

Study of Global Health Strategy Based on International Trends

—Promoting Universal Health Coverage Globally and Ensuring the Sustainability of Japan's Universal Coverage of Health Insurance System: Problems and Proposals—^{*1}

JMAJ 58(3): 78-101, 2015

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Abstract

The Japanese government at present is implementing international health and medical growth strategies mainly from the viewpoint of business. However, the United Nations is set to resolve the Post-2015 Development Agenda in the fall of 2015; the agenda will likely include the achievement of universal health coverage (UHC) as a specific development goal. Japan's healthcare system, the foundation of which is its public, nationwide universal health insurance program, has been evaluated highly by *the Lancet*. The World Bank also praised it as a global model.

This paper presents suggestions and problems for Japan regarding global health strategies, including in regard to several prerequisite domestic preparations that must be made. They are summarized as follows.

(1) The UHC development should be promoted in coordination with the United Nations, World Bank, and Asian Development Bank. (2) The universal health insurance system of Japan can be a global model for UHC and ensuring its sustainability should be considered a national policy. (3) Trade agreements such as the Trans-Pacific Partnership (TPP) should not disrupt or interfere with UHC, the form of which is unique to each nation, including Japan. (4) Japan should disseminate information overseas, including to national governments, people, and physicians, regarding the course of events that led to the establishment of the Japan's universal health insurance system and should make efforts to develop international human resources to participate in UHC policymaking. (5) The development of separate healthcare programs and UHC preparation should be promoted by streamlining and centralizing maternity care, school health, infectious disease management such as for tuberculosis, and emergency medicine such as for traffic accidents. (6) Japan should disseminate information overseas about its primary care physicians (*kakaritsuke* physicians) and develop international human resources. (7) Global health should be developed in integration with global environment problem management. (8) Support systems, such as for managing large-scale disasters of international scale or preventing the spread of infectious diseases, should be developed and maintained. (9) International healthcare policy, which the Japanese government is trying to promote in accordance with international trends, and international development of Japanese healthcare industry should be reconsidered.

Key words Universal health coverage, UHC, Universal health insurance of Japan, *Kokumin-Kaihoken*, Global health, Post-2015 Development Agenda, TPP

^{*1} This report was made based on excerpts from the JMARI Working Paper No.342 originally published in Japanese in May, 2015.

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Background, Purpose, and Methods of the Study

Background and purpose

The Japanese government at present is implementing international health and medical growth strategies mainly from the viewpoint of business. However, using these strategies is potentially problematic: people from other countries might interpret the use of such strategies as an effort of international cooperation that is in favor of a certain business-biased class.

In the fall of 2015, the United Nations is set to resolve the Post-Millennium Development Goals (Post-MDGs) for after 2015; the main concept will be sustainability. The resolution will likely include the achievement of universal health coverage (UHC)*² as a specific development goal.

The foundation of the Japanese healthcare system lies in *Kokumin-Kaihoken*, a nationwide universal health coverage of public insurance system (hereinafter referred to as the JP-UHC) that has been highly evaluated by *the Lancet*. The World Bank also praised it as a global model. However, ensuring the sustainability of the Japanese healthcare system is a major issue: in addition to declining birth rates and the aging of Japanese society, for years, it has accumulated substantial financial deficits because of the stagnant economy.

Focusing on the JP-UHC program, this research aims to present proposals and challenges pertaining to Japan's global health*³ strategies, including in regard to prerequisite, domestic preparations that must be made.

Methods

As described as follows, the authors collected materials, which were organized, analyzed, and considered: the authors 1) collected publications and obtained information from the Internet, 2) attended relevant international and domestic conferences, and 3) interviewed experts within and outside of the Japan Medical Association (JMA).

Proposing global health strategies requires an understanding of the current status of developing countries and regions. Therefore, we also con-

ducted a schematic investigation and analysis of ASEAN countries, which are the main constituent members of the Confederation of Medical Associations in Asia and Oceania (CMAAO) and also geopolitically relevant to Japan.

Health Indicators in Japan and the ASEAN Countries

Health-related indicators in Japan

The Japanese healthcare system was ranked first overall in a ranking of the healthcare systems of all member states that the World Health Organization (WHO) published in 2000.¹ In contrast, the United States, which the Japanese healthcare system is often compared to for relative evaluation, was ranked 15th.

The Japanese healthcare system, along with Switzerland, received an A rating in a ranking of healthcare systems in 9 major countries that the Conference Board of Canada conducted in 2012.² The US was given a D rating.

Evaluation of the achievement of the MDGs among ASEAN countries

Many countries began to pursue the MDGs, development goals (including in regard to the eradication of poverty and hunger) to be achieved by 2015, in 1990. The MDGs have been widely recognized as international development goals (**Table 1**).³

By extracting major goals and targets and specific indicators for each MDG, the UN developed the following global assessment categories (as of 2014).⁴

Green: Target already met or expected to be met by 2015.

Yellow: Progress insufficient to reach the target if prevailing trends persist.

Red: No progress or deterioration.

Gray: Missing or insufficient data.

As a global comparison, Japan and eastern Asia have many green marks compared with southern Africa (Sub-Saharan Africa), southern Asia, western Asia, and Oceania, which have many yellow and red marks.

In regard to MDGs related to healthcare, south-eastern Asia received red marks for the following targets: "Reduce maternal mortality by

*² A healthcare system in which all people can receive necessary care without any concern over being reduced to poverty.

*³ Healthcare related to global issues that requires cooperation and collaboration across and beyond national boundaries.

Table 1 Millennium Development Goals (MDGs) (2000)

Goal 1	Eradicate extreme poverty and hunger
Goal 2	Achieve universal primary education
Goal 3	Promote gender equality and empower women
Goal 4	Reduce child mortality
Goal 5	Improve maternal health
Goal 6	Combat HIV/AIDS, malaria, and other diseases
Goal 7	Ensure environmental sustainability
Goal 8	Develop a global partnership for development

(Source: United Nations Millennium Project. MDGs.⁹)

three quarters” and “Access to reproductive health” under “Goal 5 Improve Maternal Health,” as well as “Halt and begin to reverse the spread of HIV/AIDS” under “Goal 6 Combat HIV/AIDS, malaria and other diseases.”

International Trends in Global Health and the UN’s Post-2015 Development Goals

Historical background of global health⁵

(Table 2)

*Epoch 1 <5>^{*4}: Establishment of the WHO*

After the WHO was established in 1948, international health initiatives begun by the League of Nations were further expanded.

Epoch 2 <12>: Clarification of the importance of primary health care in the Declaration of Alma-Ata

The Declaration of Alma-Ata, which became the foundation for international healthcare policy thereafter, was adopted in a joint meeting of the WHO and UNICEF in 1978. This was the first international declaration that clearly stipulated the significance of primary health care.

Epoch 3 <17, 21, 31>: Clarification of the importance of “sustainable development goals” in the Earth Summit

The UN Conference on Environment and Development of 1992 (also known as the Earth Summit, or UNCED)⁶ was held in Rio de Janeiro, Brazil; during the conference, treaties such as the Framework Convention on Climate Change and the Convention on Biological Diversity were signed.⁷ This meeting greatly influenced ideas about global environment protection and sustainable development. In response to this, the

3rd Conference of the Parties to the UN Framework Convention on Climate Change (also known as the COP3 or the Kyoto Conference) was held in 1997. In this conference, the Kyoto Protocol, which specified reduction targets for greenhouse gas emissions by 2012 based on 1990 as a reference year, was adopted. At the UN Conference on Sustainable Development in Rio de Janeiro in 2002, which was held as a follow-up meeting to the Earth Summit, participants agreed to integrate the sustainable development goals (SDGs) as part of the post-2015 development goals.⁸

Epoch 4 <22>: Establishment of MDGs in the UN Millennium Summit

The Millennium Declaration and MDGs were adopted at the UN Millennium Summit of 2000. Various goals to be achieved by 2015, including the eradication of poverty and hunger, were established; for most goals, 1990 was used as a reference year.

Epoch 5 <23, 28, 29, 30, 34, 37, 39, 44, 46>: Manifestation of activities aiming to make human security and UHC globally mainstream

Following the presentation of a final report by the Commission on Human Security to the UN Secretary-General in 2003,⁹ activities aiming to make UHC globally mainstream gained traction. The idea of fully encompassing primary health care, which is the basis of UHC, was established by the Commission on Human Security.

The Lancet issued a special issue entitled “Japan: Universal Health Care at 50 Years” in 2011,¹⁰ opening up the opportunity for Japan and the World Bank to begin a joint research project, the Japan-World Bank Partnership Program on UHC; the project has already issued

*4 Please note that the numbers in < > correspond to the numbers in Table 2.

Table 2 Historical background of global health and the Post-2015 MDGs

Year	Event (conferences, declarations, resolutions, reports, etc.)	Description
19th century	<1> (N/A)	• Diseases unique to tropical regions (tropical medicine) became increasingly studied in order to protect the health of Europeans living in colonial territories.
1868	<2> The International Committee of the Red Cross (ICRC) was launched	• International movements advance primarily in Europe.
1920	<3> The League of Nations Health Committee was established	• Efforts in international health advance worldwide.
1947	<4> The World Medical Association (WMA) was established	• On September 17, 1947, physicians from 27 countries gathered in Paris as part of a general assembly that led to the birth of the WMA.
1948	<5> The World Health Organization (WHO) was established	• The World Health Organization (WHO) was established. • The WHO Constitution led to the launch of special organizations in the United Nations (UN), further expanding efforts in international health.
1951	<6> The Colombo Plan for Cooperative Economic and Social Development in Asia and the Pacific (the Colombo Plan) was launched	• The Colombo Plan, which aimed to build a foundation for international cooperation, was launched.
1955	<7> The 1955 Afro-Asian Conference, also called the Bandung Conference, was held	• The Afro-Asian Conference was held in Bandung, Indonesia; the conference enhanced the international influence of African and Asian countries that had become independent from colonial rule.
1950s to 1960s	<8> The Basic Healthcare Approach (BHCA) was promoted; however, this approach retained an evident partiality toward large university hospitals	• Many Asian and African countries emphasized preventing disease in rural areas through the BHCA by promoting the deployment of quasi-physicians and/or health assistants; however, the approach continued to retain a partiality toward large university hospitals.
1961	<9> The Organisation for Economic Co-operation and Development (OECD) was established	• As the movement toward an organization to facilitate cooperation among countries in Europe and North America for the development of economic liberalism gained traction, the Organization for European Economic Cooperation (OEEC) was gradually disbanded and the Organisation for Economic Co-operation and Development (OECD) that exists today was established.
1974	<10> *The Japan International Cooperation Agency (JICA) was founded in Japan	• Japan became actively involved in international cooperation.
1975	<11> The WHO Executive Board adopted a resolution to promote primary health care (PHC)	• The 5th WHO Executive Board meeting adopted a resolution to promote PHC.
1978	<12> The Declaration of Alma-Ata, which emphasized the importance of PHC, was adopted at a joint meeting of the WHO and UNICEF	• The Declaration of Alma-Ata, a historical declaration that became the foundation of international healthcare policy thereafter, was adopted at a joint meeting of the WHO and UNICEF held in Alma-Ata, Kazakhstan in 1978. • A shared understanding in international health was reached in regard to "Health for All by the Year 2000." This brought about a historic paradigm change in international health. • The declaration emphasized human values and strongly advocated for the importance of international and domestic equality, health as a human right, the role of national governments, PHC, and international partnerships. • The declaration was the first international declaration to clearly specify the significance of PHC.
1986	<13> WHO Ottawa Charter for Health Promotion ¹¹ (also called the Ottawa Charter)	• In the Ottawa Charter for Health Promotion (a health strategy built upon the Declaration of Alma-Ata on PHC that was promulgated with the aim of achieving a global society in which all people can lead healthy lives), specific action plans based on "Health for All by the Year 2000" were developed.

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Table 2 Historical background of global health and the Post-2015 MDGs (continued)

Year	Event (conferences, declarations, resolutions, reports, etc.)	Description
1986	<14> Chernobyl nuclear power plant accident	<ul style="list-style-type: none"> On April 26, 1986, an accident occurred at the No.4 reactor at the Chernobyl nuclear power plant, located in what was then the Ukrainian Soviet Socialist Republic. A total of 28 power-plant operators and firefighters died of massive radiation poisoning in the accident. About 135,000 residents who lived within a radius of 30 km from the nuclear power plant were evacuated or migrated. According to a report by the UN Scientific Committee released in February 2011, 25 years after the accident, over 6,000 children have developed thyroid cancer because of the accident and 15 of those had passed away by 2005.¹²
1990	<15> The inaugural issue of the UN Development Programme (UNDP) Human Development Report was published	<ul style="list-style-type: none"> Since 1990, the UNDP Human Development Report has advocated a “human development” approach: in this approach, it is argued that human development should aim to expand choices and opportunities available in people’s lives based on their self-will and that furthermore, the options essential to human life must be augmented. These options include being able to live a long, healthy life; fulfilling intellectual desires; and having the economic means necessary to live with a certain quality of life.
	<16> World Summit for Children	<ul style="list-style-type: none"> In the 1990s, the World Declaration on the Survival, Development and Protection of Children and the Plan of Action for Implementing the Declaration were formulated. Both indicated that children were a political challenge of the utmost priority. These action plans were aimed at creating welfare societies.
1992	<17> The UN Conference on Environment and Development (UNCED), also known as the “Earth Summit”	<ul style="list-style-type: none"> The UN Conference on Environment and Development was held in Rio de Janeiro, Brazil in June 1992. The conference positioned global environmental issues such as global warming and acid rain as common human issues. The aim of the conference was to facilitate both environmental protection and development under the philosophy of “sustainable development.” The conference achieved: (1) the adoption of the Rio Declaration on Environment and Development, (2) the signing of the UN Framework Convention on Climate Change, (3) the signing of the Convention on Biological Diversity, (4) the adoption of the Statement of Forest Principles, and (5) the adoption of Agenda 21.
1994	<18> International Conference on Population and Development (Cairo, Egypt)	<ul style="list-style-type: none"> People in general began to share ideas related to reproductive health: reproductive health was conceived of as being part of a state of complete physical, mental, and social well-being; reproductive health was conceived of as dealing with the reproductive processes, functions, and system at all stages of life—not merely the absence of reproductive diseases or infirmities. Reproductive rights were also considered: all couples and individuals were considered entitled to the basic right to decide, freely and responsibly, the number, spacing, and timing of their children and to have the information and means to do so; furthermore, all people were considered to have the right to attain the highest standards of sexual and reproductive health. The conference fomented a paradigm shift.¹³
1995	<19> World Summit for Social Development	<ul style="list-style-type: none"> At the World Summit for Social Development held in Copenhagen, Denmark, participating nations adopted a declaration and action plan that represented a new consensus about the need to put humanity at the center of development. At one of the largest gatherings of national leaders worldwide, 117 heads of state or government pledged that their most important goals were to conquer poverty, achieve full employment, and foster stable, safe, and just societies.

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Table 2 Historical background of global health and the Post-2015 MDGs (continued)

Year	Event (conferences, declarations, resolutions, reports, etc.)	Description
1996	<20> New development strategies were undertaken by the OECD	<ul style="list-style-type: none"> Based on the realization that the autonomous efforts are key to successful development and that development assistance plays an important supplementary role, the OECD Development Assistance Committee (DAC) adopted new development strategies with several goals, including halving the population of poor people worldwide before 2015 and having elementary education available in all nations.
1997	<21> The 3rd session of the Conference of Parties to the UN Framework Convention on Climate Change (COP3), and the establishment of Kyoto Protocol	<ul style="list-style-type: none"> The Kyoto Protocol established reduction targets to be achieved by 2012 for greenhouse gas emissions in developed countries and nations transitioning to a market economy were set, based on 1990 as a reference year. This constituted humanity's first step to addressing the problem of global warming in the mid-to-long term in the 21st century and after.
2000	<22> UN Millennium Summit, UN Millennium Declaration, and UN Millennium Development Goals (MDGs)	<ul style="list-style-type: none"> In the UN Millennium Declaration, governments agreed on 8 issues: (1) values and principles, (2) peace, security, and disarmament, (3) development and poverty eradication, (4) the protection of the shared environment, (5) human rights, democracy, and good governance, (6) the protection of vulnerable groups, (7) the special needs of Africa, and (8) strengthening the UN. Various Millennium Development Goals (MDGs) to be achieved by 2015 were established, including the eradication of poverty and hunger; 1990 was the reference year for many goals. MDGs soon became common development goals for the entire international community; they have exerted a major influence in regard to government policies on international cooperation and development and on public opinion.
2003	<23> Submission of the Commission on Human Security's final report to the UN Secretary-General	<ul style="list-style-type: none"> In response of a request from Japan at the 2002 UN Millennium Summit, the Commission on Human Security was launched with Ms. Sadako Ogata and Mr. Amartya Sen as co-chairs. The Commission on Human Security's final report was submitted to UN Secretary-General Kofi Annan in 2003. The final report focused on individuals and communities, emphasizing the need to protect and empower each individual person.
2005	<24> *The Health and Development Initiatives (HDIs): Japan's contribution toward achieving the health-related MDGs	<ul style="list-style-type: none"> In order to further contribute to the achievement of the MDGs, Japan presented the idea of the HDIs and announced financial aid totaling 5 billion USD over 5 years based on the HDIs at the High-Level Forum on Health MDGs in Asia and the Pacific (June 2005). Based on the HDIs, Japan has helped developing nations in achieving the health-related MDGs.
2008	<25> The 4th Tokyo International Conference on African Development (TICAD IV)	<ul style="list-style-type: none"> The establishment of human security and health issues in Africa, including as part of achieving the MDGs, was discussed at the conference. Discussion at the conference emphasized the importance of human resources in healthcare and cooperation.
	<26> The G8 Hokkaido Toyako Summit	<ul style="list-style-type: none"> The summit addressed global issues in international health; presented specific action plans toward achieving international goals, such as the MDGs, that governments have already agreed upon; and affirmed the promotion of comprehensive strategies to supplement existing efforts.

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Table 2 Historical background of global health and the Post-2015 MDGs (continued)

Year	Event (conferences, declarations, resolutions, reports, etc.)	Description
2011	<27> Accident at the Tokyo Electric Power Company (TEPCO) Fukushima Daiichi Nuclear Power Plant	<ul style="list-style-type: none"> • After the Great East Japan Earthquake and subsequent tsunami, the TEPCO Fukushima Daiichi Nuclear Power Plant experienced a very serious accident that was rated a 7 on the International Nuclear Event Scale. • As a result, a large amount of radioactive materials were released into the atmosphere. • As of June 7, 2012, 163,000 had evacuated from Fukushima Prefecture due to the tsunami and nuclear power plant accident. • As of September 2012, 501 people had been subject to secondary thyroid inspections.
	<28> The 64th World Health Assembly Resolution on Universal Coverage	<ul style="list-style-type: none"> • In response to the 2010 World Health Report, "Health Systems Financing: The Path to Universal Coverage," the WHO adopted the WHA Resolution on Sustainable Health Financing Structures and Universal Coverage at its 64th assembly.
	<29> A special issue of <i>the Lancet</i> , "Japan: Universal Health Care at 50 Years," was published	<ul style="list-style-type: none"> • This special issue was published to mark the 50th anniversary since the achievement of UHC in Japan and disseminate information regarding the Japanese experience with the international community. • The issue presented scientific analysis pertaining to the factors that contributed to realizing a society conducive to longevity in Japan; the advantages and limitations of the JP-UHC system; the reality of high-quality, low-cost healthcare; success and challenges in regard to long-term care insurance that had arisen in Japanese society given its rapid aging; and the role and predominance of Japan in health diplomacy. • This was the first special issue of <i>the Lancet</i> to feature a single advanced nation.
2012	<30> Japan and the World Bank initiated a joint research program on universal health coverage (UHC)	<ul style="list-style-type: none"> • In January 2012, a research project was initiated with the aim of comprehensively reviewing all approaches to realizing and sustaining UHC from both the aspects of finance and human resources (for the provision of services). • The results were summarized and published in "Universal Health Coverage for Inclusive and Sustainable Development: A Synthesis of 11 Country Case Studies" and "Universal Health Coverage for Inclusive and Sustainable Development: Lessons from Japan."
	<31> UN Conference on Sustainable Development (Rio + 20) and Sustainable Development Goals (SDGs)	<ul style="list-style-type: none"> • The UN Conference on Sustainable Development, also known as "Rio + 20," was held in Rio de Janeiro, Brazil in June 2012. As the follow-up meeting to the 1992 UN Conference on Environment and Development, which greatly influenced how global environmental protection and sustainable development are currently conceptualized (as seen in the Framework Convention on Climate Change and the Convention on Biological Diversity), Rio + 20 resulted in the outcome document "Future We Want." • Rio + 20 declared its support for achieving the MDGs through increasing incomes, making decent work available, eradicating poverty, and pursuing a sustainable green economy able to protect the health of the environment. • Governments agreed to launch an inter-governmental negotiation process regarding SDGs and to organize and integrate SDGs into the Post-2015 development goals.

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Table 2 Historical background of global health and the Post-2015 MDGs (continued)

Year	Event (conferences, declarations, resolutions, reports, etc.)	Description
2012 to 2013	<32> A report was issued by the UN High-level Panel	<ul style="list-style-type: none"> In July 2012, the UN Secretary-General established the High-Level Panel of eminent persons on the Post-2015 Development Agenda, responsible for advising the UN Secretary-General in discussions regarding the establishment of the Post-2015 development goals. In May 2013, the Panel submitted its report to the UN Secretary-General regarding the Post-2015 development goals. According to the report, the Post-2015 development goals should be founded on respect for universal human rights, the purposes of MDGs should be achieved, and extreme poverty should be eradicated by 2030.
2013	<33> The 5th Tokyo International Conference on African Development (TICAD V) <34> *Prime Minister Abe published a paper entitled "Japan's Strategy for Global Health Diplomacy: Why It Matters."	<ul style="list-style-type: none"> With the central tenets of a "robust and sustainable economy," "inclusive and resilient society," and "peace and stability," the TICAD V addressed some new themes in the area of healthcare, including UHC; it also introduced the concept of "bottom of the pyramid" business based on health-related opportunities (such as in regard to water and nutrients) to target the 4 billion low-income people in the world. Following international trends, Japan has positioned international health as a key issue in Japanese diplomacy: manifesting the idea of "human security," the aim is to make basic healthcare services available to everyone in the world (i.e., under the auspices of UHC) by bringing Japanese experience and knowledge to bear. <i>The Lancet</i> published a paper contributed by Prime Minister Abe regarding diplomatic strategies in international health. This was the first time a paper on international health was published by a world leader in the G8. The paper indicates that to ensure global health, the aim must be to make basic healthcare services available to everyone in the world (i.e., under the auspices of UHC) and that it is important to have comprehensive measures in place. It was made clear that health is considered a pillar of diplomacy in Japanese foreign policy and that the country seeks to promote UHC.
	<35> *Development of diplomatic strategies in international health in Japan	<ul style="list-style-type: none"> Contributing to health issues that the world has in common has been positioned as the key issue in Japanese diplomacy; the plan is to strengthen efforts toward achieving global UHC, i.e., making basic healthcare services, including preventive medicine, treatment, and rehabilitation, available for everyone as needed at an affordable cost. Progress toward achieving MDGs in maternal and child health has been delayed in some regions of the world including sub-Saharan Africa, necessitating continuing efforts from Japan. New and effective development goals must be developed, considering that there are new issues not covered in the MDGs (e.g., diabetes, non-infectious diseases such as cancer, and population aging) that increasingly need to be addressed.
	<36> The UN Secretary-General Ban Ki-moon's report on the Post-MDGs Development Agenda, "A Life of Dignity For All"	<ul style="list-style-type: none"> UN Secretary-General Ban released "A Life of Dignity For All: Accelerating Progress towards the Millennium Development Goals," a report on the Post-MDGs Development Agenda. The report presented his vision of the Post-MDGs Development Agenda while referring to the report submitted to him by the High-Level Panel of eminent persons on the Post-2015 Development Agenda on May 31, 2013 entitled "A New Global Partnership: Eradicate Poverty and Transform Economies through Sustainable Development."

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Table 2 Historical background of global health and the Post-2015 MDGs (continued)

Year	Event (conferences, declarations, resolutions, reports, etc.)	Description
2013	<37> The special events on MDGs at the 68th UN General Assembly, and its side event "What People Want: A Report from the Global Conversation On the Post-2015 Agenda"	<ul style="list-style-type: none"> In the 68th UN General Assembly, Prime Minister Abe pointed out the importance of UHC and the mainstreaming of disaster prevention in relation to MDGs. The UN General Assembly and United Nations Development Group (UNDG) held a side event on the Post-2015 development goals and health. The usefulness of UHC (i.e., the fact that UHC enables every person to receive basic healthcare services) in context of the Post-2015 development goals was discussed. UHC can meet diverse health needs and can contribute to realizing a more equitable society; its importance was reconfirmed. Conceptualizing what human security as well as UHC that manifests human security is crucial to deal with challenges pertaining to achieving the MDGs in the health sector for which solutions have been delayed. These ideas should be made clear in the Post-2015 development goals.
	<38> Special events on MDGs	<ul style="list-style-type: none"> An outcome document was adopted at the special events on MDGs hosted by the UN General Assembly Chair. With the nearing of the target year for the MDGs, the preamble to these events made clear that the commitment to reach the goals had to be renewed and efforts to reach the goals had to be strengthened to ensure achievement by 2015. Among other things, the text calls for the acceleration of progress, indicates importance of promoting global partnership for development, and states 6 items related to the Post-2015 development goals.
	<39> Global Conference on Universal Health Coverage (a conference of ministers and top experts)	<ul style="list-style-type: none"> Co-hosted by the Government of Japan and the World Bank, a conference of ministers and top experts on health policy was successfully held in Tokyo to recapitulate the Joint Research Program of Japan and the World Bank Group on Health and to share experiences and issues pertaining to UHC in developing countries. This was the first international conference of this nature to take place, not to mention the first in Japan.
2014	<40> Report by the Open Working Group of the General Assembly on SDGs	<ul style="list-style-type: none"> The report presented development goals and targets. These later formed the framework for UN Secretary-General Ban's general report on sustainable development, entitled "The Road to Dignity by 2030." The report listed 17 development goals; Goal 3 proposed to "ensure healthy lives and promote well-being for all at all ages."
	<41> The WHO Secretary-General declared "a public health emergency of international concern" in response to the Ebola outbreak in West Africa	<ul style="list-style-type: none"> Based on available information, the Emergency Committee of International Experts unanimously agreed that the Ebola crisis in Guinea, Liberia, Sierra Leone, and Nigeria constituted "a public health emergency of international concern." On August 8, 2014 the WHO Secretary-General endorsed the Committee's recommendation and declared the Ebola outbreak in West Africa an international public health emergency.
	<42> Intergovernmental Panel on Climate Change (IPCC) 5th Assessment (Integration) Report	<ul style="list-style-type: none"> The report summarized the main points of the most comprehensive climate change study, which was undertaken by over 800 researchers. The results of this study had been published in the previous 13 months prior to the publication of this report. The report pointed out more clearly than did previous assessments that human factors, including greenhouse gas emissions, are the main cause of the global warming that has been observed since the mid-20th century. According to the report, global emissions must be reduced to 40-70% of 2010 levels by 2050 and be down to zero by 2100 in order to fully ensure that warming can be controlled within 2°C.

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Table 2 Historical background of global health and the Post-2015 MDGs (continued)

Year	Event (conferences, declarations, resolutions, reports, etc.)	Description
2014	<43> The UN Secretary-General's general report for sustainable development, "The Road to Dignity by 2030," was released	<ul style="list-style-type: none"> In December 2014, the advance version of "Synthesis Report of the Secretary-General on the Post-2015 Sustainable Development Agenda" was submitted to the UN General Assembly. It called for inclusive, agile, and concerted actions to realize an era of sustainable development for all people. The report placed humanity and the planet at its center; the expectation was that it would guide the development of a new global agenda. The report also welcomed the outcome document of the Open Working Group, stating that the 17 SDGs and 169 targets proposed in the document should become the foundation for new post-2015 goals.
	<44> G7 members UK, Germany, France, and Italy opted to participate in the Chinese-led Asian Infrastructure Investment Bank (AIIB)	<ul style="list-style-type: none"> The UK announced its decision to join the China-led AIIB with the anticipation of becoming a founding member; it was the first among the G7 nations to choose membership. Germany, France, and Italy also announced their participation. The AIIB will compete against the existing Asian Development Bank led by Japan. It is likely to have a major impact on the International Monetary Fund and the World Bank, which are closely tied to the Asian Development Bank.
	<45> Prime Minister Abe announced the Sendai Cooperation Initiative for Disaster Risk Reduction at the 3rd UN World Conference on Disaster Risk Reduction	<ul style="list-style-type: none"> The World Bank has sought to reduce poverty, hunger, and disease; Japan is actively involved in the World Bank's efforts through cooperation in regard to UHC. The Sendai Cooperation Initiative for Disaster Risk Reduction is another effort by Japan to actively support the World Bank's measures.
	<46> WMA Council Resolution on Trade Agreements and Public Health	<ul style="list-style-type: none"> In April 2015, the WMA Council Resolution on Trade Agreements and Public Health was adopted by the 200th WMA Council Session held in Oslo, Norway. Its preamble specifies that "[trade agreement] Negotiations should take account of their potential broad impact especially on health and ensure that health is not damaged by the pursuit of potential economic gain." One of its recommendations to National Medical Associations is to "Ensure trade agreements do not interfere with governments' ability to regulate health and health care, or to guarantee a right to health for all. Government action to protect and promote health should not be subject to challenge through an investor-state dispute settlement (ISDS) or similar mechanism."
2015	<47> (Scheduled) UN General Assembly Post-2015 Development Agenda Resolution	<ul style="list-style-type: none"> Reviewed from various viewpoints, the Post-2015 Development Agenda is expected to be adopted to succeed the current MDGs.
	<48> (Scheduled) The 21st session of the Conference of Parties to the UN Framework Convention on Climate Change (COP21) (Paris, France)	<ul style="list-style-type: none"> At the upcoming COP21 in 2015, the international community, including those nations that did not participate in the Kyoto Protocol (such as China and the United States), is expected to agree on an international framework for climate change for 2020 and after.
2016	<49> (Scheduled) 2016 G7 Summit (to be held in Japan)	<ul style="list-style-type: none"> In 2016, the G7 Summit will be held in Japan for the first time in 8 years. It will be the first G7 Summit after the resolution of the UN General Assembly Post-2015 Development Agenda and the COP21. It is expected that, in concert with the promotion of UHC by the UN, World Bank, and Japan, UHC will become mainstreamed as an international development trend.

Note: The asterisk (*) indicates independent actions of Japan.

Note: The grayed-out cells framed in thick lines indicate significant global actions.

its final report.¹⁴ In 2013, Prime Minister Abe published a paper entitled “Japan’s strategy for global health diplomacy: Why it matters.”¹⁵ In the same year, some proactive activities aiming to make UHC the global mainstream took place, such as a side event to the 68th UN General Assembly, “Post-2015: Health and Development,”^{16,17} and the Global Conference on Universal Health Coverage for Inclusive and Sustainable Growth,¹⁸ which was attended by ministers and top experts in health policy and in which Japan played a major role.

Considering China’s moves to establish the Asian Infrastructure Investment Bank (AIIB), the promotion of UHC modeled after the JP-UHC program is extremely important to raising the profile of the World Bank and the Asian Development Bank, in which Japan is strongly influential.

Furthermore, the World Medical Association (WMA) Council Resolution on Trade Agreements and Public Health¹⁹ was adopted at the 200th WMA Council session in Oslo, Norway, in April 2015. This resolution ensures that trade agreements such as the TPP “do not interfere with governments’ ability to regulate health and health care, or to guarantee a right to health for all.”

Epoch 6 <42, 43, 47, 48>: Plan to resolve the Post-2015 Development Agenda, which includes UHC that revolves around the planet (environment) and humanity

The UN General Assembly is expected to resolve the Post-2015 Development Agenda, which will be inclusive of goals for UHC, in the fall of 2015. Based on a general report by the UN Secretary-General entitled “The Road to Dignity by 2030,”²⁰ the Post-2015 Development Agenda will be oriented toward sustainable development and will be conceptually based on a consideration of the planet (environment) and humanity.

Furthermore, the 21st session of the Conference of Parties to the UN Framework Convention on Climate Change (COP21) will be held in Paris at the end of 2015; in this session, a new international agreement regarding the framework for CO₂ emission reduction targets for 2030 is expected to be achieved.

Epoch 7 <27, 41, 45>: Mainstreaming an awareness of global threats such as emerging and re-emerging infectious diseases, large-scale natural disasters, and nuclear disasters as the global health problems

The WHO Secretary-General declared in 2014

that the Ebola outbreaks, in which Ebola hemorrhagic fever spread at an unprecedented scale in West Africa, constituted a public health emergency of international concern. As the example of the avian flu also demonstrates, it is evident that infectious disease control remains a very important issue for global health.

Large-scale hurricanes and typhoons are growing in number; these are also a global health concern. Large-scale earthquakes induced at plate subduction zones and epicentral earthquakes in populated inland areas may also cause tsunamis. The potential for nuclear power plant accidents is also rapidly increasing. Disaster management at the global scale should be made a mainstream global health issue.

Development trends in the UN Post-2015 Development Goals

In December 2014, the UN Secretary-General Ban Ki-moon submitted an advance version of “Synthesis Report of the Secretary-General on the Post-2015 Sustainable Development Agenda” to the UN General Assembly.²⁰ The summit and the UN General Assembly in September 2015 are expected to adopt a resolution with places humanity and the planet at its core and to develop a new global agenda based on human rights; the UN Secretary-General’s report will serve as a draft. In concert with the announcement of the synthesis report, the Secretary-General also presented 17 sustainable development goals proposed by the open working group.²¹

The Post-2015 Sustainable Development Agenda that will be resolved at the summit and the UN General Assembly in September 2015 will likely strongly reflect the principles for development goals and health issues considered by the open working group. In the UN Secretary-General’s report, development goals and targets related to UHC are also laid out (Table 3).²¹

Historical Background of Healthcare Policy in Japan and Suggestions for ASEAN Countries

Evaluation axes to achieve UHC and 4 principles to realize UHC as advocated by the WHO

When all people can receive good quality healthcare (including preventative medicine, health promotion, medical treatment, rehabilitation,

Table 3 Extracted text pertaining to UHC from the “Report on Sustainable Development Goals” proposed by Open Working Group under “Goal 3: Ensure healthy lives and promote well-being for all at all ages”²¹

- 3.7 By 2030, ensure universal access to sexual and reproductive health care services, including for family planning, information and education, and the integration of reproductive health into national strategies and programmes
- 3.8 Achieve universal health coverage (UHC), including financial risk protection, access to quality essential health care services, and access to safe, effective, quality, and affordable essential medicines and vaccines for all

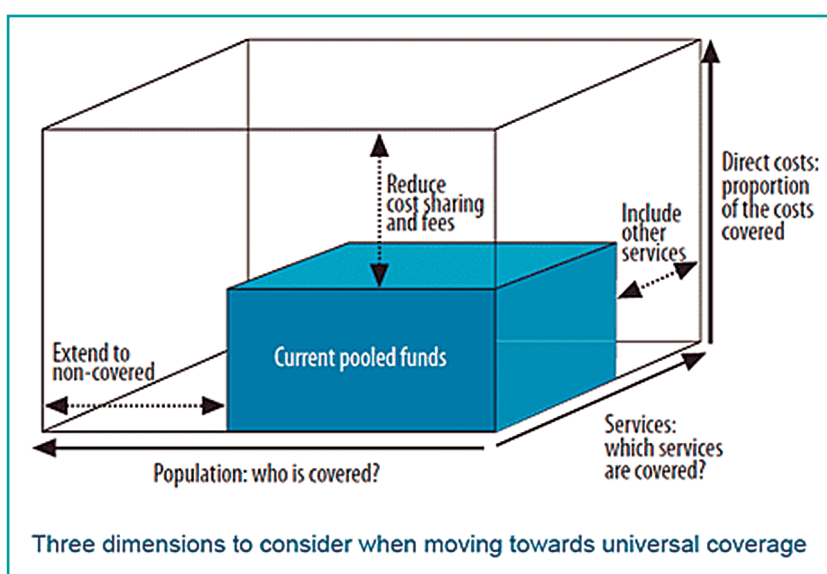


Fig. 1 The 3 dimensions of universal coverage as proposed by the WHO²³

palliative care, etc.) without any concern over being reduced to poverty, we can say that UHC has been achieved. Moving towards UHC requires progress on 3 fronts: the range of services that are available, the proportion of the costs of those services that are covered, and the proportion of the population that is covered (**Fig. 1**).^{22,23,24}

Four key ingredients:

1. Equitable access must be promoted by removing financial barriers, especially direct payments.
2. Prepayment must be compulsory.
3. Large risk pools are essential.
4. Governments need to cover health costs for people who cannot afford to contribute.

Characteristics of the JP-UHC program

The JP-UHC program of Japan guarantees free access to healthcare for all people in Japan, anywhere and whenever, regardless of their income level. The program is able to provide for all people through the public health insurance system, which is supported by the employee insurance and community insurance programs. Japan is regarded as having achieved UHC and its system and programs are believed to be fully mature.¹⁴

Events leading up to the establishment of the JP-UHC system

Health insurance system before World War II

Before World War II, the health insurance sys-

tem in Japan was modeled after the German system, although it was in the style of social insurance. The Health Insurance Act, which applied only to certain workers, was established in 1922. This was the beginning of the employee insurance program.

Meanwhile, the problem of poverty in rural areas was surfacing as a social issue. Because healthcare costs were a financial burden for farmers, National Health Insurance Act was passed in 1938 and came into effect within the same year. (This pre-war version of the act is hereinafter referred to as the “old National Health Insurance Act.”) Soon after, Japan entered a state of war, and the government increasingly put its efforts into the national health insurance program to promote its Healthy Soldiers and Healthy People policy.

Establishment of the JP-UHC program after World War II

After World War II ended, the Constitution of Japan was promulgated in 1946. Article 25 of the Constitution states that “All people shall have the right to maintain the minimum standards of wholesome and cultured living.” The right to live was therefore stipulated.

During the economic depression after the World War II, the national health insurance program faced widespread delinquency in regard to insurance premiums. In addition, inflation sent healthcare expenditures soaring, forcing the program into a tight corner. In light of this, the national health insurance program was reformed in 1948; operational responsibility for the program was, in principle, shifted from unions to municipalities. Moreover, joining the program became compulsory for those who lived in municipalities participating in the national health insurance program.

The old National Health Insurance Act was entirely revised in 1958; the new National Health Insurance Act was put in effect. This new act required, in principle, all municipalities to participate in the health insurance program as part of a national project. The JP-UHC was fully achieved in 1961, when all municipalities had joined the program.

Several major differences existed between the old and the new National Health Insurance Acts. The new act obligated municipalities to participate in and manage the national health insurance program; to ensure universal coverage,

all municipal residents were required to join the program unless they were already covered by the employee insurance program.²⁵ In addition, under the old act, the national program offered significantly poorer benefits compared to the employee insurance program; the new act made the benefits offered by the national program equal and, furthermore, increased the benefit ratio.

Historically speaking, the financial burden of the employee insurance program was lighter and its benefits were greater compared with the national insurance program. This gap was questioned from the viewpoint of equality. Moreover, for many years, copayments per visit differed between the 2 programs. These 2 programs were completely equalized relatively recently, in 2003.

Changes in policyholders (by insurance program)

The first health insurance law in Japan was the Health Insurance Act of 1922, which was applicable only to people in certain workplaces such as factories, mines, and the offices of transportation companies; the act covered only 3% of the entire population.

The Ministry of Health and Welfare was established in 1938 and the old National Health Insurance Act was enacted in the same year. Health insurance membership reached 9.9% of the population in the following year. In 1939, the Mariners Insurance Act and Office Workers Health Insurance Act were enacted, providing health insurance to sailors as well as people working in business and financial offices. With the revised old Health Insurance Act, family members of policyholders became eligible to receive health insurance benefits; they could join voluntarily.

The range of those eligible for health insurance programs rapidly expanded from 1940 to 1943; this was in part because in 1941, Japan entered the early phase of World War II. The old Health Insurance Act was again revised in 1942 to incorporate the Office Workers Health Insurance Act and to make family membership, which was formerly voluntary, mandatory; by 1943, 74.6% of the population was enrolled (Fig. 2).^{26,27,28}

Japan was defeated in World War II in 1945; by 1949, membership had considerably dropped, to 55.9%.

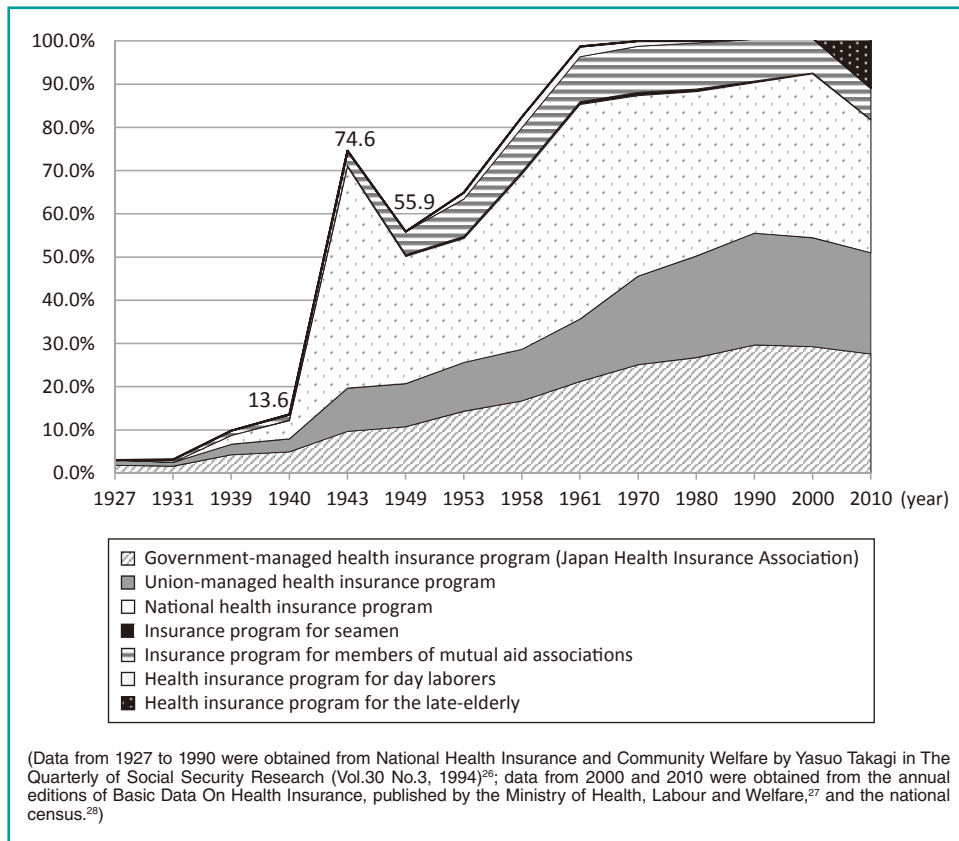


Fig. 2 Changes in the proportion of health insurance policyholders out of the national population (by insurance program)

Please note that the data on the health insurance program for day laborers are pursuant to the provision of Article 3, Paragraph 2 of the Health Insurance Act.

Please also note that the health insurance program for the late-elderly was initiated in 2008. The data on total population size are based on the national census for Japanese citizens.

Complementary health policies

In addition to its insurance program, Japan implements many unique health policies in regard to maternal and child health management, school health management, infection control (such as for tuberculosis), and emergency medicine for traffic accidents. In reviewing the current health standards and considering future policies in ASEAN countries, Japan's experience with health policies will likely be very useful.

Health policies in regard to maternal and child health may be taken as an example. After World War II, an administrative section in charge of public health for mothers and children was established on the orders of General Headquarters (GHQ), which also lent its sup-

port. The war-era "Handbook for Expected Mothers" was revised and a new "Maternal and Child Handbook" was introduced (this handbook was renamed the "Maternal and Child Health Handbook" in 1966). It is believed that the introduction of the "Maternal and Child (Health) Handbook" greatly contributed to improving maternal and child health.

School health management has a long history in Japan, beginning in 1872, when the school system was established following the end of the rule of the samurai in the Meiji Restoration. The school physician system was promulgated in 1898; 1 school physician was stationed at each public school nationwide.

After World War II, school health was

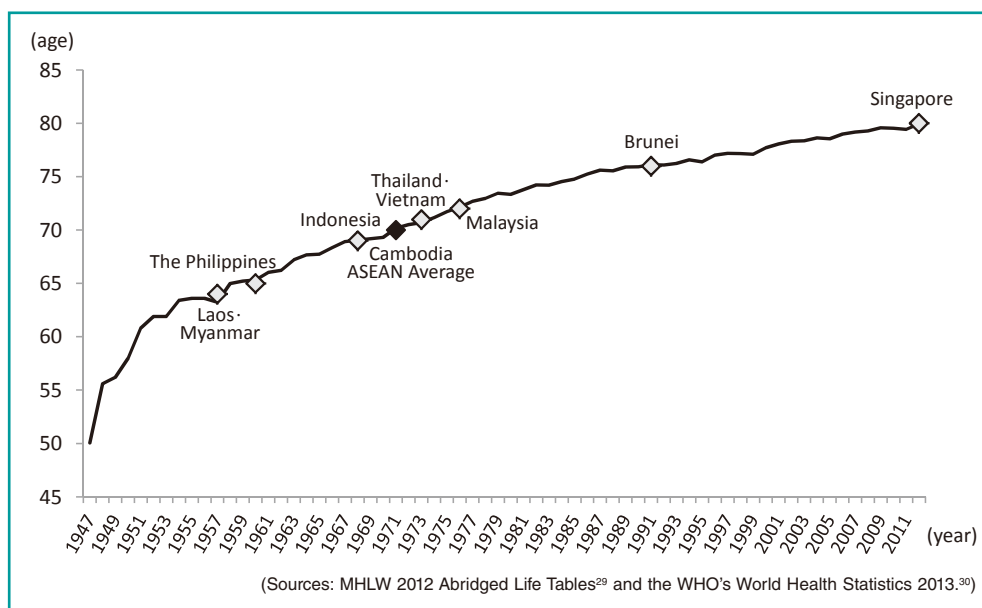


Fig. 3 Changes in average life expectancy for males in Japan and standards in ASEAN countries

focused on tuberculosis control (using the tuberculin reaction test and the BCG vaccine) and roundworm control (using pinworm egg inspection and antiparasitic treatment). As illustrated in these examples, through school health, Japan has accumulated considerable child health experience in the school, home, and community contexts.

Comparison of main health indicators between Japan and ASEAN countries

Comparing the current average life expectancy in ASEAN countries against historical changes in Japan, the current average life expectancy for men in ASEAN countries roughly corresponds to the period between 1945 and 1955 in Japan (Fig. 3).^{29,30}

In Laos and Myanmar, which have been experiencing low levels of economic development, the infant mortality rate roughly corresponds to the period between 1950 and 1958 in Japan. Other figures from many other countries can be considered to correspond to the period between 1963 and 1972 in Japan.

Since the 1940s, maternal mortality in Laos, Myanmar, Indonesia, and Cambodia has been similar to that in the period between 1940 and 1945 in Japan (Fig. 4).^{30,31}

Tuberculosis morbidity in Laos and Myanmar is similar to that between 1955 and 1964 in Japan, but in Cambodia, which economic level is still low, tuberculosis morbidity remains serious—at levels equivalent to before 1953 in Japan. Tuberculosis morbidity in Indonesia is close to that in Japan in 1965, which is average for ASEAN countries. Singapore and Brunei have experienced high levels of economic development, but tuberculosis morbidity (73 and 94 persons per 100,000 people, respectively) in these countries, while not poor, roughly corresponds to that in Japan in 1978 (Fig. 5).^{30,32,33}

Japanese healthcare policy's contribution to economic development and suggestions for ASEAN countries

Japan underwent rapid economic growth after World War II. The two decades between 1954 and 1973 in particular are referred to as the high economic growth period; in this period, annual economic growth rates (real rates) were around 10%.

The Japanese experience suggests that it is important for the ASEAN countries to make the protection of national health a national goal in order to achieve future economic growth. The introduction of a nationally standardized

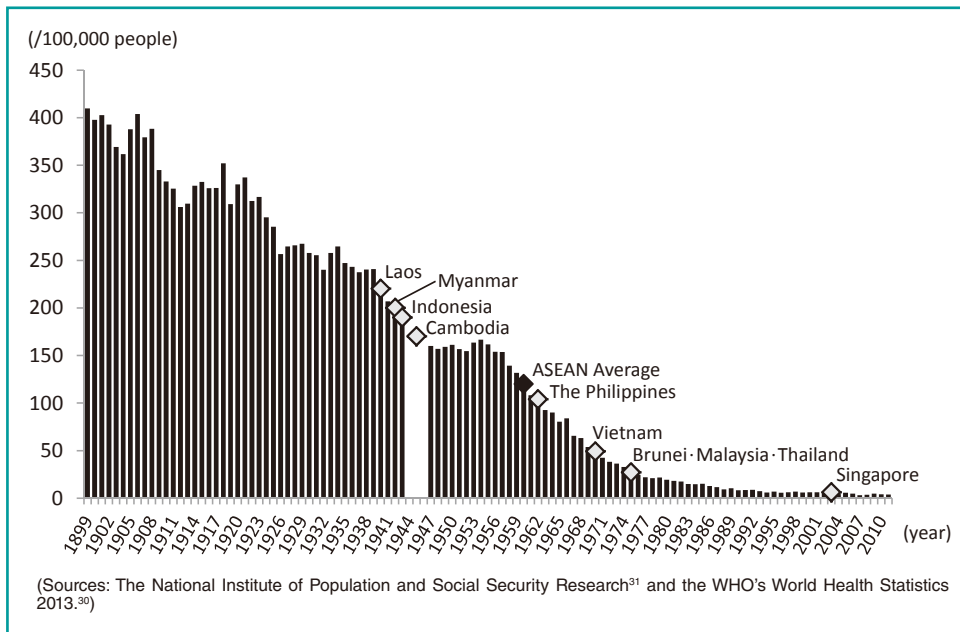


Fig. 4 Maternal mortality rate (per 100,000 people)

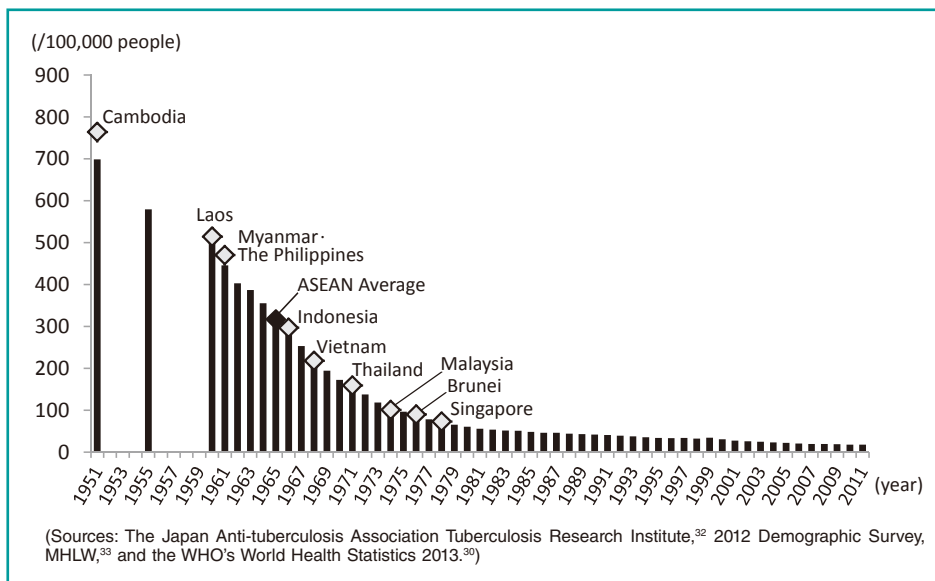


Fig. 5 Tuberculosis morbidity (per 100,000 people)

health insurance system and the preparation of healthcare provision standards—i.e. UHC—are essential as a first step. Protecting the health of workers and all citizens can ensure countries a stable future workforce and facilitate economic

growth.

In addition, providing healthcare requires securing human resources in regard to healthcare, including physicians. Developing such human resources takes time. To ensure a solid

Table 4 Petition to Minister of Health and Welfare Masa Nakayama from Japan Medical Association President Taro Takemi (Submitted on August 18, 1960)

1. Lift restrictions in medical practice
Correct the manual in the guidelines; medical practice should be based on principles and case-by-case treatment should be provided according to the physician's discretion. The government standards should therefore be lifted. Physicians should be free to use any medications legally available on the Japanese market.
2. Raise the unit price in the medical fee schedule.
3. Relax the complicated clerical process.
4. Consolidate Tables 1 and 2 of the medical fee schedule and eliminate regional differences

(Source: Journal of Japan Medical Association. 1960;44(4):1.³⁵)

training system, it is therefore recommended that training institutions with appropriate training staff be established to secure such resources.

Implementing government policies that are complementary to the health insurance system is also essential.

Achievements of the JMA Related to the Establishment of the JP-UHC Program and the JMA's Contribution to International UHC

Activities and contributions related to the JP-UHC program

Response to the double-registration system

To bring the nation closer toward achieving the JP-UHC program, the Health Insurance Act was revised in April 1957 and a double-registration system for physicians and medical institutions was implemented. In the same month, the JMA, which had been opposed to the revision of the act on the grounds that the double-registration system would damage the physician-patient relationship, negotiated with the Minister of Health and Welfare and won a concession: the Minister agreed that JMA would review the text of the revised law before it was officially passed.

In addition, the JMA opposed revision because the revised law was to stipulate the number of patients a physician should see in a day and was to indicate doses for medicines and injections in detail, which would have limited physicians' discretion if realized.

Activities toward lifting restrictions on medical practice

In the government healthcare program, a conditional reimbursement system is used: the term "medical care practices with restrictions" refers

to the fact that only treatments and prescriptions that meet governmental guidelines (called the medical care rules) are reimbursed according to the official medical fee schedule; other medical practices are not reimbursed.³⁴ The government provided a list of medications that physicians could use by disease and in descending order of priority; daily doses of medications with proven effects were also limited.

In August 1960, the year before UHC was achieved in Japan, the JMA submitted to the Minister of Health and Welfare a letter of petition outlining 4 prerequisites that would need to be fulfilled before the JP-UHC program could be initiated, claiming that initiating the program as it was would eradicate respect for life and academia, sacrifice people's welfare, and strengthen the power of the self-righteous, totalitarian bureaucrats in charge of the insurance program (**Table 4**).³⁵

However, the pay rise in the medical fee schedule that was requested in the petition was never realized; moreover, the lifting of the care restrictions was deferred. Consequently, the JMA instructed physicians across the nation to temporarily close their practices in February 1961. In response to this, the 3 highest officials in the Liberal Democratic Party (LDP), the JMA president, and the president of the Japan Dental Association held a conference at the end of the same month; subsequently, the government agreed to partially relax the care restrictions.

When the Minister of Health and Welfare failed to fulfill this agreement as promised, the JMA announced that all physicians (including dentists) would withdraw their registrations as government insurance physicians after August of the same year. As a result, the Minister of Health

and Welfare and the LDP's three highest officials repeatedly negotiated until the 4 items in the JMA's petition were agreed upon; consequently, the JMA canceled its withdrawal campaign.

The Roundtable Conference on Healthcare was then established as part of acquiescence to the JMA's four demands. The conference enabled the relaxation of care restrictions (a de facto lifting of care restrictions) in November and an additional pay rise in the medical fee schedule in December of that year.

Correction of the plan for a universal coverage system proposed by the government

Taro Takemi, the JMA president at the time, believed that the movement toward a universal coverage system was unstoppable.³⁶ He did not oppose the introduction of the system itself as he had believed that the Japanese social security system would gradually enter maturity. However, he also believed that the universal coverage system the government had proposed allowed for too much bureaucratic interference, which would impair physicians' professional freedom. His actions were intended to eliminate such interference and force revisions to the governmental plan.

JMA's international activities

Activities in the WMA

The WMA was created in September 1947 to "serve humanity by endeavoring to achieve the highest international standards in Medical Education, Medical Science, Medical Art and Medical Ethics, and Health Care for all people in the world."³⁷

Recently, the Proposed WMA Statement on Trade Agreements and Public Health was adopted as the WMA Council Resolution at the 200th WMA Council Session held in Oslo, Norway in April 2015. This resolution recommended that trade agreements include exclusions to prioritize the protection of public health over commercial interests and that government action in the interest of public health should take priority over trade agreements.¹⁹

Activities in the CMAAO

The first CMAAO congress met in Tokyo, Japan in April 1959.³⁸

At the 44th CMAAO Mid-term Council in 2008, the JMA reported that the JMA and its four affiliated hospital organizations had developed the Voluntary Action Plan of Global Warming Measures in Hospitals in August 2008

and that the JMA had adopted the action plan as an executive decision in response to the Cabinet decision to adapt the Kyoto Protocol Target Achievement Plan.³⁹

Since it was held during the worldwide economic crisis that set in after the Lehman shock, the main theme of the 2009 General Assembly in Bali was the impact of the global financial crisis on the health system. The JMA presented a lecture entitled "Japanese Healthcare System to Protect the Public from the Global Financial Crisis" and reported that the social unrest triggered by concerns over healthcare experienced in other nations, such as the US, had not occurred in Japan largely because of the JP-UHC and the Japanese healthcare system based.⁴⁰

Takemi Program's contribution to UHC

The Takemi Program in International Health (hereinafter Takemi Program) is an academic research program in international health that was established at the Harvard School of Public Health in July 1983.⁴¹ Takemi Program participants are called Takemi Fellows; there were 251 fellows from 53 countries in the program between 1984 and 2014.

Professor Michael Reich, who has been in charge of the Takemi Program, was listed as one of the authors of the special issue of *the Lancet* on Japan.¹⁰ He has greatly contributed to the promotion of UHC in Japan. His recent efforts include serving as a moderator during a panel discussion session at the ministerial conference of the aforementioned Global Conference on Universal Health Coverage.

International activities in disaster relief

JMA began investigating a framework of a new disaster relief program called the *iJMAT*, which stands for international Japan Medical Association teams. The *iJMAT* was developed under the expectation that Japan will have to accept rescue relief from overseas if and when a disaster of unprecedented scale hits the Tokyo metropolitan area (e.g., an epicentral earthquake) or the southeast and/or southern coastline of mainland Japan (e.g., a Nankai Trough earthquake). At present, the *iJMAT* mainly assumes that Japan will accept medical teams from overseas at present, but in the future, it is envisioned that the *iJMAT* will also serve as a framework for sending medical teams from Japan to work overseas in response to medical emergencies such as Ebola hemorrhagic fever.

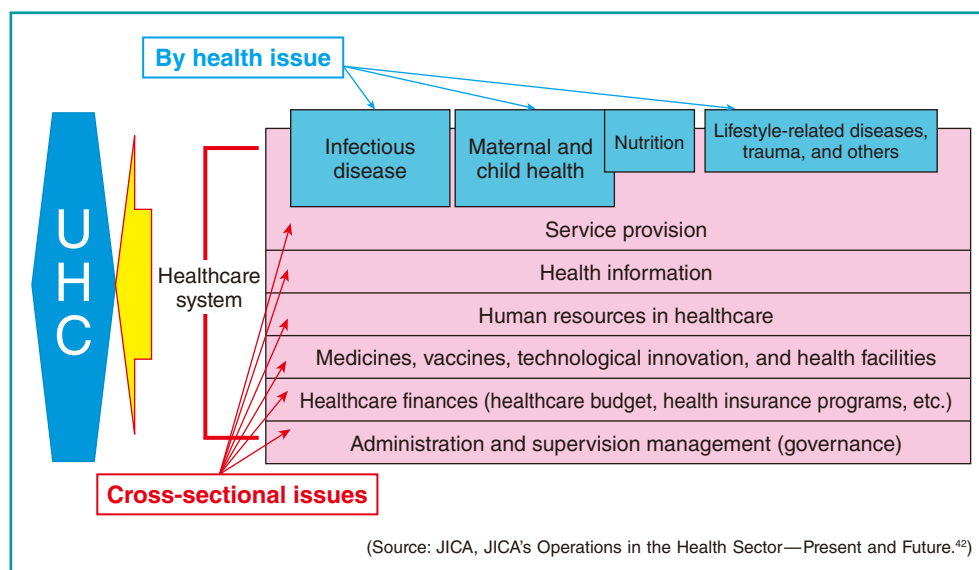


Fig. 6 Conceptual diagram of efforts in the health sector undertaken by the Japan International Cooperation Agency (JICA)

International Healthcare in Japan and the Development of the International Healthcare Industry

In industrial policy, it is common to discuss both international healthcare and the development of the international healthcare industry together. In the following sections, however, the perspective of international healthcare and the perspective of the development of the international healthcare industry are taken as two separate perspectives in the consideration of Japanese global health strategies.

International healthcare

Series of strategies implemented by JICA for achieving UHC

In various developing countries, the Japan International Cooperation Agency (JICA) has been carrying out infrastructure development and many international healthcare projects in the health sector including in regard to maternal and child health, infectious diseases, and HIV (Fig. 6).⁴²

Based on many years of experience, JICA operates on the understanding that implementing international healthcare requires “accurate health information, a quality health workforce

and facilities to provide services, administrative structures for the provision of medical products and vaccinations, and sound governance for formulating and implementing such plans and budgets.” On this basis, JICA has supported developing countries in achieving UHC.

Diplomatic Strategy for International Health proposed at the Economic Cooperation Infrastructure Strategy Conference

In May 2013, the 4th Economic Cooperation Infrastructure Strategy Conference was held to discuss important issues relating to Japan and international economic cooperation. At the meeting, Minister of Foreign Affairs Kishida proposed the Diplomatic Strategy for International Health.

His proposal called for strengthening strategic collaboration with international organizations, strengthening domestic systems and human resources, and continuing to provide support in Africa toward achieving MDGs. UHC, the third item on the Post-2015 Development Agenda, is listed as an important challenge.

Activities by the MHLW and non-profit organizations

The Ministry of Health, Labour and Welfare (MHLW) has engaged in efforts in international healthcare over the years. As an example, Japan

has hosted the ASEAN and Japan High Level Officials Meeting on Caring Societies since 2003. This large-scale conference is held to facilitate the exchange of information regarding social security and healthcare systems among ASEAN countries that can subsequently be put into practice. Japan has been executing a project to share information with ASEAN countries: the Japanese government has accepted trainees from ASEAN countries that aim to achieve UHC, such as Myanmar.

Professional, non-governmental, and non-profit organizations in Japan have engaged in many projects in international healthcare. Research institutes and universities as well as independent physicians and researchers have engaged in research projects in various ways.

To give a few examples of Japan's efforts in the field of international health in ASEAN countries, Japan has promoted the Maternal and Child Health Handbook (e.g., in Indonesia), school health systems (e.g., in Myanmar), and UHC through strengthening social security systems (e.g., in Indonesia).

International development of the healthcare industry

Establishment of Medical Excellence Japan

Medical Excellence Japan (MEJ) is an incorporated general association created by the government and the private sector.⁴³ It was established in 2011 to coordinate international business development. The purpose of MEJ is to promote inbound business (facilitating the treatment of overseas patients in Japan) and outbound business (facilitating the export of Japanese healthcare services and equipment as a package overseas).

Headquarters for Healthcare Policy and Task Force for the International Development of Healthcare

The Task Force for the International Development of Healthcare, which was established within the Cabinet's Headquarters for Healthcare Policy, aims to promote efforts in regard to the international business development of medical technology and services by facilitating collaboration among relevant ministries and agencies. The relevant ministries and agencies include the Ministry of Foreign Affairs (MOFA), MHLW, Ministry of Economy, Trade and Industry (METI), and Ministry of Education, Culture, Sports, Science and Technology. These ministries

and agencies initiated a discussion with relevant organizations (JICA, MEJ, etc.) in regard to the overseas health sector in August 2013.

Furthermore, an ad-hoc working group on the ASEAN Health Initiative was established in July 2014.

Industrial Competitiveness Council (Headquarters for Japan's Economic Revitalization)

In June 2014, the government's Industrial Competitiveness Council named the promotion of inbound and outbound business in healthcare and long-term care as one of the important items in the Japan Revitalization Strategy (Revised 2014).⁴⁴ The Council also presented a course of action in which the prime minister would actively promote healthcare as an industry; this course of action has already been approved by the Cabinet.

METI's projects in international business development

METI has developed business models to realize the Japan Revitalization Strategy and strengthen its collaboration with the private sector, universities, and academic societies. As a specific attempt to promote international business development in the healthcare sector, METI has initiated a project to promote globalization in regard to both inbound and outbound business pertaining to medical/health equipment and services.

—Inbound business

Inbound business was not debated fully in the past. There are many issues to consider, such as the preparedness of medical institutions receiving foreign patients and the medical fee schedule for such patients. Sensitive issues that require caution come with accepting patients from abroad, such as the potential risk of infectious disease. Therefore, relevant cases in other countries must be studied and a careful approach must be taken. Some issues need to be resolved promptly through further discussion, such as how to balance care for foreign patients with care for patients covered by the Japanese healthcare system (i.e., Japanese citizens and foreign residents).

—Outbound business

A total of 21 outbound business projects were implemented in FY2014. An additional 13 projects were conducted either with the supplementary budget or by the MEJ. Many of these projects were executed by private business consortia constituted of manufacturers and medical

institutions; these projects either involved the construction of hospitals or medical centers in the target nation or the sale and maintenance of advanced medical equipment.

This approach shows some improvement over the traditional approach of wholesale exporting a hospital, but it also raises a few concerns. For example, projects have tended to focus on a particular social class in the target nation; furthermore, sustainability is never guaranteed. It is advised that involved parties in Japan take action from the shared viewpoint of supporting the future development of UHC in the target nation. Another recommendation would be to involve medical associations in the target nation in a project to achieve stable long-term operations.

MOFA and Memorandum of Cooperation

The MOFA has supported international business development by providing training programs and loaning medical equipment and through grants and public-private partnership projects (PPPs). Recently, the MOFA reached agreements with 12 countries, including 4 ASEAN countries (Cambodia, Laos, Myanmar, and Vietnam) to sign a Memorandum of Cooperation in regard to the healthcare sector.

Establishing the AEC

The ASEAN Economic Community (AEC) is expected to be launched at the end of 2015. It aims to build political stability and facilitate economic development in the ASEAN region, which has a total population exceeding 600 million. The AEC is expected to ease the movement of people, goods, and services across borders, eliminate tariffs, lift bans on the entry of skilled workers, and relax regulations on investment. The AEC will have a substantial effect on the healthcare sector as well.

Suggestions and Problems for Japan's Global Health Strategies

(1) UHC development should be promoted in coordination with the United Nations, World Bank, and Asian Development Bank.

It is likely that the Post-2015 Sustainable Development Agenda, which will succeed the UN MDGs, will be based on UN Secretary-General Ban Ki-moon's general report for sustainable development entitled "The Road to Dignity by 2030." Goal 3 of the general report is, "Ensure

healthy lives and promote well-being for all at all ages"; in this regard, UHC will play a major role.

World Bank President Jim Yong Kim named Japan as a leading global model for UHC. Moreover, Prime Minister Abe wrote that "I will first and foremost spare no efforts to incorporate UHC as a crucial element of the Post-2015 Development Agenda" in a paper he contributed to *the Lancet*.

As shown here, the UN, World Bank, and Japanese government consider UHC one of the main themes in global health. It is therefore important to make preparations to include the promotion of UHC in Japan's global health strategy while taking into consideration cooperation with UN, the World Bank, and the Asian Development Bank.

(2) Ensuring the sustainability of the JP-UHC system should be considered a national policy.

As stated earlier, Prime Minister Abe discussed the active promotion of UHC in his global health strategy. Minister of Finance Aso stated that Japan should actively share its experience with the international community and contribute to tackling the challenges that we have in common by drawing on the experiences of the JP-UHC.

UHC is now being promoted as the future core of global health. However, with regard to the JP-UHC system, an editorial in *the Lancet* pointed out that "Combined with rising healthcare costs and an ageing population, Japanese doctors—like those elsewhere—worry about the sustainability of the JP-UHC under such pressures."¹⁰

Thus, the Japanese government must make efforts to ensure the sustainability of the JP-UHC system. The government should recall that, as a joint research program between Japan and the World Bank indicated, national effort as well as competition between political parties led to universal coverage in Japan. The government must confront the issue of ensuring the sustainability of the JP-UHC system as a national policy.

(3) Trade agreements such as the Trans-Pacific Partnership should not disrupt or interfere with achieving UHC.

The 200th WMA Council in April 2015 adopted the WMA Council Resolution on Trade Agreements and Public Health.¹⁹ Its first recommendation is to "advocate for trade agreements that protect, promote and prioritize public health

over commercial interests and ensure wide exclusions to secure services in the public interest, especially those impacting on individual and public health,” calling for nations to guarantee wide exclusions. Its second recommendation is to “Ensure trade agreements do not interfere with governments’ ability to regulate health and health care, or to guarantee a right to health for all.”

Therefore, government action to protect and promote health should not be sued through an investor-state dispute settlement (ISDS) or similar mechanism. Trade agreements such as the TPP should not interfere with the effort to achieve UHC in each country and should not interfere with the unique form of UHC each country may develop.

(4) Japan should disseminate information overseas regarding the course of events that led to the establishment of the JP-UHC system and make efforts to develop international human resources to participate in UHC policymaking.

In developing countries, how Japan overcame the difficulties it faced in the establishment of the JP-UHC system has drawn attention.

According to the analysis of “Lessons from Japan,” a joint research program of Japan and the World Bank, national efforts as well as competition between political parties led to universal coverage in Japan. In fact, political leadership directly played a role in realizing a standardized medical fee schedule across the nation. The joint research program also indicated this negotiation process can serve as an effective model for other countries. In the course of establishing universal coverage in Japan, an organization of physicians with professional autonomy stood at the front lines, on the basis of their profession, to fight for a better healthcare system against the bureaucratic leadership.

Other countries should be able to access information related to this fact and many others pertaining to the establishment of the JP-UHC system. It is also important that the national medical associations in all of the CMAAO countries actively propose UHC systems to their national governments.

To this end, it is essential to educate and train people to ensure that there are international human resources capable of supporting UHC policymaking in collaboration with the World Bank, the Asian Development Bank, etc.

(5) The development of separate healthcare programs and UHC preparation should be promoted by streamlining and centralizing maternity care, school health, infectious disease management such as for tuberculosis, and emergency care such as for traffic accidents.

In addition to its insurance system, Japan has unique health policies including in regard to maternal and child health management, school health management, infection control (for diseases such as tuberculosis), and emergency medicine for traffic accidents.

Considering that current health statistics in ASEAN countries are roughly equivalent to figures from 1940 to 1965 in Japan, Japan’s past experience, including as described above, can greatly help these countries. Japan is likely to further contribute to ASEAN countries in these 4 main healthcare areas.

For this reason, these 4 areas should be made the center of Japan’s efforts for facilitating UHC by streamlining and centralizing services in target nations and developing individualized healthcare programs according to the circumstances of each target nation.

(6) Japan should disseminate information overseas about *kakaritsuke* physicians and engage in international human resources development.

According to the Organisation for Economic Co-operation and Development (OECD), physicians in charge of primary care must be generalists (i.e., their area of practice must be general medicine as construed in the British and other healthcare systems; such physicians, for example, family physicians, have no specific area of expertise). *Kakaritsuke* physicians in Japan who practice medicine at private clinics do not meet this definition because they are trained in general clinical medicine as well as in specific areas of medicine, with comprehensive capabilities entrusted with community medicine, health and welfare.

The primary care system in Japan, in which clinical physicians serve as *kakaritsuke* physicians, has produced excellent outcomes. Therefore, negotiations with the OECD should take place and an international awareness campaign about the primary care system in Japan should be conducted.

The healthcare system in Japan is greatly

dependent on the primary care provided at clinics; this practice should be made known internationally. Education and training to develop medical human resources from an international point of view are necessary to deepen knowledge regarding activities related to primary care provision and medical practice.

(7) Global health should be developed in concert with a consideration of the management of global environment problems.

In response to the 5th Assessment (General) Report of the Intergovernmental Panel on Climate Change (IPCC),⁴⁵ UN Secretary-General Ban stated that the General Report on the Post-2015 Sustainable Development Agenda would serve as a guideline for negotiations toward establishing a global agenda that places humanity and the earth at the core and is supported by human rights. Many of Ban's goals employ the word "sustainability" to support SDGs.

The future development of global health should take the ideas of the Post-2015 Sustainable Development Agenda into consideration and address the environmental issues of the planet in an integrated fashion.

(8) Support systems, such as for managing large-scale international disasters and preventing the spread of infectious diseases, should be developed and maintained.

Changes in climate will likely produce frequent high tides and hurricanes of unprecedented scale, causing damage in regions of the planet such as the ASEAN countries, where the sea-water temperature has been rising significantly.

In addition, in the future, the number of nuclear reactors in the world is expected to double, heightening the potential risk of nuclear accidents more than ever. Healthcare systems will be tasked with handling the negative influence on humans of radioactive materials dispersed during accidents and with treating the effects of radiation.

Furthermore, global health must respond to the threat of epidemics, as the example of Ebola hemorrhagic fever has recently shown. Infectious diseases with high mortality rates can rapidly spread through towns in developing countries, posing difficulties that mankind has never faced before.

In light of the above, Japan needs to prepare global and large-scale disaster management regimes and develop support systems to prevent

highly mortal infectious diseases from spreading. To aid these objectives, it is crucial that the *i*JMAT program, an international version of the JMAT (Japan Medical Association Team) program that currently operates under the assumption that Japan will accept relief from overseas, be expanded to encompass both the receiving and sending of relief teams internationally.

(9) International healthcare policy, which the Japanese government is trying to promote in accordance with international trends, and international development of Japanese healthcare industry should be reconsidered.

Suggestions as to international healthcare policy of Japan

1. Collaboration should be facilitated and reinforced among separate programs, including those related to maternal and child health. Overseas UHC support should be strengthened through cooperation with local healthcare stakeholders; human resource development should be a focus.
2. Japan has insufficient human resources to promote international healthcare. Thus, efforts should be made in regard to human resource development—for example, an international healthcare training course should be provided.
3. Information regarding JICA activities should be widely disseminated through the use of easily understandable materials in order to improve both domestic and international recognition.
4. In addition, it is urgent that human resources development is undertaken in Japan to ensure that there are sufficient personnel capable of dealing with emerging and reemerging infectious diseases.

Suggestions as to the international expansion of the Japanese healthcare industry

1. Profit-oriented outbound business targeting a specific social class excludes the poor and may interfere with the improvement of local healthcare.
2. Any outbound business should be required to be based on a long-term vision and to benefit UHC in the target nation. The possibility of collaborating with medical associations within target nations should also be investigated.
3. For inbound business, it is urgent that operational principles and rules are considered among the relevant authorities and healthcare organizations and institutions.

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