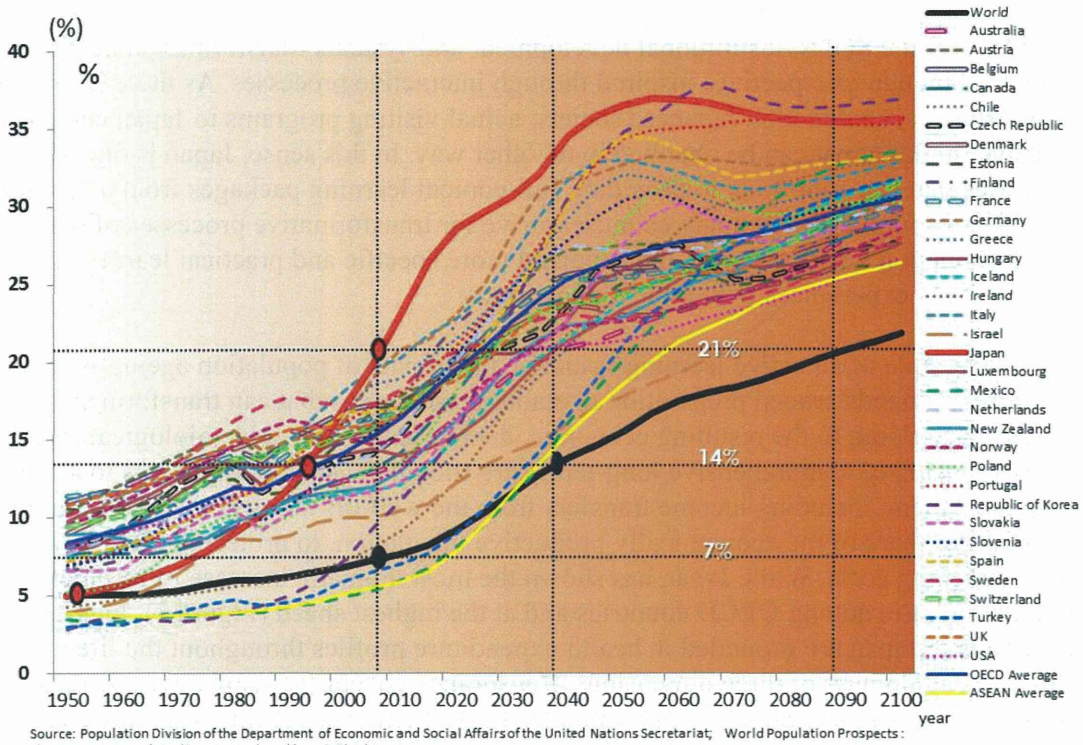
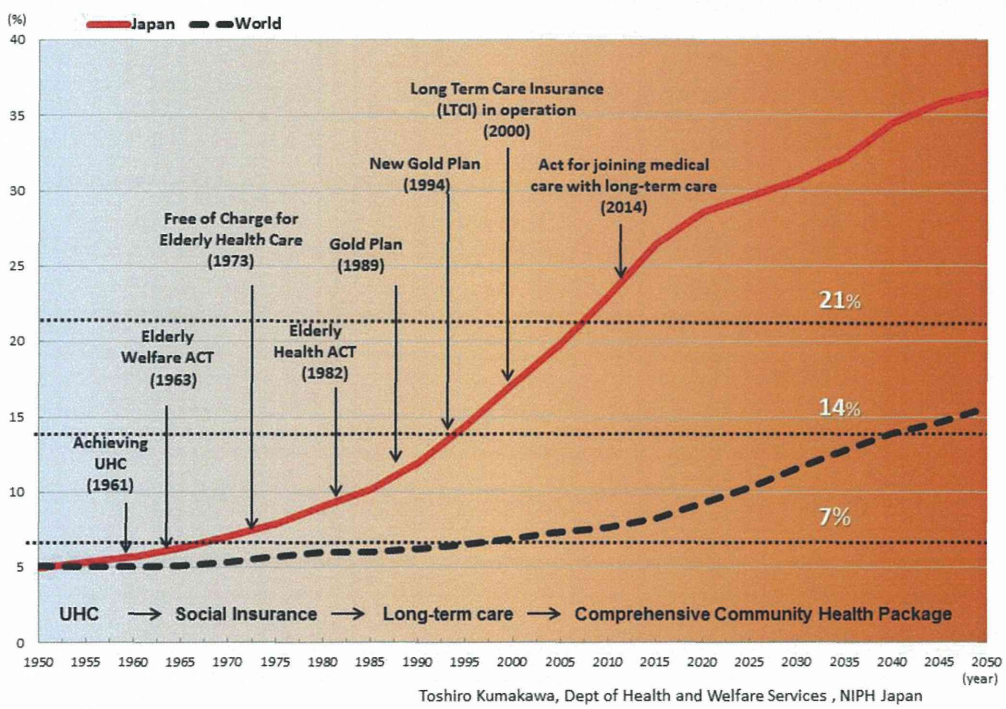
Figure 3: Projection of elderly population ratios



Source: Population Division of the Department of Economic and Social Affairs of the United Nations Secretariat; World Population Prospects: The 2012 Revision, http://esa.un.org/unpd/wpp/index.htm

Toshiro Kumakawa, Dept of Health and Welfare Services, NIPH Japan

Figure 4: Policy innovation in Japan responding to demographic transition



Toshiro Kumakawa, Dept of Health and Welfare Services , NIPH Japan

Responses to ageing populations are complicated by the fact that ageing is not just about older people, but is multi-dimensional and multi-generational. It has implications for taxation policy, the design of social security systems, the provision of health and social services from "womb to tomb," and other aspects of public policy. It can be highlighted by a well-elaborated process of policy innovations in accordance with social transitions as undertaken by the Government of Japan (Table 1). Their response covered pensions and social security, labor and savings, macroeconomic impacts, as well as health service provision and long-term care. Indeed, Japan's on-going efforts in maintaining universal health coverage are "active learning resources" to those critical learners, especially in the areas of political will, evidence-based forecasting, systems design, flexible policy amendment, and multi-stakeholder engagement.

Table 1: Policy innovations to cope with social transition

	1920-1959 (1940)*	1960-1975 (1970)*	1975-1989 (1980)*	1990-1999 (1990)*	2000 and after
GDP(1990 Int. GK$)	2,874	9,714	13,428	18,789	21,935
Average life expectancy (men/women)	47/50	69/75	72/77	77/83	79/86
IMR(1000birth)/TFR	90.5/4.0	13.1/2.13	7.5/1.75	4.4/1.54	2.2/1.39
Causes of death	1. Tuberculosis, 2. Pneumonia and bronchitis, 3. Cerebrovascular disease	1. Cerebrovascular disease, 2. Malignant neoplasm, 3. Cardiovascular disease	1. Cerebrovascular disease, 2. Malignant neoplasm, 3. Cardiovascular disease	1. Malignant neoplasm, 2. Cardiovascular disease, 3. Cerebrovascular disease	1. Malignant neoplasm, 2. Cardiovascular disease, 3. Cerebrovascular disease
Number of physicians (population of 100,000)	105.9	121.2	150.6	176.5	211.7
Major policies and laws	1937 Public Health Center Act 1947 Food Sanitation Act 1948 Medical Practitioners Act, Act on Public Health Nurses, Midwives and Nurses, Preventive Vaccination Act 1951 Tuberculosis Prevention Act, Quarantine Act 1958 Maternal and Child Health Act, School Health & Safety Act	1965 Maternal and Child Health Act 1970 Waste Disposal Law 1968 Air Pollution Control Act 1970 Water Pollution Control Act 1972 Labor Safety Standards Act	1982 Health and Medical Service Act for the Aged, Act on Assurance of Medical Care for Elderly People	1994 Community Health Act 1995 Mental Health Act 1997 Long-Term Care Insurance Act	2000 Child Abuse Prevention Act 2002 Health Promotion Act

Data were quoted from journal of health and welfare 2014/2015

Regarding the transformative nature of the learning process, Japan can provide successive references as a dynamic and longitudinal process. For instance with learning programs for community health policies in Japan, the themes and topics have been changing over time and the learner can enrich the practical implications for policy innovations through enhanced understanding of historical and social contexts (Table 2).

Table 2: Trends and training topic modifications

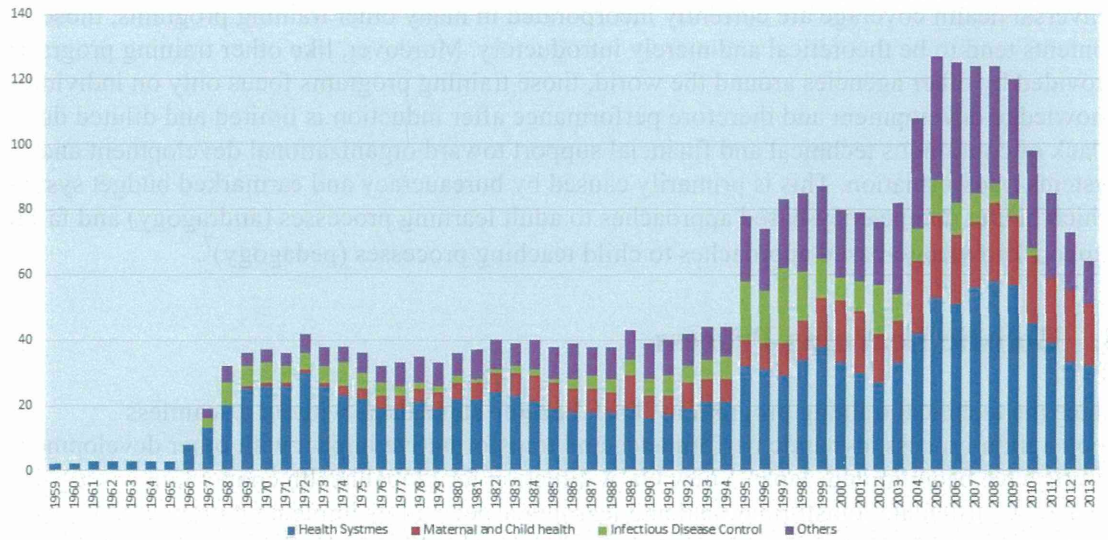
	1920-1959 (1940)*	1960-1975 (1970)*	1975-1989 (1980)*	1990-1999 (1990)*	2000 and after
General trends	Quantitative amplification of national and regional public health leaders Training of practitioners involved in PHC, such as maternal and child health and infections control	Development of human resource involved in policy development and practitioners concerning environmental pollution	Burgeoning of themes concerning measures against lifestyle-related diseases and health care for elderly. Training of sophisticated public health professionals and researchers	Reinforcement of capabilities of human resources that plan, formulate and adjust community health policies Response to aging and informatization Reduction in the training period and trial operation of remote education	Cultivation of management and leadership related to cross-cutting action assignments such as medical care, health, welfare (elderly care), etc. and health crisis management, etc. Increase of short-term training by theme to respond to new health issues.
Infections control	Training of practical leaders with knowledge of measures and techniques by diseases such as tuberculosis, sexually transmitted diseases, etc.	Training of practical leaders of tuberculosis measures, bacterial food poisoning, etc.		Development of human resources who are the support and driving force of shaping the crisis management system in communities, such as measures against emerging and re-emerging infections, collective occurrence of infections, and AIDS, etc.	
Maternal and child health	Training of practical leaders with basic techniques concerning family planning, medical checkup activities	Training of practical leaders who promote improvement of comprehensive maternal and child health throughout life -course , such as improvement of adolescent health.		Development of human resources who are the support and driving force of shaping the crisis management system involved in prevention of child abuse, domestic violence, etc.	
Lifestyle-related diseases and geriatric care			Training of practical leaders on measures by diseases concerning lifestyle-related diseases such as prevention of cardiovascular diseases Training of practical leaders concerning health care of the aged (medical checkups and health education)	Development of human resources who can comprehensively plan measures against lifestyle-related diseases. Training of practitioners who support the elderly care insurance system	Based on the viewpoint of medical expenses optimization, reinforcement of management capabilities of measures against lifestyle-related diseases by utilizing big data, Development of human resources promoting the coordination amongst health, medical care, and welfare service.
Leadership and management	Training of human resources who perform public health administration.			Reinforcement of health information management and processing capabilities. Reinforcement of capabilities for formulation of community health plans	Integration of leadership and management capabilities for all training.

Edited from annual report of National Institute of Public Health 1938-2015

3. Challenges in Japan's Technical Cooperation for its Health Sector

The Government of Japan uses an array of development assistance schemes to meet the diverse needs of developing countries around the world. Japan's bilateral assistance through the Japan International Cooperation Agency (JICA) to developing countries has several major components such as technical cooperation, grant aid, ODA loans, volunteer programs, emergency and disaster relief program etc. In terms of technical cooperation projects in the health sector, JICA conducts an annual average of 93 projects (Figure 1), which have amounted to a total $ 23 billion since 2000. The most popular cooperation area is health systems strengthening, followed by maternal and child health and infectious disease control.

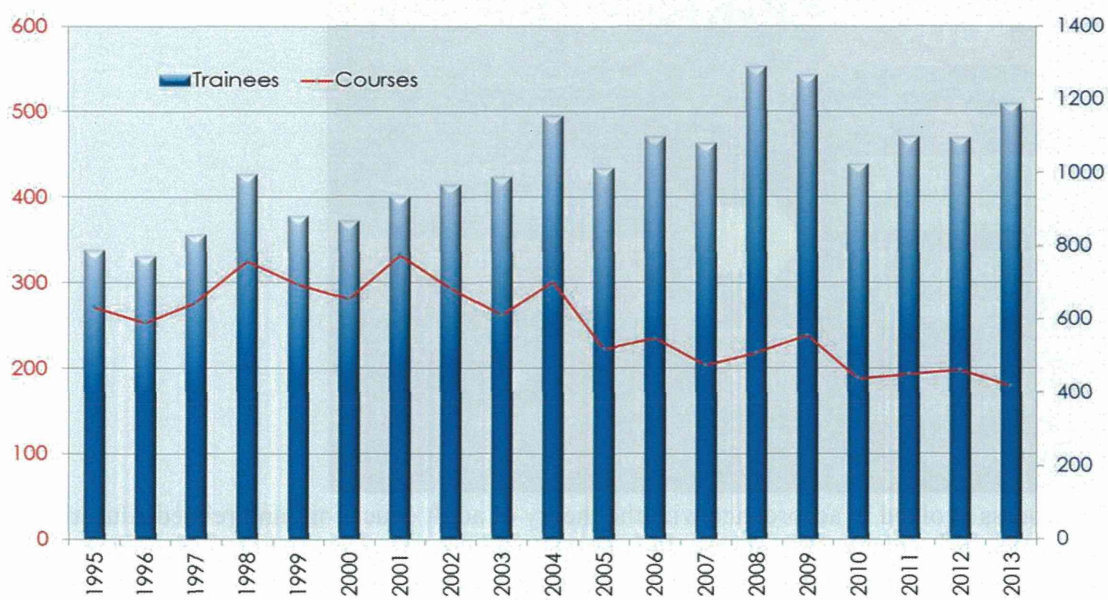
Figure 1: Number of technical cooperation projects on health sector



Modified from *http://www.jica.go.jp/english/publications/reports/annual/index.html*

Technical training programs in Japan are another major form of technical cooperation. In the health sector, an annual average of 251 short-term training courses (2-8 weeks) and 1018 trainees amounted to a total of 15,104 trainees since 2000 (Figure 2). The most popular training course is "health systems strengthening" (44 courses, 404 trainees in 2013) amounting to 45% of total programs in the health sector. While the training content focused more on service provision and medical intervention, emerging contents such as health financing, aging society and strategic management have gained serious attention at the request of the trainees[6]. Consequently, special training courses targeting health insurance and active aging societies were developed and implemented (3 courses, 46 trainees in 2014).

Figure 2: Number of courses and trainees in the health sector



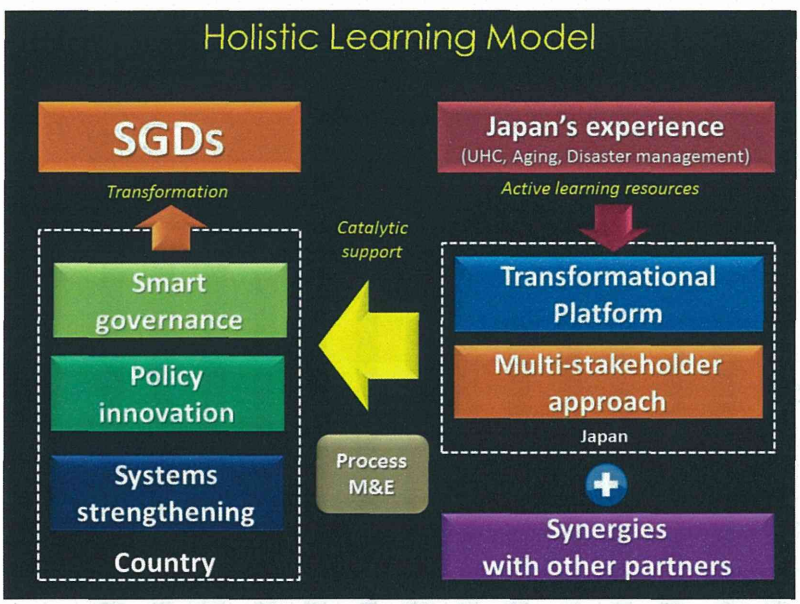
Although the introduction of history and lessons-learned from Japan's experience on achieving universal health coverage are currently incorporated in many other training programs, those contents tend to be theoretical and merely introductory. Moreover, like other training programs provided by other agencies around the world, those training programs focus only on individual knowledge development and therefore performance after induction is limited and diluted due to a lack of continuous technical and financial support toward organizational development and systems transformation. This is primarily caused by bureaucracy and earmarked budget systems, which hinder competency-based approaches to adult learning processes (andragogy) and fail to support knowledge-based approaches to child teaching processes (pedagogy)[7].

4. Holistic Learning Process

Since the technical training program in Japan became standalone without a seamless cooperation process, dynamic performance and transformative impact with other developmental efforts have been limited. Japan's new ODA direction for global health cooperation is truly in demand to articulate transformational and learning aspects in its implementation, which enables policy innovations in recipient countries toward the realization of the SDGs and well-being in their societies. While the training program in Japan still maintains a significant position within Japan's overall development assistance, new training programs can be incorporated as part of a broader whole learning process to enhance active learning resources that inspire proactive and creative thinking among stakeholders for sustainable systems development.

Under these circumstances, this article proposes a "***holistic learning process***" as a new direction for Japan's ODA. It consists of a ***transformational platform*** and ***multi-stakeholder approach,*** and is also enhanced by ***synergetic efforts by other development partners*** (Figure 5).

Figure 5: Holistic learning process



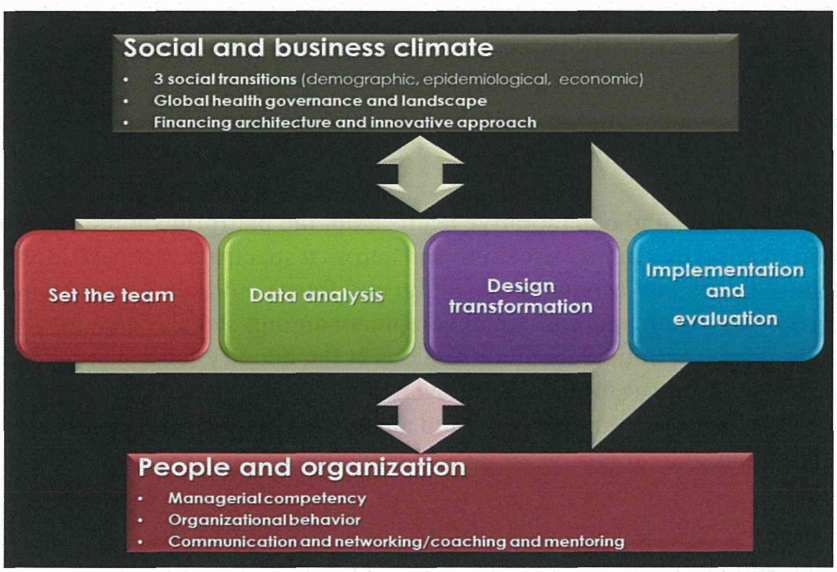
The process evolved in accordance with the theory of adult education[8] and related educational reform agenda[9]. The learning process here to facilitate the integration and transformation of present systems becomes the means by which the government can deal critically with reality and articulate how the people can participate in the transformational process of the entire world[10].

Because Japan's achievement of universal health coverage in 1961 was partly fueled by a popular movement motivated by concerns about national security (campaign against the Japan-US Security Treaty in 1960), the process provides a learning platform for both government and civil society in promoting social movements toward realizing human security.

Organizational Development

The focus on the holistic learning process is to enhance organizational capacities to ensure equitable healthcare provision and resilient health systems at the local as well as the national levels. This approach for organizational development is contextually influenced by social dynamism, and ultimately by the people who operate the organization. One of the empirical lessons here is that internal leadership is essential, as they know the working mechanisms better than external consultants. Thus, the development process should be articulated to guide, coach, and collaborate with national and local managers until they are able to drive the organizational design and development process. Besides providing solutions and manpower, this collaborative team can engage with managers as supportive catalysts to develop choices and innovative options that enhance the effectiveness of the organization. Based on gap analyses, the holistic learning process determines the criteria for success by designing goals that reference the organization's vision and mission. Following organizational vision-making, the collaborative team can explore the pros and cons of various models and approaches, whose concrete implications can be seen in actual cases and experiences in their own countries, in Japan, and elsewhere. National and local managers equipped with strategic management and interactive communication skills can begin to influence the steps in their design processes and influence implementation aiming at achieving universal health coverage (Figure 6).

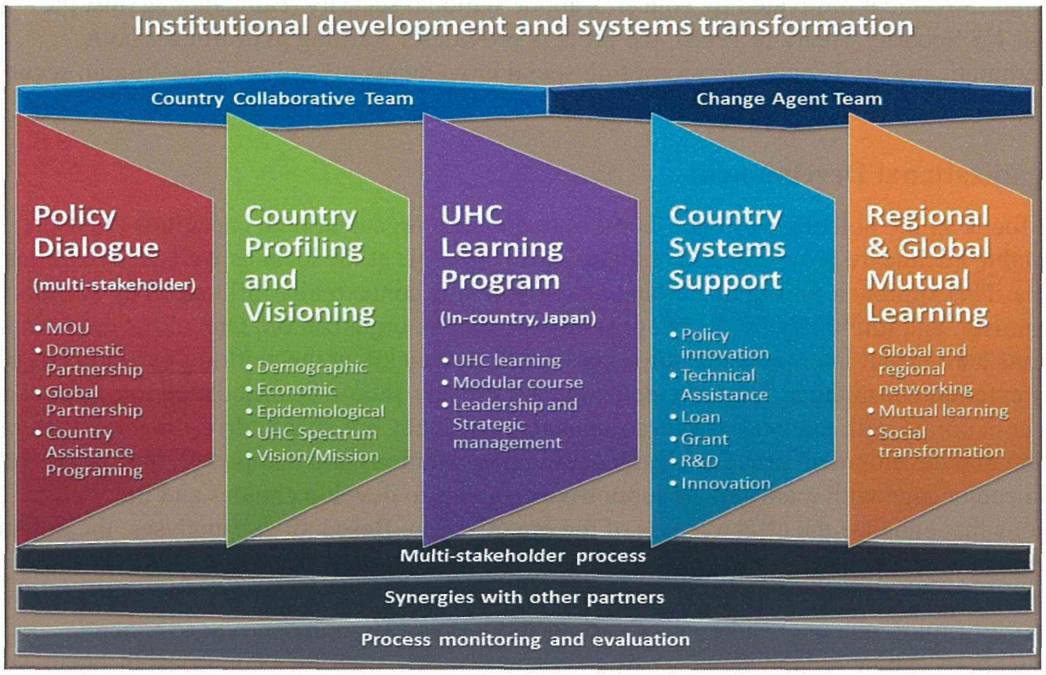
Figure 6: Organizational development



Transformational Platform

The holistic learning process is a comprehensive and successive logic process for institutional development and systems transformation. The process is enhanced by two essential pillars, ***transformational platforms*** and ***multi-stakeholder processes***. (Figure 7)

Figure 7: Transformational platform



Transformational platform: Seamless aspect

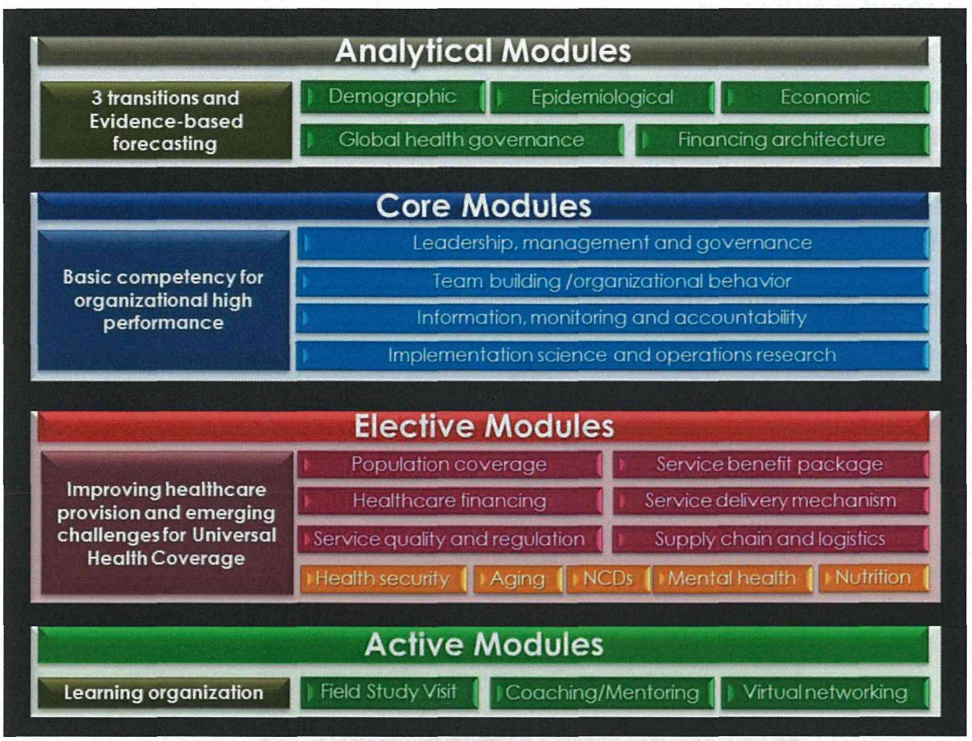
This platform has progressive sequences for institutional development and health systems transformation. At the initial engagement, the platform provides opportunities for policy dialogue with multi-stakeholder engagement. It is encouraged that an official agreement is reached through a Memorandum of Understanding between the two countries (normally the ministries of health)[11]. Synchronously, the country implementation process is continuously facilitated by a country collaborative team that consists of individuals from both from recipient country and Japan. It is desirable that essential membership should articulate a multi-stakeholder approach that enhances representation from government, NGOs, the private sector, civil society, and academics institutions.

Followed by an official agreement and collaborative team setup, the platform should facilitate evidence-based decision making by country profiling and across a spectrum that pays attention to demographic, epidemiological, and economic transition and future outlook. The exercise of forecasting evidence promotes vision and mission development among stakeholders in designing health systems. This can initiate learning sessions at the country level that reference health economy, global and local case studies, and relevant academic papers. It is very important that the overall learning process be monitored and periodically evaluated for its progress toward common goals and targets by all the stakeholders.

Followed by country profiling and visioning, the country collaborative team is exposed to a holistic UHC learning program, through a lively learning opportunity in Japan. This short leaning course between 2-4 weeks provides well-elaborated learning modules on demands articulated by initial policy dialogue in the country (Figure 8). The course program consists of analytical, core, elective, and active modules. These seamless learning modules emphasize learning and the transformative aspects of individual, organizational, and institutional development, as well as the strengthening of strategic leadership and management from the community to local/national managers. In particular, the most important aspect of the learning process is that capacity development should enhance organizational behavior and institutional

transition to harmonize between vertical (program) and horizontal (systems) approaches to leverage resilient health systems.

Figure 8: Holistic UHC learning modules



Following the UHC learning program, the actual technical cooperation and/or financial assistance (grants or loans) can facilitate concrete health systems strengthening under the blueprints held by stakeholders. Especially at this stage, collaborative efforts with other partners or sectors are essential to complement synergetic effects toward resilient systems strengthening.

Transformational Platform: Dynamic Aspect

In terms of scientific validity, the platform provides evidence-based forecasting through demographic, economic, and epidemiological transitions, which can facilitate "vision and mission" development for designing future resilient health systems in a long-term perspective. Here, UHC profiling and the spectrum approach are vital to manipulate health systems strengthening and social transformation in a systemic manner (see the Special Colum 2).

During the learning process, analytical modules may start during the initial period of team establishment at the country level. The collaborative team dissects their own health systems using forecasting perspectives based on 3 dimensional aspects; demographic, epidemiological, and economic transition.

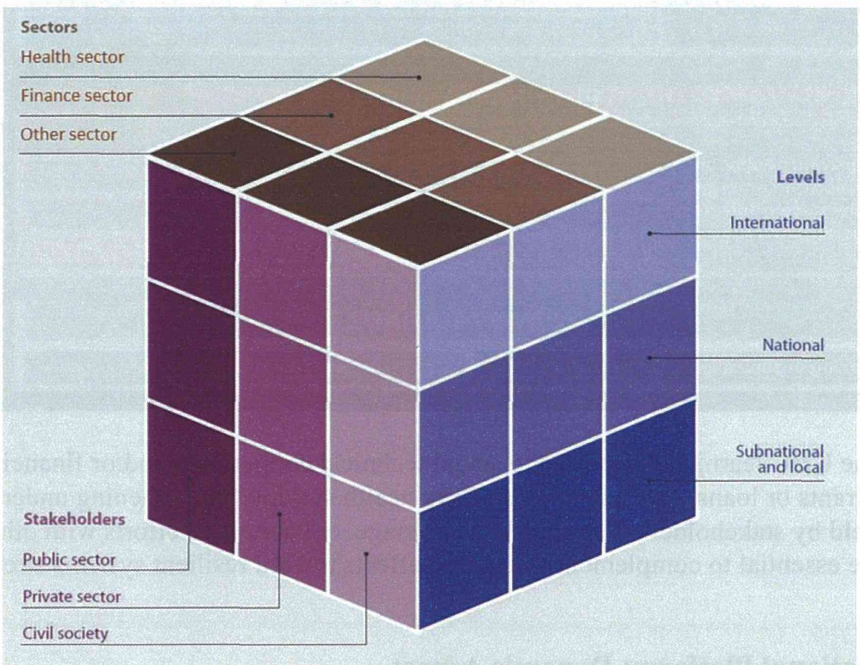
The platform is also supported by integrated efforts by other development partners and global initiatives. Since the Government of Japan became a signatory to the Global Compact of the International Health Partnership plus[12] in 2015, efforts on the aid effectiveness and harmonization should be mainstreamed and cherished throughout the course of the holistic learning process. While JICA, NCGM and NIPH in Japan have engaged MOUs with several

global partnership programs, synergies with other networking mechanism are essential to complement systems transformation in accordance with the whole-of-system approach[13] (see Column (3) Synergies with other global partners).

Multi-stakeholder approach

The multi-stakeholder approach[14] is a governance structure that brings stakeholders together to participate in dialogue, decision making, and implementation of solutions toward common goals. The approach was initiated by Agenda 21[15] adopted by the Earth Summit in 1992 and became an instrumental backdrop for the development of the SDGs[16]. A stakeholder refers to an individual, group or organization that can come from national and local government, the NGO sector, the private sector, the informal sector, or civil society (Figure 9).

Figure 9: Multi-stakeholder approach



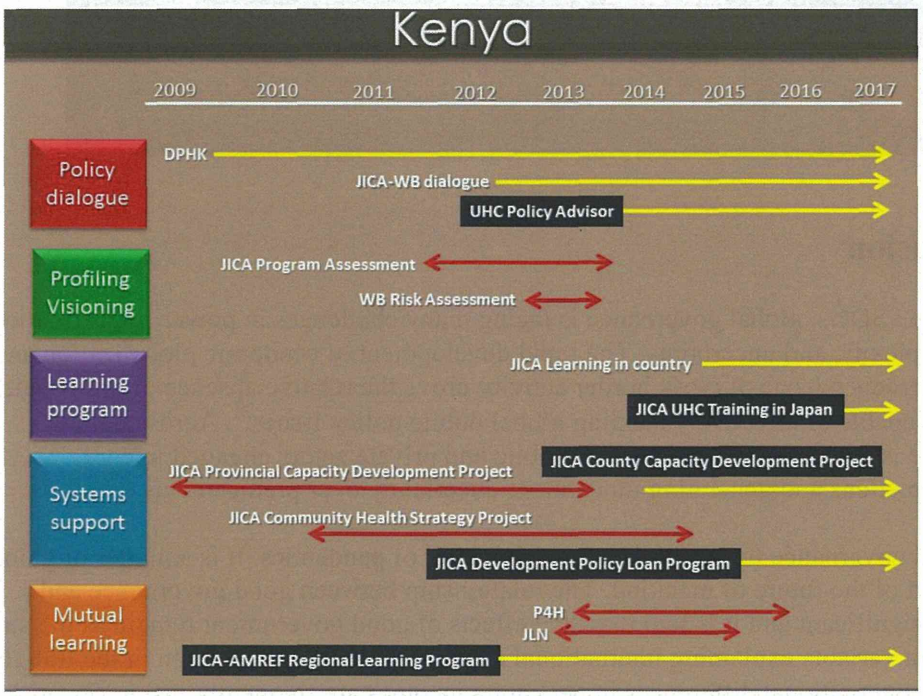
Solutions are often as complex as the problems, and all stakeholders have ideas about possible solutions and need to be part of them. The challenge is providing them with the fora to bring their wisdom to the table effectively and equitably[17]. Hence, multi-stakeholder approaches should enhance democracy by increasing opportunities for effective participation by those most directly impacted by decisions, particularly those at the grassroots who so often are voiceless in these processes. The platform should ensure the multi-stakeholder approach from the beginning of the policy dialogue at the country level. The interactions of stakeholder engagement within the country and between the country and Japan can initiate social movements in the course of the holistic learning process, in which policy innovations can enhance the legitimacy of the SDGs by reflecting people's voices for social well-being.

Precedent Country Cases (Kenya and Vietnam)

The case of **Kenya** tried cutting-edge efforts in its holistic learning process toward achieving UHC. Since 2009 JICA has been supporting policy formulation in the field of UHC through

dispatching experts to the Ministry of Health. To develop local health managers for their managerial capacities in the devolution process and expand the provision of essential health services at the community level, JICA initiated seamless and dynamic interventions in the country such as the Project for Strengthening Management for Health in Nyanza Province (2009-2013), Strengthening Community Health Strategy (2011-2014) and has also supported the Organizational Capacity Development Project for the Management of Devolved Health Systems in Kenya (2014-2019). Particularly with respect to the synergy between technical cooperation and financial assistance, JICA signed a concessional loan agreement with the Government of Kenya to provide the Health Sector Policy Loan (4 billion yen, $ 33 million)[18], which is the first Japanese ODA loan for Africa with the objective of achieving UHC. The purpose of the UHC loan programs consists of Free Maternity Services (FMS), Health Insurance Subsidy Program (HISP), which promotes health insurance enrollment among the poor, and Result-Based Financing (RBF) for primary care facilities. In 2016, an active learning program in Japan will be implemented with multi-stakeholder engagement while institutional development and systems strengthening will continue[19]. (Figure 10)

Figure 10, Holistic Learning Process in Kenya



The case of **Vietnam** shows a unique approach initiated by official dialogue under the memorandum of understanding (MoU) between the Ministries of Health of Japan and Vietnam. The holistic learning process has progressed particularly through intensive and regular technical discussions on designing health insurance schemes and the financial implications. Further UHC research articulated bottlenecks of Vietnam's health insurance systems, and policy dialogue further promoted private sector involvement in benefits packages, cost containment, and provider payment mechanisms. In 2016, a health policy advisor will be dispatched as a long-term expertise to accelerate reforms on social security systems by promoting means of different development modalities[20]. (Figure 11)