	3,909 (39.1%)
Somewhat oppose	1,732 (17.3%)
Strongly oppose	431 (4.3%)
Don’t know / no response	3,161 (31.6%)

The proportion expressing support (46.8%) exceeded those opposed (21.6%). However, “don’t know / no response” accounted for 31.6%, indicating that a substantial share of respondents had not formed a clear view.

Centralization of healthcare functions in cancer care is currently an active topic of national-level policy discussion and is expected to be examined at the regional level in the future. In the Ministry of Health, Labour and Welfare’s Study Group on the Future of the Cancer Care Delivery System (hereafter, the Study Group), discussions are underway on restructuring the system with a view to 2040. In June 2025, consensus was reached on a direction to centralize cancer care involving highly specialized medical technologies. To date, Japan’s cancer care policy has emphasized “equitable distribution” to ensure access to a consistent standard of care nationwide. However, in the context of population decline and anticipated shortages of healthcare professionals, there is growing recognition of the need to maintain and improve quality by concentrating case volumes for highly specialized procedures such as complex cancer surgery and radiation therapy.

The findings of this survey show that while approximately half of respondents support centralization, about 30% remain undecided. The sizable proportion of respondents withholding judgment suggests a need for greater public communication and dialogue on both the benefits of centralization and the support measures required for patients and their families.

[Key findings from cross-tabulation: support for or opposition to centralization]

- By gender, overall support (strongly + somewhat) was higher among men (50.8%) than women (43.0%), a difference of 7.8 percentage points. Women were more likely to respond “don’t know” (34.1%) than men (29.0%), indicating a larger undecided group.

- By age group, support was highest among those aged 70 and above (51.6%) and lowest among those in their 20s (42.2%). With increasing age, both support and opposition increased (opposition: 18.4% in 20s to 24.9% in 70+), while the proportion of “don’t know / no response” declined. This suggests that older individuals are more likely to hold a clear position, whereas younger individuals are more likely to remain undecided.

- By cancer experience, support was highest among those currently undergoing treatment (72.5%), followed by those with past experience (60.2%), those with family experience only (55.6%), and those with no personal or family experience (46.0%). The gap between those currently undergoing treatment and those with no experience was approximately 26 points. "Don't know / no response" was 11.2% among those currently undergoing treatment versus 32.2% among those with no experience, a gap of about 20 points. Greater personal relevance was associated with more clearly formed opinions and stronger support for centralization.

- By residential area, support was somewhat lower in towns and rural/mountainous areas (41.3%) compared to major designated cities (50.6%), a difference of about 9 points.

5.2 Reasons for Opposition to Centralization (Q12)

Table 5-2. Reasons for Opposition to Centralization (Q12, n=2,163; multiple responses allowed)

Reason	Number of responses (%)
Physical burden of traveling long distances	1,299 (60.1%)
Financial burden of transportation and accommodation	1,014 (46.9%)
Lack of available transportation for long-distance travel	715 (33.1%)
Greater sense of security with local healthcare providers	681 (31.5%)
Disruption to work or education due to long-distance travel	562 (26.0%)
Concerns about regional disparities in care due to centralization	554 (25.6%)
Concerns about declining quality of care at local hospitals	436 (20.2%)

The most common reasons for opposition were the physical burden of traveling long distances (60.1%) and the financial burden of transportation and accommodation (46.9%), indicating that travel-related costs are the primary concern. In addition, over 30% cited lack of transportation options (33.1%) and a preference for local providers (31.5%), suggesting that, particularly for residents in areas with limited public transport, centralization is perceived as a threat not only to access to cancer care but to the availability of healthcare services itself in their communities themselves.

The Study Group has also highlighted the importance of strengthening support for transportation and accommodation costs for patients traveling long distances. The reasons identified in this survey confirm that these policy challenges are strongly perceived at the public level.

5.3 Conditions for Accepting Long-Distance Travel for Care (Q13, Q14)

Table 5-3. Conditions for Accepting Long-Distance Travel (Q13; multiple responses allowed)

Condition	Number of responses (%)
Availability of transportation	4,673 (46.7%)
Public financial support for transportation and accommodation	4,418 (44.2%)
Follow-up system through coordination with primary care physicians	4,327 (43.3%)
Reduced visit frequency through use of telemedicine	2,252 (22.5%)
Not acceptable under any conditions	592 (5.9%)

The top three conditions—availability of transportation (46.7%), financial support for travel and accommodation (44.2%), and coordination with primary care providers (43.3%)—were all cited by over 40% of respondents. This indicates the need for a comprehensive support system integrating mobility support, financial assistance, and local healthcare coordination, rather than reliance on any single measure. In Q14 (ranking of importance), these three factors also ranked consistently as the top priorities, confirming the coherence of public needs.

Although relatively lower at 22.5%, the use of telemedicine to reduce visit frequency has also been proposed by the Study Group as a means of providing care to patients in remote areas. Given that the majority of cancer patients are aged 60 and above, limited familiarity with digital technologies may pose a barrier to the adoption of telemedicine. The figure of 22.5% likely reflects the still-limited awareness and experience with telemedicine at present. However, under the amendment to the Medical Care Act that took effect in April 2026, telemedicine is now formally defined in law, with requirements for registration and compliance set by ministerial ordinance. This is expected to facilitate the development of a safe and reliable environment for patients to use telemedicine.

Only 5.9% indicated that long-distance travel would not be acceptable under any circumstances, suggesting that with appropriate support systems in place, the majority of the public may be willing to accept traveling for care.

Table 5-4. Conditions for Accepting Long-Distance Travel: Proportion Ranked 1st–3rd (Q14, n=7,013)

Condition	Ranked 1st (%)	Ranked 2nd (%)	Ranked 3rd (%)
Availability of transportation	2,359 (33.6%)	1,461 (30.3%)	661 (23.5%)
Public financial support for transportation and accommodation	2,153 (30.7%)	1,584 (32.9%)	566 (20.1%)
Coordination with primary care providers	2,028 (28.9%)	1,176 (24.4%)	1,008 (35.8%)
Reduced visit frequency through telemedicine	464 (6.6%)	564 (12.3%)	578 (20.5%)
Other	9 (0.1%)	1 (0.0%)	9 (0.1%)

The ranking results in Q14 further confirm that the same three conditions consistently occupy the top positions, underscoring the coherence of public preferences.

6. Participation in Cancer Screening

This chapter reports on participation in screening for gastric, colorectal, lung, breast, and cervical cancers; awareness of different types of screening (municipal population-based screening and workplace-based screening); and attitudes toward sharing workplace screening data with municipalities. The Fourth Basic Plan to Promote Cancer Control Programs sets a target screening rate of 60%; however, the findings of this survey highlight a substantial gap from this target. In addition, limited understanding of the screening system itself may be a factor inhibiting participation.

6.1 Participation Status for Each Type of Cancer Screening (Q15)

Table 6-1. Participation Status for Each Type of Cancer Screening (Q15) (target age groups only)

Screening	Target (n)	Regular participation	If opportunity arises	Rarely	Never screened	Unknown
Gastric (50–69)	3,179	34.5%	12.4%	10.8%	29.2%	13.1%
Colorectal (40–69)	4,741	30.9%	12.1%	8.7%	33.7%	14.6%
Lung (40–69)	4,741	32.5%	10.0%	8.1%	34.5%	15.0%
Breast (women 40–69)	2,365	33.2%	13.0%	10.6%	28.7%	14.5%
Cervical (women 20–69)	3,577	27.4%	11.1%	10.0%	33.1%	18.3%

Note: To ensure comparability with the target screening rate (60%) set in the Fourth Basic Plan to Promote Cancer Control Programs, the analyses in this chapter are restricted to the age groups used for calculating screening rates in the Comprehensive Survey of Living Conditions (gastric cancer: 50–69; colorectal, lung, and breast cancer: 40–69; cervical cancer: 20–69).

Across all cancer types, the proportion reporting regular participation ranged from 27% to 35%. Meanwhile, those who had never been screened accounted for around 30%: 29.2% for gastric cancer, 33.7% for colorectal cancer, and 34.5% for lung cancer. Similar patterns were observed for breast cancer (28.7%) and cervical cancer (33.1%).

The Fourth Basic Plan to Promote Cancer Control Programs sets a target screening rate of 60%. In this survey, however, the regular screening rate—calculated using the same target age groups as those used in the Comprehensive Survey of Living Conditions—was approximately 27–35%, leaving a substantial gap of 25–33 percentage points from the national target and indicating that achieving the target remains a considerable challenge. In addition, 13–18% selected "unknown / no response" across all screening types, suggesting that a certain proportion of respondents are not aware of their own screening status.

There were no major differences in regular participation across screening types, suggesting that participation is less driven by disease-specific factors and more by whether individuals have an established habit of undergoing screening. In other words, those who regularly participate tend to undergo multiple screenings, while those without such a habit tend to avoid screening altogether.

[Key findings from cross-tabulation: screening uptake]

- By age group, regular screening rates increased with age across almost all screenings. For gastric cancer screening (ages 50–69), the rates were 32.6% in the 50s and 36.8% in the 60s. For colorectal cancer screening (ages 40–69), the rates were 23.1% in the 40s, 33.2% in the 50s, and 36.7% in the 60s. For lung cancer screening (ages 40–69), the rates were 23.9% in the 40s, 33.9% in the 50s, and 40.3% in the 60s. For cervical cancer screening (women aged 20–69), the rates were 14.0% in the 20s, 24.2% in the 30s, 31.1% in the 40s, 34.8% in the 50s, and 28.4% in the 60s. Overall, screening participation tended to rise with age.
- By gender, for gastric cancer screening (ages 50–69), men (35.7%) were slightly higher than women (33.3%). In contrast, for colorectal and lung cancer screening (ages 40–69), women (colorectal: 31.6%,

lung: 33.3%) slightly exceeded men (colorectal: 30.3%, lung: 31.7%). Overall, no substantial gender differences were observed.

- By individual income, clear gradients were observed. For gastric cancer screening (ages 50–69), regular participation was 28.1% among those earning under 1 million yen (≈ under USD 6,500), 33.1% for 1–3 million yen (≈ USD 6,500–19,400), 38.1% for 3–6 million yen (≈ USD 19,400–38,700), and 52.4% for those earning 6 million yen or more (≈ USD 38,700 or more).[1] This represents a 24.3-point gap between the highest and lowest income groups, suggesting a strong association between economic status and screening behavior. A similar pattern was observed by household income, with a gap of approximately 24 points between those earning under 3 million yen (≈ under USD 19,400; 25.6%) and those earning 12 million yen or more (≈ USD 77,400 or more; 50.0%).

- By insurance type, individuals covered by employment-based health insurance consistently showed higher participation rates across all age groups. For gastric cancer screening (ages 50–69), the rate was 43.3% among those with employment-based insurance compared to 26.6% for those with National Health Insurance (+16.7 points). For colorectal cancer screening (ages 40–69), the rates were 38.3% versus 25.5% (+12.8 points), respectively. The gap was largest in the 50s (gastric: +22.5 points; colorectal: +22.0 points) and narrowed in the 60s (gastric: +14.7 points; colorectal: +10.1 points).

- By cancer experience, for gastric cancer screening (ages 50–69), regular participation was 34.0% among those currently undergoing treatment (n=47), 45.1% among those with past cancer experience (n=164), and 41.2% among those with family experience only (n=1,197), compared to 31.3% among those with no personal or family experience (n=1,484). The 13.8-point gap between those with past experience and those with no experience suggests that both direct and indirect exposure to cancer is associated with increased screening participation.

6.2 Awareness of Screening Types (Q16)

Table 6-2. Awareness of Screening Types (Q16)

Response option	Number of responses (%)
Aware of both	3,810 (38.1%)
Aware of municipal screening only	1,230 (12.3%)
Aware of workplace screening only	600 (6%)
Did not know they are separate systems	2,740 (27.4%)
Unknown / no response	1,620 (16.2%)

Cancer screening in Japan is primarily provided through two systems: population-based screening conducted by municipalities and workplace-based screening conducted by medical institutions contracted by employers. However, only 38.1% of respondents were aware of both. Combining those who were aware only of municipal screening (12.3%) and only of workplace-based screening (6.0%), about 20% were aware of only one of the two. When those who "did not know they are separate systems" (27.4%) and those who selected "don't know / no response" (16.2%) are included, more than 40% did not have a sufficient understanding of how the system is structured.

It should be noted that, in the case of workplace-based screening, cancer screening is not always mandatory, and some workplaces may not offer it. Therefore, among those who reported that they were not aware of workplace-

[1] All yen amounts in this report are followed by approximate USD equivalents based on an exchange rate of 1 USD ≈ 155 JPY (as of May 2026). For reference, the average annual personal income in Japan was approximately 4.6 million yen (approx. USD 29,700) as of the latest national survey. The income brackets used in this analysis (under 1 million / 1–3 million / 3–6 million / 6 million yen or more) correspond approximately to under USD 6,500 / USD 6,500–19,400 / USD 19,400–38,700 / USD 38,700 or more.

based screening, a substantial proportion may not simply lack awareness but may in fact not have access to cancer screening through their workplace. This highlights a structural issue in that the provision of cancer screening is not standardized across insurers.

Even so, overall awareness of how the screening system is structured remains low, and such limited awareness may lead to missed opportunities for screening. For example, when individuals lose access to workplace-based screening due to retirement or job change, they may fail to switch to municipal screening and consequently drop out of cancer screening altogether. The high rates of non-participation observed in the previous section may, in part, be attributable to this lack of understanding of the system.

It should also be noted that, in addition to population-based and workplace-based screening, cancer screening in Japan includes other options such as comprehensive medical check-ups that individuals arrange on their own.

[Key findings from cross-tabulation: awareness of screening types]

- There were marked differences by age group. The proportion who reported being "aware of both" was only 12.3% among those in their 20s, compared to 53.1% among those aged 70 and above. In particular, the proportion who "did not know they are separate systems" was high among those in their 20s (42.8%) and 30s (41.7%), indicating that the structure of the screening system itself is not well understood among younger populations.

- By gender, the proportion reporting "aware of both" was higher among women (43.4%) than men (32.4%), a difference of approximately 11 percentage points. While men are more likely to encounter screening primarily through workplace-based programs, women are exposed not only to workplace screening but also to municipal invitations for breast and cervical cancer screening, making them more likely to be aware of both systems.

- By cancer experience, the proportion aware of at least one system (either municipal or workplace-based screening) was 82.7% among those currently undergoing treatment, 81.8% among those with past cancer experience, and 74.4% among those with family experience, compared to only 50.5% among those with no personal or family experience. The gap of approximately 30 percentage points indicates that awareness of the screening system increases through both direct and indirect exposure to cancer.

6.3 Sharing of Workplace Screening Data with Municipalities (Q17)

Table 6-3. Attitudes Toward Sharing Workplace Screening Data with Municipalities (Q17)

Response option	Number of responses (%)
Support	2,702 (27%)
Somewhat support	3,578 (35.8%)
Somewhat oppose	672 (6.7%)
Oppose	293 (2.9%)
Don't know / no response	2,755 (27.6%)

Regarding whether municipalities should be able to access information on cancer screening conducted through workplaces, the combined proportion of "support" (27.0%) and "somewhat support" (35.8%) reached 62.8%, well above a majority. In contrast, opposition ("somewhat oppose" 6.7% and "oppose" 2.9%) totaled 9.6%, while 27.6% selected "don't know / no response."

Under the current system, information on cancer screening conducted in the workplace is not shared with municipalities, making it difficult for local governments to comprehensively track residents' screening status. As a result, municipalities may send duplicate screening invitations to individuals who have already been screened

through their workplace, while facing difficulties in accurately identifying and reaching those who have not been screened through either system.

The findings of this survey indicate a relatively high level of public acceptance of centralized management of screening data. As noted in the previous section, awareness of the screening system itself remains limited. In this context, establishing mechanisms that enable municipalities to accurately identify residents' screening status through data linkage and to provide targeted outreach to those who have not been screened can be positioned as a foundational measure to improve screening uptake.

[Key findings from cross-tabulation: sharing of workplace screening data]

- By age group, support was higher among older respondents, reaching approximately 68% among those aged 60 and above, compared to 53.1% among those in their 20s, suggesting greater acceptance of data linkage among older populations.

- Support was significantly higher among individuals with screening experience (69.6%) than among those without (56.3%), indicating that prior screening experience is associated with greater understanding of data sharing. By cancer experience, support was highest among those currently undergoing treatment (85.2%), followed by those with past experience (79.6%) and those with family experience (77.3%), compared to 60.6% among those with no personal or family experience. The proportion selecting "don't know / no response" was only 8.2% among those currently undergoing treatment, compared to 28.3% among those with no experience, a gap of approximately 20 percentage points. These results suggest that greater personal relevance is associated with clearer and more supportive views on the institutional issue of sharing screening data with municipalities.

7. Attitudes Toward Cancer Genomic Medicine and Genetic Testing

This chapter reports on awareness of cancer genomic medicine, levels of understanding after explanation, support for earlier insurance coverage of gene panel testing (Comprehensive genomic profiling; CGP), and attitudes toward direct-to-consumer genetic testing. While cancer genomic medicine is a core technology underpinning personalized medicine, public awareness remains extremely low. At the same time, the finding that a majority expressed understanding when provided with appropriate information—and showed support for expanding insurance coverage—suggests that public support for advanced medical technologies can be strengthened depending on how information is communicated. This chapter also reveals particularly pronounced differences by cancer experience, with clear structural gaps in both knowledge and attitudes between those with cancer experience and those without.

7.1 Awareness of Cancer Genomic Medicine (Q18) and Understanding After Explanation (Q19)

Table 7-1. Awareness of Cancer Genomic Medicine (Q18)

Response option	Number of responses (%)
Well understood, including content	516 (5.2%)
Heard of it but do not know the content	3,521 (35.2%)
Never heard of it	5,963 (59.6%)

Cancer genomic medicine refers to medical care that comprehensively analyzes genetic mutations in cancer cells to identify the most appropriate treatment for each individual patient. In Japan, CGP was covered by public insurance in 2019. However, in this survey, only 5.2% of respondents reported that they were “well aware, including the content” of cancer genomic medicine. Even when combined with those who had “heard of it but do not know the content” (35.2%), overall awareness reached only 40.4%. Nearly 60% (59.6%) reported that they had “never heard of it,” indicating that even several years after insurance coverage was introduced, awareness at the general population level remains limited. For reference, in the Cabinet Office’s 2019 Public Opinion Survey on Cancer Control and Tobacco Control, 6.6% reported being “well aware” of cancer genomic medicine and 33.8% reported knowing “only the term,” figures broadly comparable to those observed in this survey.

Table 7-2. Understanding of Cancer Genomic Medicine After Explanation (Q19)

Response option	Number of responses (%)
Fully understood	604 (6%)
Mostly understood	4,981 (49.8%)
Not very well understood	2,095 (21%)
Hardly understood	740 (7.4%)
Don’t know / no response	1,580 (15.8%)

In contrast, in Q19—which assessed understanding after respondents were provided with an explanation of cancer genomic medicine—55.8% indicated understanding (“fully understood” 6.0% + “mostly understood” 49.8%). This suggests that if appropriate information is provided, a majority of the public can understand the concept. It also indicates that low awareness is likely due not to lack of interest but to limited opportunities to encounter relevant information. In practice, information on cancer genomic medicine tends to be concentrated in specialized media and has not sufficiently reached the information channels that the general public routinely engages with.

[Key findings from cross-tabulation: awareness of cancer genomic medicine]

- By age group, awareness was higher among older populations. The combined awareness rate (“well understood” + “heard of it”) was 51.5% among those aged 70 and above, compared to 27.3% among those in their 20s.

- By gender, awareness was slightly higher among men (43.1%) than women (37.8%), a difference of 5.3 percentage points.
- By individual income, awareness was substantially higher among those earning 6 million yen or more (≈ USD 38,700 or more; 58.4%) compared to those earning less than 1 million yen (≈ less than USD 6,500; 33.3%), a gap of 25 points, highlighting the association between socioeconomic status and health literacy.
- By cancer experience, awareness was 75.0% among those currently undergoing treatment, 66.8% among those with past cancer experience, and 51.8% among those with family experience, compared to only 35.2% among those with no personal or family experience—a gap of approximately 40 points. When limited to those who reported "well understood, including content," the proportion reached 34.2% among those currently undergoing treatment, nearly seven times the overall average (5.2%). This suggests a much deeper level of understanding among those directly affected by cancer, likely reflecting exposure to CGP as a treatment option in clinical settings.

7.2. Support for Earlier Public Insurance Coverage of Comprehensive Gene Panel Testing (Q20)

Table 7-3. Support for Earlier Insurance Coverage of Comprehensive Gene Panel Testing (Q20)

Response option	Number of responses (%)
Support	1,387 (13.9%)
Somewhat support	4,228 (42.3%)
Somewhat oppose	853 (8.5%)
Oppose	318 (3.2%)
Don't know / no response	3,214 (32.1%)

Regarding whether comprehensive gene panel (CGP) testing should be covered by public insurance from an earlier stage of treatment, the combined proportion of "support" (13.9%) and "somewhat support" (42.3%) reached 56.2%, exceeding a majority and substantially outnumbering opposition (11.7%). Under the current system, CGP testing is covered by insurance only after standard treatment has been completed or when no standard treatment exists. These findings suggest relatively strong public support for introducing such testing at earlier stages.

Among those who supported the measure (n=5,615), the most common reason was that "it would be desirable if it leads to treatment at an earlier stage" (71.7%), followed by "it would increase the number of people who could potentially be saved" (61.0%) and "it would increase the likelihood of receiving the most appropriate treatment" (45.0%). These responses reflect expectations for improved treatment outcomes and the realization of personalized medicine. In addition, 32.9% expressed institutional support, indicating that "it is worth covering under public insurance." It should be noted that, at the time of the survey, a report indicating that early use of gene panel testing could increase the rate of reaching treatment by approximately 25% was presented. However, such figures are subject to ongoing research and may evolve as new evidence emerges. Accordingly, the interpretation of these findings should take into account that respondents' expectations regarding gene panel testing were likely influenced by this reported figure (25%).

Among those who opposed the measure (n=1,171), the most frequently cited reasons were concerns that "national healthcare expenditure would increase excessively" (33.2%) and that "even if an optimal drug is identified, it may not be usable if it has not been approved" (30.1%). The former reflects concerns about the sustainability of healthcare financing, an issue that is also discussed in Chapter 8. The latter highlights the issue of "drug lag," whereby treatments identified through testing may not be available in Japan due to regulatory approval delays, suggesting that expanding insurance coverage for testing must be accompanied by improvements in the drug approval system.

The proportion selecting "don't know / no response" was relatively high at 32.1%, consistent with the low

awareness of cancer genomic medicine noted in the previous section. This likely reflects that a substantial proportion of respondents withheld judgment due to insufficient access to the information needed to form an opinion.

[Key findings from cross-tabulation: awareness of cancer genomic medicine]

- By age group, support increased with age. While the support rate was 41.7% among those in their 20s, it reached 68.1% among those aged 70 and above. At the same time, the proportion selecting "don't know / no response" was high among younger respondents—41.3% in their 20s and 38.1% in their 30s—indicating that around 40% of younger individuals withheld judgment, highlighting persistent gaps in access to information on genomic medicine.

7.3 Direct-to-Consumer Genetic Testing (Q23)

Table 7-4. Intention to Use Direct-to-Consumer Genetic Testing (Q23)

Response option	Number of responses (%)
Have used	238 (2.4%)
Would like to use in the future	3,671 (36.7%)
Do not want to use	2,890 (28.9%)
Don't know / no response	3,201 (32.0%)

In recent years, direct-to-consumer genetic testing (DTC genetic testing), which allows individuals to access genetic testing without going through a medical institution, has been expanding in the market. In this survey, only 2.4% reported that they had "already used" such tests. However, 36.7% responded that they "have not used it but would like to in the future," indicating a certain level of latent interest.

At the same time, 28.9% reported that they "have not used it and do not want to use it," while 32.0% selected "don't know / no response," suggesting a near balance between those interested and those who are reluctant or undecided. The reasons underlying reluctance likely include concerns that many of these tests have not been sufficiently validated in terms of clinical utility or accuracy, uncertainty about how highly sensitive personal genetic information is stored and used by testing companies, and anxiety about how to respond to unexpected findings such as genetic predispositions. In addition, some respondents may be concerned about the risk of misinterpreting results and the psychological burden associated with receiving genetic information without the involvement of healthcare professionals.

A notable finding is that among respondents currently undergoing treatment, 23.0% reported that they had "already used" such tests, approximately ten times higher than the overall average (2.4%). This suggests that the use of genetic testing outside medical institutions may be more widespread than expected among patients currently receiving treatment. Whether such use occurs in parallel with gene panel testing in clinical settings, or as a complement or substitute, and how results are interpreted and utilized, fall beyond the scope of this survey and remain important areas for future investigation.

8. Attitudes Toward Medical Costs and the Healthcare System

This chapter provides a comprehensive overview of public attitudes toward the high-cost medical expense benefit system[2], measures to sustain the system, cost-sharing for advanced treatments, public funding for cancer screening and preventive care, the expansion of mixed billing[3], and the future direction of public health insurance[4]. Rising healthcare costs and the sustainability of the system are issues that extend beyond cancer care to the broader social security system in Japan. Through these questions, this chapter elucidates the overall landscape of public perceptions regarding financial burden and expectations toward the system. A notable feature across all questions is that "don't know" responses account for 20–30%, indicating that public debate on healthcare financing and systems remains at a relatively early stage. It should also be noted that many of the questions in this chapter presuppose an understanding of specialized policy concepts—such as the high-cost medical expense benefit system, advanced treatments, mixed billing, and the combined insured and uninsured care expenses system[5] and that responses may therefore be strongly influenced by prior knowledge of these systems.

8.1 Awareness of the High-Cost Medical Expense Benefit System (Q27)

Table 8-1. Awareness of the High-Cost Medical Expense Benefit System (Q27)

Response option	Number of responses (%)
Well understood	1,140 (11.4%)
Somewhat understood	3,960 (39.6%)
Have heard the name only	2,590 (25.9%)
Not aware at all	2,310 (23.1%)

The combined proportion of those who "well understood" (11.4%) and "somewhat understood" (39.6%) was 51.0%, meaning that only about half of respondents had a sufficient level of awareness. When combined with those who had "heard the name only" (25.9%) and those who were "not aware at all" (23.1%), approximately half did not understand the substance of the system.

The high-cost medical expense benefit system is a safety net that reduces patients' financial burden by setting a monthly ceiling on out-of-pocket medical expenses. It plays a particularly important role in cancer care, where many patients rely on this system. However, the system is currently at a major turning point. From the perspective of ensuring the sustainability of Japan's social security system, the government has considered raising the upper limits on out-of-pocket payments and submitted a bill to the Diet in 2025. This proposal faced strong opposition from patient organizations and the public and was subsequently shelved. Following this, the Ministry of Health, Labour and Welfare established an Expert Committee on the Future of the High-Cost Medical Expense Benefit System, which included patient representatives. After eight rounds of deliberation, the committee compiled its "Basic Approach to the Reform of the High-Cost Medical Expense Benefit System" in December 2025.

The findings of this survey highlight that, even as discussions on system reform advance, approximately half of the public—who may ultimately be affected by these reforms—do not sufficiently understand the system itself. To enable meaningful public debate on reform, improving awareness of the system must be a prerequisite.

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[2] High-Cost Medical Expense Benefit System: A financial protection mechanism that limits patients' monthly out-of-pocket spending on covered healthcare services. Expenses exceeding the limit are reimbursed.

[3] Mixed billing: Under Japan's healthcare system, healthcare services are generally classified as either covered or not covered by public insurance. In principle, patients cannot combine covered and non-covered services within the same episode of care; otherwise, they may be required to pay the full cost of all services received.

[4] Public health insurance system: Japan operates a universal public health insurance system under which all residents are required to enroll in a public health insurance plan. Patients generally pay 10–30% of medical costs out of pocket, with the remainder covered by insurance.

[5] Combined insured and uninsured care expense system: An exception to the general prohibition on mixed billing. It allows certain approved non-covered services to be provided alongside covered services, with patients paying the full cost of the non-covered portion while retaining insurance coverage for the covered portion.

[Key findings from cross-tabulation: awareness of the high-cost medical expense benefit system]

- By age group, there was a substantial gap: awareness (“well understood” + “somewhat understood”) was 29.7% among those in their 20s, compared to 66.8% among those aged 70 and above. Notably, 43.3% of those in their 20s reported that they were “not aware at all,” indicating an urgent need to improve awareness among younger populations.

- By cancer experience, large differences were observed. Awareness was 83.7% among those currently undergoing treatment, 80.3% among those with past cancer experience, and 68.2% among those with family experience, compared to 44.6% among those with no personal or family experience—a gap of approximately 39 percentage points. This suggests that individuals who have experienced cancer are more likely to encounter and become familiar with the system through information provided in clinical settings when facing high medical costs.

- By individual income, awareness was significantly higher among those earning 6 million yen or more (≈ USD 38,700 or more; 67.9%) compared to those earning less than 1 million yen (≈ less than USD 6,500; 41.2%), indicating a pronounced information gap associated with income.

8.2 Policy Options for Sustaining the High-Cost Medical Expense Benefit System (Q28)

Table 8-2. Policy Options for Sustaining the High-Cost Medical Expense Benefit System (Q28; multiple responses allowed)

Policy option	Number of responses (%)
Raising the out-of-pocket ceiling for high-income individuals	4,100 (41.0%)
Additional cost-sharing for extremely high-cost treatments	2,170 (21.7%)
Excluding treatments with unclear effectiveness from coverage	1,974 (19.7%)
Revising the preferential cost-sharing caps for those aged 70 and above	1,662 (16.6%)
Maintain the current system without revision	830 (8.3%)
Maintaining the system through tax increases (e.g., consumption tax)	573 (5.7%)
Increasing social insurance premiums	551 (5.5%)

When asked which measures would be necessary to sustain the high-cost medical expense benefit system (multiple responses allowed), the most widely supported option was “raising the upper limit of out-of-pocket payments for higher-income individuals” (41.0%). This was followed by “requiring additional payments for extremely high-cost new treatments” (21.7%) and “excluding treatments with insufficiently established effectiveness from coverage” (19.7%). In contrast, support for across-the-board increases in public burden—such as “maintaining the system through higher taxes, including consumption tax” (5.7%) and “increasing social insurance premiums paid by all” (5.5%)—was relatively low.

These results indicate that while the public supports maintaining the system, there is strong endorsement of the principle of ability-to-pay (i.e., distributing the burden according to individuals’ financial capacity). Indeed, the Ministry of Health, Labour and Welfare’s expert committee has also identified “system design based on the principle of ability-to-pay” as a guiding approach, and is considering more finely differentiated income brackets for cost-sharing. The findings of this survey suggest that such policy directions are broadly aligned with public preferences.

It should also be noted that “don’t know / no response” accounted for 29.3%, indicating that a substantial proportion of respondents lack sufficient information to form a view on the highly technical issue of healthcare financing.

[Key findings from cross-tabulation: policy options for sustaining the high-cost medical expense benefit system]

This question allowed multiple responses, and differences in support patterns were observed by cancer experience.

- For the most frequently selected option, "raising the out-of-pocket ceiling for higher-income individuals," support was 39.8% among those currently undergoing treatment, 53.6% among those with past cancer experience, and 53.0% among those with family experience, compared to 38.3% among those with no personal or family experience. Support among those with past or family experience exceeded the overall average (41.0%) by approximately 12 percentage points, indicating stronger endorsement of ability-to-pay principles among these groups.

- For "additional cost-sharing for extremely high-cost new treatments," support was 26.0% among those currently undergoing treatment, 29.6% among those with past experience, and 28.4% among those with family experience, compared to 19.9% among those with no experience—again exceeding the overall average (21.7%) among those with cancer experience.

- For "don't know / no response," the proportion was relatively low among those currently undergoing treatment (10.2%) and those with past experience (9.6%), compared to 26.0% among those with no experience. This consistent pattern suggests that cancer experience is associated with more clearly formed views on policy issues related to system reform.

8.3 Views on Cost-Sharing for Advanced Treatments (Q24)

Table 8-3. Views on Cost-Sharing for Advanced Treatments (Q24)

Response option	Number of responses (%)
Should be covered by public insurance as much as possible	2,549 (25.5%)
High-cost advanced treatments should be covered through out-of-pocket payment or private insurance	2,081 (20.8%)
Difficult to judge	2,511 (25.1%)
Don't know / no response	2,828 (28.3%)

When asked about how the costs of advanced cancer treatments—such as comprehensive gene panel testing and immunotherapy—should be covered, opinions were divided into three broad groups. Approximately 25–30% supported coverage through public insurance, approximately the same proportion favored out-of-pocket payment or private insurance, and a similarly large proportion selected "don't know / no response." These findings indicate that no clear societal consensus has yet emerged on this issue.

The results reflect the inherent dilemma involved in determining how advanced treatments should be financed. Expanding public insurance coverage would reduce patients' financial burden, but would inevitably place additional pressure on healthcare financing. Conversely, relying on out-of-pocket payment or private insurance for high-cost advanced treatments may improve fiscal sustainability, but could also create disparities in access to treatment based on individuals' economic circumstances.

Underlying this issue is a structural tension: while innovative pharmaceuticals have made it possible to save lives that previously could not be saved, many of these treatments are extremely expensive and place substantial pressure on healthcare budgets. As shown in the section on cancer genomic medicine (Q20), although a majority supported extending public insurance coverage for earlier use of comprehensive gene panel testing, approximately 30% also expressed concern about rising national healthcare expenditure. In other words, the desire to ensure broad access to advanced treatments coexists with unresolved concerns regarding the associated financial burden.

It should also be noted that this question used the term "high-cost advanced treatments," which encompasses a broad spectrum of therapies. Some are already covered by public insurance, while others are currently provided under frameworks such as combined insured and uninsured care or fully self-funded care because evidence remains insufficient. As noted at the beginning of this chapter, accurate interpretation of this question presupposes a relatively advanced understanding of the healthcare system. Accordingly, these findings should be interpreted with the recognition that respondents' levels of knowledge likely varied considerably. In addition, the range of treatments envisioned by the term "advanced treatments" may also have differed substantially across respondents.

[Key findings from cross-tabulation: views on cost-sharing for advanced treatments]

- The proportion responding that advanced treatments "should be covered by public insurance" was 41.8% among those currently undergoing treatment, 35.7% among those with past cancer experience, and 33.2% among those with family experience, compared to 23.5% among those with no personal or family experience. This represents a gap of approximately 18 percentage points between those currently undergoing treatment and those with no experience. At the same time, the proportion selecting "don't know / no response" was only 11.7% among those currently undergoing treatment, compared to 29.1% among those with no experience, a gap of approximately 17 points. These findings suggest that greater personal relevance is associated with more clearly formed views on this issue.

8.4 Public Funding for Cancer Screening and Preventive Care (Q25)

Table 8-4. Attitudes Toward Public Funding for Cancer Screening and Preventive Care (Q25)

Response option	Number of responses (%)
Should increase compared to current levels	2,517 (25.2%)
Current level is sufficient	3,863 (38.6%)
Should decrease compared to current levels	773 (7.7%)
Don't know / no response	2,847 (28.5%)

Regarding public spending (tax funding) on cancer screening and preventive care, the most common response was that "the current level is sufficient" (38.6%), followed by "should increase" (25.2%) and "don't know / no response" (28.5%) at similar levels. Only 7.7% responded that spending "should decrease," suggesting that there is at least no strong resistance to public investment in preventive care.

The Fourth Basic Plan to Promote Cancer Control Programs also identifies cancer prevention as one of its three central pillars. However, as reported in Chapter 6, regular participation rates in cancer screening remain low, at approximately 25–29%. This indicates that a gap persists between support for "enhancing screening through public funding" and individuals' actual participation in screening. A key challenge will therefore be how to translate public support for investment in prevention into concrete behavioral changes leading to higher screening uptake.

These findings can also be interpreted in relation to Q28 (policy options for sustaining the high-cost medical expense benefit system). While Q28 revealed resistance toward across-the-board increases in public burden, respondents appeared relatively more supportive of prevention and screening measures, which are more familiar and easier to understand. Compared with questions directly tied to increases in individuals' financial burden, public spending on screening and prevention may be easier to support because it is perceived as involving less immediate personal cost.

[Key findings from cross-tabulation: public spending on cancer screening and preventive care]

- By cancer experience, the proportion responding that spending "should increase" was 43.9% among those currently undergoing treatment, 35.8% among those with past cancer experience, and 34.1% among those with family experience, compared to 22.5% among those with no personal or family

experience. This represents a gap of approximately 21 percentage points between those currently undergoing treatment and those with no experience. The stronger support for public investment in preventive care among those directly affected by cancer may reflect a heightened recognition of the importance of prevention based on personal experience.

8.5 Views on Expanding Mixed Billing (Q26)

Table 8-5. Views on Expanding Mixed Billing (Q26)

Response option	Number of responses **(%)**
Should be freely available	1,720 (17.2%)
Caution is needed to avoid treatment disparities based on financial means	2,279 (22.8%)
Expansion is acceptable if accompanied by subsidies for low-income individuals	1,814 (18.1%)
Expansion should be approached cautiously when treatment effectiveness is unconfirmed	875 (8.8%)
Don't know / no response	3,294 (32.9%)

Responses regarding the expansion of mixed billing (the general practice of combining insured and uninsured medical services, which is largely restricted under Japan's current system) were widely dispersed, with "don't know / no response" accounting for the largest share at 32.9%.

The expansion of mixed billing has long been debated within Japan's healthcare system. Under the current system, when insured and uninsured services are used together, patients are generally required to pay the full cost, including the insured portion. However, limited exceptions are permitted under the combined insured and uninsured care expenses system (including advanced medical care and patient-proposed healthcare services). Proponents argue that expanding mixed billing would broaden treatment options and improve access to unapproved drugs and advanced therapies. Opponents, on the other hand, raise concerns that it could create disparities in access to care based on financial means, weaken incentives for obtaining regulatory approval and insurance coverage, and ultimately narrow the scope of benefits covered by public insurance.

The fact that over 30% selected "don't know" likely reflects the difficulty of understanding mixed billing itself. As shown in Q27, awareness of the high-cost medical expense benefit system was only around 50%; mixed billing is an even more complex matter, making it unsurprising that many respondents lacked sufficient information to form an opinion. In particular, understanding the issues raised in this question presupposes familiarity with the relationship between the current combined insured and uninsured care expenses system (including advanced medical care and patient-proposed healthcare services) and mixed billing itself, as well as the exceptions to the principle that combining insured and uninsured care results in full out-of-pocket payment, including for the insured portion. Advancing public consensus on this issue will require clearer discussion, from the patient perspective, of the concrete implications of expanding mixed billing.

[Key findings from cross-tabulation: views on expanding mixed billing]

- By cancer experience, a particularly notable pattern was observed for the response option stating that "expansion should be approached cautiously because treatment disparities based on financial means should be avoided." Support for this option was highest among those currently undergoing treatment (34.7%), followed by those with past cancer experience (27.7%), those with family experience (27.4%), and those with no personal or family experience (22.3%). This suggests that direct experience with cancer treatment heightens awareness of concerns regarding disparities in access to treatment based on economic circumstances.

- At the same time, support for expansion itself ("should be freely available") was also somewhat higher among those with cancer experience (21.9% among those currently undergoing treatment vs. 16.6% among those with no experience), indicating that views within those directly affected are not uniform.

8.6 Future Direction of Public Health Insurance (Q29)

Table 8-6. Future Direction of Public Health Insurance (Q29)

Response option	Number of responses (%)
Even with increased public burden, comprehensive coverage should be maintained	2,060 (20.6%)
Without increasing public burden, limits and priorities should be set for diseases and treatments covered by insurance	4,180 (41.8%)
Cannot say either way	3,760 (37.6%)

Regarding the future direction of public health insurance, the most common response was that "without increasing the public burden, certain limits and priorities should be established regarding the diseases and treatments covered by insurance" (41.8%). In contrast, only 20.6% supported the view that "even if the public burden increases somewhat, a wide range of diseases and treatments should continue to be covered by insurance," while 37.6% responded "cannot say either way / don't know."

The Expert Committee on the Future of the High-Cost Medical Expense Benefit System has also emphasized the need for continued discussion from the broader perspective of "how society as a whole should address rising healthcare expenditures," particularly in the context of the development and spread of high-cost drugs. The findings of this survey illustrate how public opinion intersects with these system-level policy debates.

At the same time, the high proportion responding "cannot say either way" (37.6%) highlights the difficulty of making judgments regarding this trade-off. Narrowing the scope of insurance coverage may help contain healthcare costs, but it also raises anxiety that individuals or their family members may be unable to access necessary treatment in the event of serious illness. As also seen in Q24 (views on cost-sharing for advanced treatments), where opinions were similarly divided, no clear public consensus has emerged regarding whether greater priority should be placed on "the sustainability of the system" or on "security and reassurance in times of need."

[Key findings from cross-tabulation: future direction of public health insurance]

- By age group, the proportion responding "cannot say either way" was particularly high among younger respondents, reaching 50.5% among those in their 20s and 45.9% among those in their 30s. In contrast, the proportion was lowest among those aged 70 and above (29.6%), while support for "comprehensive coverage even with increased burden" was highest in this age group (27.2%). This suggests that older populations, whose cancer risk increases with age, are more likely to favor maintaining broad insurance coverage.

- By gender, men were somewhat more likely to support "setting limits and priorities" (men 40.9%, women 42.6%), while women were somewhat more likely to respond "cannot say either way" (women 39.3%, men 35.7%).

- By cancer experience, support for "comprehensive coverage even with increased burden" was 47.4% among those currently undergoing treatment, 31.2% among those with past cancer experience, and 27.0% among those with family experience, compared to only 18.6% among those with no personal or family experience. This represents a gap of approximately 29 percentage points between those currently undergoing treatment and those with no experience. At the same time, the proportion responding "cannot say either way" was only 19.4% among those currently undergoing treatment, compared to 38.6% among those with no experience, a difference of approximately 19 points. Among patients

currently undergoing treatment, nearly half supported expanding public insurance coverage even at the cost of increased burden, suggesting that direct experience as a patient strongly contributes to clearer support for strengthening public insurance coverage.

- Among individuals with annual personal income of 6 million yen or more (≈ USD 38,700 or more), support for “comprehensive coverage even with increased burden” was relatively high at 28.0%, suggesting greater willingness among higher-income groups to accept additional financial burden.

Taken together, the findings of this survey suggest that while the public holds a broad sense of concern regarding rising healthcare expenditures and the sustainability of the healthcare system, many lack concrete criteria or sufficient information to determine how these challenges should be addressed. The consistently high proportion of “don’t know” responses across Q27–Q29 indicates that public discussion of healthcare system reform remains largely confined to policy experts and stakeholders and has not yet sufficiently reached the general population.

In addition, across all questions in this chapter, consistent differences were observed according to cancer experience. Compared with those without such experience, respondents with personal or family cancer experience consistently demonstrated higher awareness, clearer directional attitudes, and lower rates of “don’t know” responses. This suggests that, as observed in Chapters 3 through 7, personal relevance strongly promotes attitude formation regarding healthcare policy issues in Chapter 8 as well.

9. Policy Recommendations: Toward Policy Promotion Grounded in the Perspectives of Patients, People Affected by Cancer, and Citizens

Based on the findings presented in Chapters 3 through 8, this chapter proposes five policy recommendations related to cancer care policy. The survey identified several key findings: (1) substantial differences in public knowledge regarding cancer care exist according to age, region, and cancer experience; (2) participation in cancer screening remains far below national targets; (3) while there is considerable latent support for advanced medical care, including cancer genomic medicine, public awareness has not kept pace; (4) although support for centralization of healthcare functions is generally high, concerns regarding the burden of travel are particularly strong in rural areas; and (5) high proportions of "don't know" responses to questions concerning healthcare financing and systems indicate that the foundation for national-level public debate remains insufficient.

9.1 Strengthening Information Provision Systems and Promoting a Multi-Layered Communication Strategy

One of the major challenges identified in this survey is the low level of awareness regarding cancer care information. For example, although awareness of surgery reached 65.6%, awareness of radiation therapy (58.5%) and drug therapy (58.4%) remained lower, and only 15–22% reported that they "well understood" these treatments, indicating that relatively few respondents understood the details, benefits, and indications of different treatment options. In addition, awareness that palliative care is provided from the early stages of treatment was extremely low at 24.8%, with more than 70% reporting insufficient awareness. Given that the breadth and quality of such knowledge directly influence patients', people affected by cancer, and the citizen's ability to make informed treatment and life decisions, information dissemination should be further strengthened from the following perspectives.

First, greater efforts should be made to disseminate accurate information regarding treatment options associated with lower physical burden, such as radiation therapy, as well as to improve understanding of palliative care. Reports indicate that the utilization rate of radiation therapy among cancer patients is 66% in the United States, 60% in Germany, and 56% in the United Kingdom, whereas in Japan the proportion of cancer patients receiving radiation therapy remained only 23.7% as of 2019. As the population ages and the number of patients unable to tolerate surgery or chemotherapy is expected to increase, there is an urgent need to create an environment in which patients can appropriately understand and actively choose lower-burden treatment options. At the same time, improving information dissemination to healthcare professionals themselves is equally important to ensure that patients are aware of the full range of treatment options. Given that the public tends to trust information provided by healthcare professionals, systems should also be established to ensure that healthcare providers receive accurate information and deliver it to patients at appropriate times.

Further dissemination of accurate understanding regarding palliative care is also needed. The Fourth Basic Plan to Promote Cancer Control Programs identifies "promotion of palliative care from the time of diagnosis" as a key policy objective and requires designated cancer care hospitals to establish palliative care teams. However, these institutional arrangements have not translated into broad public awareness or lived recognition. International evidence has accumulated demonstrating that early palliative care contributes to improved quality of life and reduced psychological distress. It is therefore necessary to communicate clearly, through multiple channels, that palliative care does not mean giving up treatment, but rather constitutes care provided alongside treatment in order to maintain quality of life.

Second, dissemination and utilization of public information resources should be incorporated into evaluation frameworks, and a multi-layered communication strategy utilizing diverse media should be established. Under the current Fourth Basic Plan to Promote Cancer Control Programs, output indicators such as website access counts for the Cancer Information Service, content update frequency, and the availability of braille and audio materials have been used to improve information provision. However, improving the process by which patients actually obtain information and make informed treatment decisions requires approaches that go beyond simply measuring website

traffic. Today, official YouTube channels, social media, and online communities have become increasingly important pathways for information dissemination in addition to traditional websites.

Accordingly, future evaluations should place greater emphasis on whether public information resources are appropriately cited and reused as reliable information in clinical explanations by healthcare professionals, community study sessions, and patient groups. Specifically, the logic model for the Fifth Basic Plan to Promote Cancer Control Programs could include indicators assessing citation and reuse of public information, as well as the use of AI and other technologies to deliver understandable and accessible push-type information proactively. In addition, the operational standards for designated cancer care hospitals should explicitly require not only dissemination of institution-specific information but also proactive communication of universally relevant information—such as standard treatments and the role of palliative care—through the use of public information resources. At the same time, active utilization of public resources such as the Cancer Information Service provided by National Cancer Center Japan can help ensure both the consistency and up-to-dateness of information while reducing the burden on individual institutions to independently create educational materials from scratch. Through collaboration among healthcare institutions, local governments, and public-private partners, it is hoped that a multi-layered system can be established in which reliable information centered on public resources is broadly disseminated.

Third, consultation and support systems should be further strengthened so that patients can reach appropriate support when needed without having to actively search for information themselves. In this survey, utilization of cancer consultation and support centers located at designated cancer care hospitals remained only 5.5%. To ensure that those wishing to seek consultation can do so at the appropriate time, greater efforts are needed both to increase awareness of these centers and to create environments that make consultation easier. In particular, mechanisms should be established to standardize referrals from medical institutions to consultation support centers immediately after diagnosis, when psychological distress is often greatest. In addition, expansion of online consultation services and stronger outreach-oriented support directed proactively toward patients are needed to reduce isolation among patients.

The use of advanced digital tools, including AI, also has the potential to dramatically improve access to information. At the same time, however, public institutions must clearly communicate important considerations regarding information quality assurance and privacy protection. Ensuring such safety and reliability constitutes an essential foundation for fostering public trust and enabling appropriate use of information.

9.2 Centralization of Screening Data and Improvement of Screening Uptake

This survey found that regular participation rates for all cancer screenings remained at only 25–29%, while more than 30% of respondents reported that they had "never undergone screening" for every type of cancer screening examined. Achieving the 60% screening target set forth in the Fourth Basic Plan to Promote Cancer Control Programs will require not only improving individual awareness, but also implementing concrete institutional measures.

First, infrastructure should be developed to enable integrated management of screening data across workplace-based and municipality-based screening programs. In this survey, 62.8% supported enabling municipalities to access information on workplace cancer screening participation, indicating that integrated management of screening data is likely to be relatively acceptable to the public. Under the current system, information on cancer screening conducted through workplaces is not shared with municipalities, preventing local governments from comprehensively understanding residents' screening status. As a result, duplicate screening recommendations may occur, while some unscreened individuals may be overlooked. If workplace and municipal screening data could be linked, municipalities would be able to more accurately identify individuals who have not undergone screening through either route and provide individualized screening recommendations according to risk and age.

However, workplace cancer screening is implemented through a wide variety of arrangements, including programs conducted solely by employers, jointly by employers and health insurance societies, or independently by health insurance societies. Operational differences exist in how screening results are handled and how employee consent is obtained, and such inconsistencies may become barriers to data integration. Furthermore, institutional

challenges have been identified, including variation across implementing bodies in screening eligibility, screening content, and screening intervals, which do not always align with national guidelines, as well as insufficient quality control. To achieve integrated management of screening data, it is essential for the national government to lead the development of standardized operational guidelines and common formats that can be used nationwide regardless of implementing body, including standardized consent forms and information-sharing documents, approaches to personal identifiers, and clearly defined consent procedures for sharing information with municipalities. Cancer screening should also be more clearly positioned as part of employers' health promotion responsibilities, consistent with the direction of recognizing it as an effort obligation under the Industrial Safety and Health Act. In line with this direction, efforts should extend beyond strengthening opportunities and encouragement for workplace screening to also encompass data integration across workplace and municipal screening systems.

Second, while establishing systems that enable individuals to continue screening throughout their lives, approaches toward unscreened populations should also be diversified. This survey found little variation in regular participation rates across different types of cancer screening. This suggests that screening behavior may depend less on awareness of specific cancers than on whether individuals have established broader health management habits. Accordingly, an important policy objective is to create systems that prevent interruptions in participation in evidence-based, guideline-recommended cancer screening at key life transitions. In particular, continuity of screening is often disrupted during retirement, job changes, or relocation, creating gaps in screening participation. To strengthen systems enabling lifelong continuity of screening, one possible approach would be proactive notifications from municipalities or employers at the time of retirement or relocation explaining how to continue screening. At the same time, approaches toward unscreened populations should be broadened through multi-faceted efforts that encourage individuals to take the first step toward screening, including screening recommendations from primary care physicians and collaboration with corporate health management initiatives.

In addition, as part of efforts to improve screening uptake among unscreened populations, targeted approaches toward lower-income groups—where participation rates are particularly low—will be essential for improving overall screening rates. This survey demonstrated that non-participation rates were highest among households with annual income below 3 million yen (≈ below USD 19,400). Future Basic Plans to Promote Cancer Control Programs should therefore establish KPIs not only for overall screening rates but also for screening participation rates stratified by household income and for non-participation rates among lower-income groups (e.g., households with annual income below 3 million yen (≈ below USD 19,400)). In particular, for populations facing barriers related to economic constraints or work arrangements, consideration should be given to combining targeted distribution of free screening coupons with support measures to reduce indirect costs associated with screening participation, such as transportation and childcare expenses. Attention should also be paid to differences in burden across generations.

9.3 Promoting Public Understanding of Cancer Genomic Medicine

Cancer genomic medicine is a form of personalized medicine that comprehensively analyzes genetic mutations in cancer cells to identify the most appropriate treatment for individual patients, and it has the potential to fundamentally transform the future of cancer care. In Japan, comprehensive gene panel (CGP) testing became covered by public insurance in 2019, and systems of designated core, base and cooperating hospitals for cancer genomic medicine have since been developed. However, this survey found that only 5.2% of respondents understood the content of cancer genomic medicine, while approximately 60% reported that they had "never heard of it." At the same time, after receiving an explanation, 55.8% expressed understanding, and 56.2% supported earlier insurance coverage for CGP testing. These findings suggest that low awareness reflects not a lack of interest, but rather insufficient opportunities to encounter relevant information, and that appropriate information provision could foster public support for advanced treatments. Based on these findings, the following measures are recommended.

First, public communication regarding cancer genomic medicine should be systematically strengthened. At present, information and media coverage related to cancer genomic medicine tend to be concentrated within specialized media and have not sufficiently reached information channels routinely accessed by the general public. The Council of Designated Core Hospitals for Cancer Genomic Medicine and related institutions should strengthen

dissemination of standardized educational materials—including videos, brochures, and web-based resources—that explain in accessible language such topics as "What is cancer genomic medicine?", "What can CGP testing reveal?", and "Which patients are eligible?". These efforts should build upon already available public resources, including content published by the Center for Cancer Genomics and Advanced Therapeutics (C-CAT) of the National Cancer Center Research Institute Japan. Mechanisms should also be established to distribute such materials not only to cancer patients and their families through cancer consultation and support centers at designated cancer care hospitals and municipal offices, but also broadly to the general public.

In addition, possibilities for public-private collaboration in information dissemination should be actively explored. National Cancer Center Japan already disseminates educational videos and public lectures through its official YouTube channel and, in partnership with Google, is working to improve access to reliable health information through the YouTube Health framework. Further expansion of such initiatives is desirable. Furthermore, Genomic Medicine Japan (GeMJ), established in 2026, is expected to function as a central coordinating body for genomic medicine policy, research, and public communication. Collaboration with this organization would also be valuable in systematizing public information dissemination.

Second, information provision regarding cancer genomic medicine should be standardized at the time of cancer diagnosis and treatment decision-making. Under the current system, CGP testing is covered by public insurance only after standard treatment has been completed or when no standard treatment exists. However, if patients are made aware of this option from an earlier stage of treatment, they may be better able to engage proactively in future treatment planning. Designated cancer care hospitals should therefore establish standardized processes to inform patients, during diagnosis and treatment planning discussions, that cancer genomic medicine constitutes a potential treatment option.

Third, institutional reforms aimed at reducing drug lag should proceed in parallel with expansion of cancer genomic medicine. The finding that 30.1% of respondents opposed earlier implementation because "even if the optimal drug is identified, it may not be available because it has not been approved" represents an important concern. Even when CGP testing identifies a potentially effective treatment, the inability to access that drug in Japan may undermine trust in the value of the testing itself. Accordingly, removal of the current restriction limiting gene panel testing to "patients with solid tumors who have completed standard treatment (including those expected to complete it)" under the reimbursement system should proceed together with accelerated regulatory approval processes for companion diagnostics and related therapies. Comprehensive institutional reforms should also include promoting use of the Patient-Proposed Healthcare Services system and expanding participation in international clinical trials.[6]

Fourth, appropriate regulatory frameworks and information environments should be established for direct-to-consumer genetic testing (DTC genetic testing). In this survey, while 36.7% expressed interest in using such testing in the future, 28.9% remained reluctant, indicating divided public opinion. In addition to regulatory measures concerning introduction of such testing, neutral information guidelines should be developed to help the public accurately understand the significance and limitations of these tests, including risks associated with obtaining genetic information outside medical institutions, such as misinterpretation of results, unnecessary anxiety, and concerns regarding management of genetic information.

Cancer genomic medicine will play a central role in the future personalization and precision of cancer treatment, and its development cannot advance without public understanding and support. Building upon already existing public information resources and patient guidelines, efforts should focus on improving accessibility and comprehensibility, while simultaneously advancing standardized communication in clinical settings and strengthening relevant institutional frameworks.

[6] In Japan, CGP and companion diagnostics (CDx) are treated as separate categories in the medical service fee schedule, unlike most other countries where they are handled together as tests for treatment decision-making. Each molecularly targeted drug requires the simultaneous approval of a specific CDx, resulting in one-to-one drug–diagnostic correspondence

9.4 Balancing the Centralization of Healthcare Functions with the Development of Patient Support Systems

Approximately half of respondents support the centralization of healthcare functions, with those generally in favor (46.8%) outnumbering those opposed (21.6%). The most frequently cited reasons for opposition were the physical burden of long-distance travel (60.1%) and the associated financial burden (46.9%). However, the underlying concerns differ considerably by age group and gender. For example, women in their 30s and 40s expressed strong concerns about balancing treatment with work and childcare, whereas older respondents tended to acutely feel the physical and financial difficulties of long-distance commuting for medical care. Accordingly, the centralization of healthcare functions should be advanced together with the development of comprehensive support systems tailored to regional demographic and geographic characteristics.

First, with regard to transportation, Regional Medical Care Visions and prefectural medical care plans should explicitly incorporate transportation services designed to secure access to medical care. In addition to the planned development of reservation-based shared taxi services (demand-responsive transport) and shuttle bus services connecting designated cancer care hospitals with surrounding areas, taxi ride-sharing services using ride-hailing applications became available nationwide in November 2021. Furthermore, in 2024, the road freight and passenger transport industry were added as a target sector under the Specified Skilled Worker residency status. Trends in transportation policy and regulatory reform should be closely monitored and strategically leveraged from the perspective of improving access to medical care, with appropriate involvement of the public sector.

Second, with regard to financial burdens such as transportation and accommodation costs, expanded public support for populations bearing disproportionately heavy burdens—particularly residents of rural areas, remote islands, and mountainous regions, as well as economically vulnerable households—should be carefully considered together with discussions on funding sources. For example, in Sado City, Niigata Prefecture, where on-island provision of radiation therapy has ended, the city has independently subsidized a portion of the ferry fares and accommodation costs incurred by cancer patients traveling to medical institutions on the mainland of Niigata Prefecture for radiation therapy. Several local governments and non-profit organizations have likewise launched initiatives to complement the transportation costs arising from the centralization of medical care, primarily targeting pediatric cancer patients and their families. These initiatives are sometimes funded through a combination of municipal general funds and subsidies, donations from local businesses, contributions from local residents, and proceeds from charity events. Drawing on diverse funding sources enables flexible operation of support tailored to local realities, grounded in the principle of citizen participation. However, mechanisms reliant on donations and single-year budgets face structural limitations in terms of financial scale and sustainability. A further challenge is that pediatric cancer patients and those currently undergoing treatment tend to be prioritized, while cancers in adults or older individuals and follow-up visits often receive lower priority. The development of a national framework providing support across the life course is therefore desirable.

Third, coordination between medical institutions should be strengthened, including through the establishment of next-generation Regional Collaboration Critical Pathways for Cancer that combine in-person and online care. As the centralization of cancer care advances and patients increasingly concentrate at designated cancer care hospitals, the role of local medical institutions in providing post-treatment follow-up and routine health management is becoming all the more important. Cancer, in particular, requires long-term follow-up. To enable primary care physicians and visiting nurses in local communities to share these responsibilities smoothly, it is essential to promote task-shifting and task-sharing while developing coordination systems among medical institutions. At present, the use of Regional Collaboration Critical Pathways for Cancer, through which designated cancer care hospitals and primary care physicians share joint care plans, is being promoted, although most of these pathways currently presume in-person care. Going forward, it will be useful to explicitly incorporate remote follow-up through telemedicine. In fact, the reimbursement system has been revised to support such developments: in fiscal year 2024, a new add-on for nurse-assisted telemedicine (D to P with N) was introduced to provide reimbursement for telemedicine conducted with a nurse present. Further revisions in the fiscal year 2026 reform—including the establishment of an assistance fee for telemedicine delivered via home-visit nursing and the expansion of eligible diseases—are advancing telemedicine for chronic conditions, including cancer. Building on such reimbursement-based incentives, the development of digital infrastructure for remote follow-up and consultation support is expected to provide a foundation that enables patients to continue receiving care with peace of mind in familiar local communities.

Fourth, the framework of the Prefectural Cancer Care Coordination Councils should be utilized to deliberate, in an integrated manner, on both the centralization of healthcare functions and the reduction of patient burdens. The

centralization of healthcare functions and the alleviation of patient burdens are two sides of the same coin and are inseparable issues. The Ministry of Health, Labour and Welfare's Study Group on the Future of the Cancer Care Delivery System, in its report "Summary of Discussions on Equitable Distribution and Centralization of Cancer Care Delivery with a View to 2040," calls on prefectures and designated cancer care hospitals to take responsibility for transparent information disclosure and accessible communication concerning the healthcare delivery system, and to lead discussions reflecting regional realities. In particular, in light of the revision of the guidelines for the establishment of designated cancer care hospitals—which has made participation in the Prefectural Cancer Care Coordination Councils mandatory for designated cancer care hospitals, providers of regional cancer care, patient organizations, and other relevant stakeholders—it is important that the Prefectural Cancer Care Coordination Councils broadly aggregate regional realities and patient needs and lead discussions, including on the development of transportation options and the design of travel cost support. Such information gathering and deliberations should also be carried forward at the national level by the Cancer Control Promotion Council.

In addition, deeper consideration is also required of the concerns held by working-age populations regarding balancing treatment with work and childcare. In April 2026, the amended Act on Comprehensively Advancing Labor Measures came into effect, formally positioning support for balancing treatment with employment as an effort obligation of employers under the law. Building on this development, it would be valuable to invite local employers and occupational health professionals to participate in the Prefectural Cancer Care Coordination Councils, and to deepen discussions—complementary to those on centralization—on issues that bridge medical care and daily life, such as the establishment of flexible working arrangements and the provision of temporary childcare in the vicinity of healthcare facilities.

9.5 Building Social Consensus Toward a Sustainable Healthcare System

Throughout this survey, the proportion of respondents selecting "don't know / no response" was relatively low for questions grounded in lived experience, such as participation in cancer screening or personal or family experience with cancer. By contrast, for questions concerning institutions and policies—such as cancer genomic medicine, the high-cost medical expense benefit system, mixed billing, and the future direction of public health insurance—the proportion of respondents withholding judgment by selecting "neither agree nor disagree" or "don't know / no response" consistently reached 20–30%. This tendency was particularly pronounced among younger respondents. This does not suggest that younger people are uninterested; rather, it suggests that opportunities to access the basic information needed to judge institutional and policy issues, and to engage in discussions about the healthcare system as a whole, may have been limited. In light of these findings, the following measures should be pursued as a foundation for carrying forward the healthcare system—including cancer care—into the next 20 years.

First, the current status and future projections of the healthcare system, as well as the advantages and disadvantages of each policy option, should be presented to citizens in an accessible manner, and strategic communication adapted to each generation should be developed. Regarding measures to sustain the high-cost medical expense benefit system, the most frequently supported option was "raising the out-of-pocket ceiling for high-income individuals" (41.0%), while strong resistance to uniform increases in burden was observed. Similarly, with regard to the scope of public insurance coverage, those who indicated that "lines should be drawn" (41.8%) substantially outnumbered those who supported "expansion of coverage even with increased burden" (20.6%), revealing candid public views on the balance between benefits and burdens. However, for more complex questions—such as cost-sharing for advanced treatments and the expansion of mixed billing—the proportion of respondents withholding judgment by selecting "don't know" was high, at 28–33%. Furthermore, these attitudes differ clearly across generations: younger respondents tend to withhold judgment, whereas older respondents show stronger support for the principle of ability-to-pay. For younger generations, communication should therefore focus on conveying the mechanisms and future trajectory of the system from the perspective that they will be both future contributors and future users. For older generations, it is important to facilitate discussions that confront the issue of sustainability head on, drawing on concrete simulations and data concerning the fairness of cost-sharing.

Second, beyond the mere provision of information, efforts to create venues for consensus-building through open dialogue should be advanced. In particular, there is a need for social processes through which citizens, including patients and people affected by cancer, can deliberate together on the desired shape of the healthcare system and the future vision of community-based healthcare. Pioneering initiatives involving citizens have already begun in some local governments. For example, in Shinshiro City, Aichi Prefecture, in the course of restructuring its municipal hospital, the city decided to relocate and rebuild the hospital following deliberations by the Shinshiro Municipal Hospital Future Vision Committee and a public comment procedure, while also soliciting input from sources including the hospital's medical staff council, the local medical association, and the council of neighborhood representatives. In the construction of the

new hospital, under the banner of “a hospital created and supported by citizens,” the city has held multiple workshops involving citizens, hospital staff, and medical professionals. The first workshop included a tour of the existing hospital so that all participants could share a common understanding of the aging and deterioration of the building. Building on this shared experience, discussions then deepened on the desired role of the hospital and how citizens themselves might be involved, and the insights gained were directly reflected in the hospital’s basic concept.

When the national government, local governments, medical institutions, and patients and people affected by cancer build dialogue from shared frontline challenges, and when decision-making processes are made visible together with a broad range of stakeholders, this carries profound significance that extends far beyond the determination of individual policy measures. In the case of cancer, although out-of-pocket payments for many standard treatments such as chemotherapy, radiation therapy, and surgery are reduced under public health insurance, the burden on household finances—when treatments not covered by insurance, hospitalization costs, transportation expenses, and living costs are taken into account—remains substantial. Various public schemes and subsidies from local governments serve as lifelines that sustain patients, people affected by cancer, and their families. Discussions on the sustainability of the healthcare system, including the future shape of community-based healthcare, should therefore be shared as urgent issues that touch on the very foundations of citizens’ lives: namely, whether a society in which people can access necessary treatment even after being diagnosed with cancer can be sustained for future generations.

Closing Remarks

Twenty years have passed since the enactment of the Basic Act on Cancer Control in 2006, during which both society and the environment surrounding healthcare have changed substantially. For cancer care to continue evolving in more meaningful ways, discussions must encompass not only the perspectives of patients and people affected by cancer, but also broader societal perspectives, including the sustainability of the healthcare delivery system and the social security system. We hope that this report will contribute to such societal discussions in the years ahead.

Appendix: Survey Overview

Table 10-1. Survey Overview

Survey method	Internet-based survey
Target population	Men and women aged 20 years and older nationwide
Valid responses	10,000 samples
Gender composition	Female 51.8%, Male 48.2%
Mean age	54.14 years (range: 20–99 years)
Survey period	February 2026

- **Survey Design**

This survey was designed as a cross-sectional study. The primary objective was to descriptively assess public attitudes, knowledge, and behaviors related to cancer at the time of the survey. In addition to descriptive analyses based on simple tabulations, cross-tabulation analyses were conducted by gender, age group, cancer experience, size of residential area, household income, and other characteristics.

- **Survey Participants**

The survey targeted a nationwide panel of men and women aged 20 years and older maintained by the survey company. Respondents were recruited using quota sampling based on region (eight geographic blocks: Hokkaido, Tohoku, Kanto, Chubu, Kinki, Chugoku, Shikoku, and Kyushu), gender (male/female), and age group (six categories: 20s through 70 years and above), in order to approximately reflect the demographic distribution of Japan as a whole. A total of 10,000 responses were collected.

- **Survey Methods**

An internet-based questionnaire survey was conducted. A total of 29 questions were administered to panel members registered with the survey company, covering cancer experience, knowledge, screening participation, attitudes toward advanced treatments, and views on healthcare financing systems. Question formats included single-answer (SA), multiple-answer (MA), and numeric-response (NU) items. Some questions used branching logic to limit respondents according to eligibility criteria (e.g., detailed questions for cancer survivors, questions for private insurance subscribers, and follow-up questions for respondents opposed to centralization of healthcare functions). The survey was conducted in February 2026.

- **Analytical Methods**

This report presents not only simple tabulations showing the number and proportion (%) of responses for each question, but also cross-tabulation analyses by gender, age group, gender-by-age group, size of residential area, insurance enrollment status, cancer screening experience, individual and household income, and cancer experience. Proportions were calculated using the number of valid responses for each question as the denominator. For multiple-answer (MA) questions, totals may exceed 100%.

- **Limitations**

As this was an internet-based survey, respondents were limited to individuals with internet access. Older individuals and those less familiar with digital devices may therefore be underrepresented, and this limitation should be considered when interpreting the findings. In addition, because this was a cross-sectional study, causal relationships cannot be inferred. Furthermore, as the survey relied on self-reported responses, the results may have been influenced by social desirability bias and recall bias.

- **Respondent Characteristics**

Table 10-2. Gender

Response option	Number of responses (%)
Female	5,179 (51.8%)
Male	4,821 (48.2%)

Table 10-3. Age

Age group	Number of responses (%)
20s	1,222 (12.2%)
30s	1,270 (12.7%)
40s	1,567 (15.7%)
50s	1,751 (17.5%)
60s	1,423 (14.2%)
70 and above	2,767 (27.7%)

Table 10-4. Highest Educational Attainment

Response option	Number of responses (%)
Junior high school graduate	289 (2.9%)
High school graduate	3,337 (33.4%)
Junior college or vocational school	1,870 (18.7%)
University (bachelor's degree)	3,717 (37.2%)
Graduate school (master's or doctoral degree)	431 (4.3%)
Don't know / no response	356 (3.6%)

Table 10-5. Occupation

Response option	Number of responses (%)
Company employee (regular)	2,743 (27.4%)
Company employee (non-regular)	440 (4.4%)
Part-time / casual worker	1,425 (14.3%)
Public servant / organizational employee	360 (3.6%)
Self-employed / freelance	627 (6.3%)
Homemaker	1,796 (18%)
Student	112 (1.1%)
Unemployed (including retirees)	2,164 (21.6%)
Other / don't know	333 (3.3%)

Table 10-6. Public Health Insurance (Q1)

Response option	Number of responses (%)
Employer-based health insurance	4,330 (43.3%)
National Health Insurance	2,993 (29.9%)
Medical Care System for Older Senior Citizens	1,017 (10.2%)
Other	65 (0.7%)
Don't know / no response	1,595 (16%)

Table 10-7. Private Health Insurance Enrollment (Q2)

Response option	Number of responses (%)
Enrolled	6,205 (62.1%)
Not enrolled	2,772 (27.7%)
Don't know / no response	1,023 (10.2%)

Table 10-8. Marital Status (SC7)

Response option	Number of responses (%)
Never married	3,240 (32.4%)
Married (with spouse)	5,460 (54.6%)
Widowed	430 (4.3%)
Divorced / separated	680 (6.8%)
No response	200 (2%)

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