

Japan's New Direction for Global Health Cooperation in the Era of the Sustainable Development Goals

Holistic learning process through multi-stakeholder approach to nurture social transformation toward achieving Universal Health Coverage and Global Well-being

Group 5 *Team Troika*

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Abstract

While the Sustainable Development Goals (SDGs) were ratified at the United Nations Summit for the Adoption of the Post-2015 Development Agenda in September 2015, it is high time that Japan should contribute to realizing the SDGs in practice. In the era of the SDGs, we are facing planetary boundaries, power fragmentation, systemic complexity, and much uncertainty. Thus, Japan's Official Development Assistance (ODA) must pay more attention to the aspect of “*transformation*” by strengthening learning processes and stakeholder engagement. To foster resilience and integrity in our societies, the people must be in the driving seat and ODA can play a catalytic role in social transformation by providing evidence, opportunities, and networking. This article proposes that a ***Holistic Learning Process*** should be at the center of global health cooperation and supported by a ***transformational platform*** and ***multi-stakeholder approach***. ***Active learning resources*** as to Japan's experiences with overcoming issues in health, security, and disaster response can provide lively aspirations to those proactive learners. This seamless and dynamic process articulates the frontier of our efforts in promoting institutional development, systems transformation, and smart governance towards enhancing resilient societies, global well-being, and a sustainable future of our planet.

Column (1) UHC profiling and spectrum matrix
Column (2) Synergies with other global partners

1. Introduction

On September 25, 2015, the 193 countries of the United Nations Sustainable Development Summit adopted the Sustainable Development Goals, also known as the Global Goals for Sustainable Development, with 17 Goals and 169 targets. The Agenda 2030 entitled “*transforming our world*” declared that “[t]his Agenda is a plan of action for people, planet and prosperity. We are determined to take the bold and transformative steps which are urgently needed to shift the world onto a sustainable and resilient path. As we embark on this collective journey, we pledge that no one will be left behind.”⁴

The MDGs have contributed an enormous impact on improving essential health service provision, reducing child and maternal mortality, and combating HIV, malaria, tuberculosis, and other diseases. However, they failed to articulate the root causes of inequities in health; interactions between health, poverty, and other social determinants; and the holistic nature of social, economic, and environmental development. Moreover, interrelated predicaments today cannot be addressed by a single set of government or other decision-makers but require cooperation between many different actors and stakeholders. It is plausible that the SDGs will be incapable of successful resolution unless all parties are fully involved from the very outset.

In the health sector, at least 400 million people do not have access to one or more essential health services and 6% of people in low- and middle-income countries are tipped into or pushed further into extreme poverty because of increasing out-of-pocket health spending⁵. This is striking evidence that efforts on improving health status themselves can boost poverty and socioeconomic disparities due to incremental costs of medicines and services. Moreover, the most recent Ebola outbreak caused catastrophe in West Africa and even far away in the United States and Europe. The global community comprehends that local risks have international repercussions and the outbreak was not just a matter of contagious diseases, but of financial crisis, climate change, and human security, as well.

In the era of the SDGs, conspicuous concerns on equity, solidarity, and resilience emerged as learning aspects of social systems. In facing planetary boundaries, all life on earth depends on our proactive and creative mindsets. This is why that the word “*transformation*” becomes significant, in which our transitional efforts determine the state of the planet for generations to come. Each of us plays a crucial role in changing lifestyles in the pursuit of health and well-being. In terms of social transformation, Japan has enormous experience in facing demographic and economic challenges over past few decades. Notably, the achievement of Universal Health Coverage in 1961 followed by rapid population aging, and the rebuilding of society after the Great Hanshin earthquake (1995) and the Great East Japan earthquake (2011) are vivid examples how the people have overcome unexpected calamity and rebuilt society through full stakeholder engagement.

At this juncture, this article urges that it is high time for the Government of Japan to contribute to turning the SDGs into a reality. In the era of the SDGs, the role of the Japan’s Official Development Assistance (ODA) must be to pay more attention on the aspect of “*transformation*” in development cooperation by strengthening learning processes and stakeholder engagement. This paper will examine and articulate Japan’s new direction for global Health cooperation in the era of the SDGs, in which a holistic learning process for institutional development, systems transformation, and smart governance is proposed to nurture resilient societies, global well-being, and a sustainable future for our planet.

2. Japan's Experience as Active Learning Resource

In the era of the SGDs, institutional development and systems transformation needs to be enhanced by new perspectives inspired through interactive processes. As there is much knowledge accumulated in Japanese society, actual visiting programs to Japan can enhance creative thinking that can be obtained in no other way. In this sense, Japan is one of few countries that can contribute to providing full-content learning packages from a vast range of active resources. While many countries strive for transformative processes of designing and formulating health systems, they demand more specific and practical learning modules from Japan's experiences with policy innovations.

For an example of an active learning resource, the impact of population ageing in many countries demands crucial preparation to elaborate strategies that can transform social systems according to the resulting economic, demographic, and epidemiological transitions. The expansion of comprehensive long-term care should consider entitlements to all those who need them, including income transfers from the well-off to lower income, coming from a shrinking share of the economically productive population, to protect against impoverishing costs. While Japan has shown the most dramatic increase of its elderly population ratio among OECD countries and at the highest speed (Figure 3), long-term care programs in Japan are grounded in health expenditure profiles throughout the life cycle. Since the attainment of three dimensions of insurance coverage (population coverage: informal sector involvement by the National Health Insurance Act in 1961, financial coverage: financial protection by the Catastrophic Medical Expense Coverage Policy in 1973, service coverage: the introduction of the Specified Mixed Medical Care Coverage System in 1984), universal health insurance coverage in Japan has continued successive policy innovations to cover medical and non-medical costs for the elderly in an effective and efficient manner (Figure 4).

Figure 3: Projection of elderly population ratios

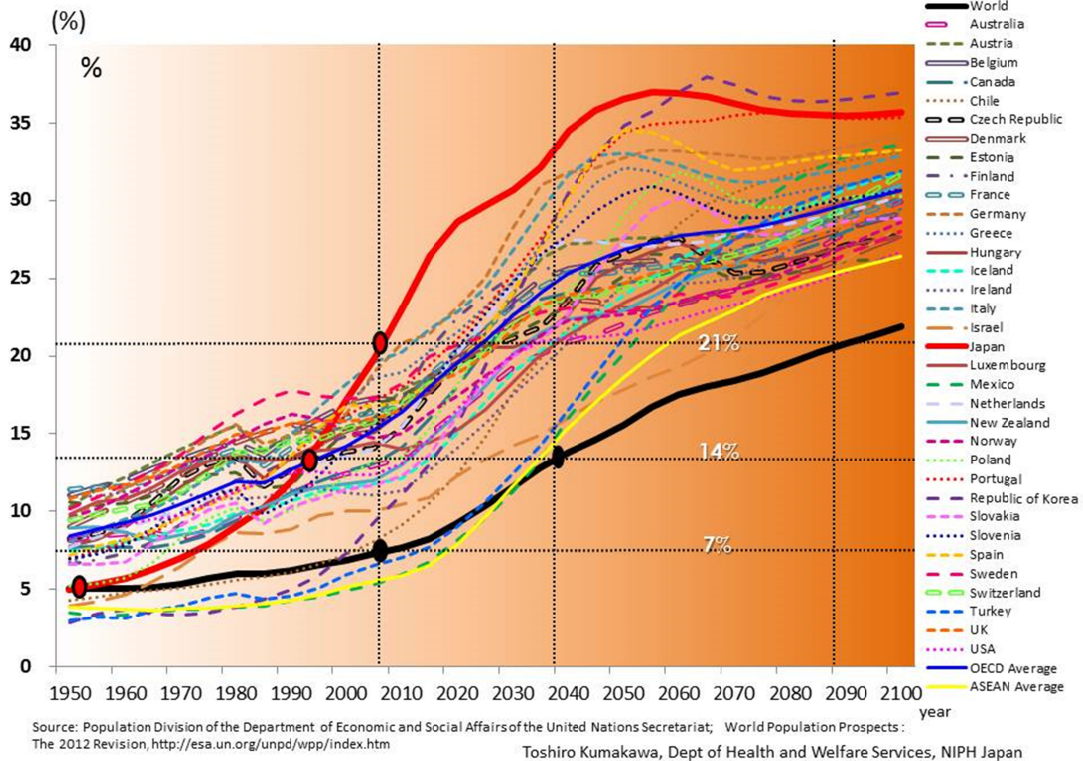
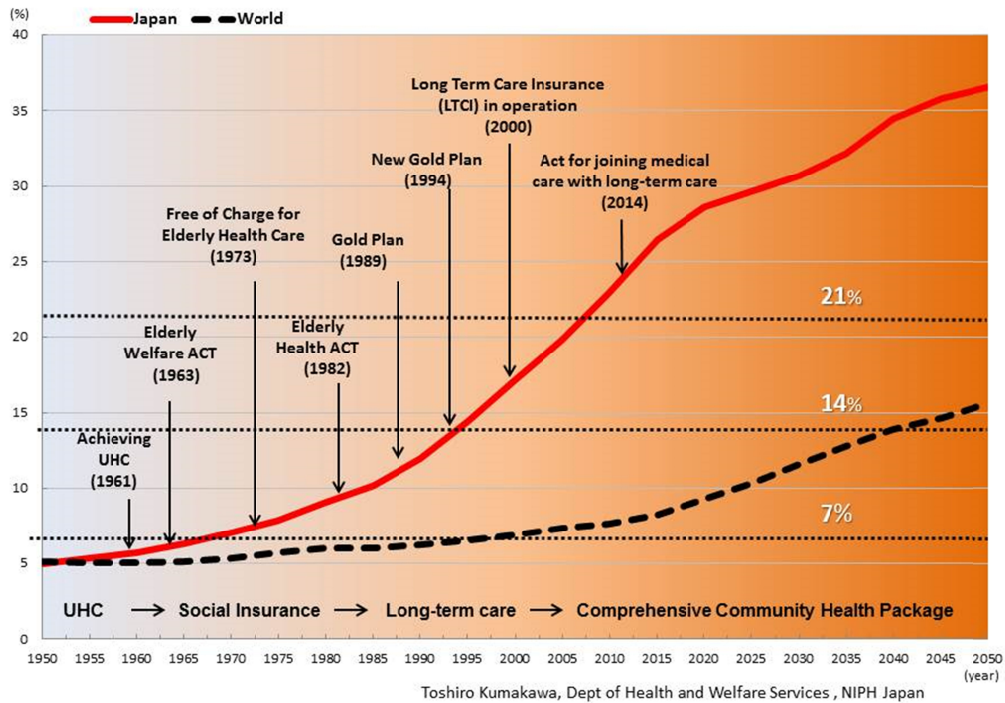


Figure 4: Policy innovation in Japan responding to demographic transition



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

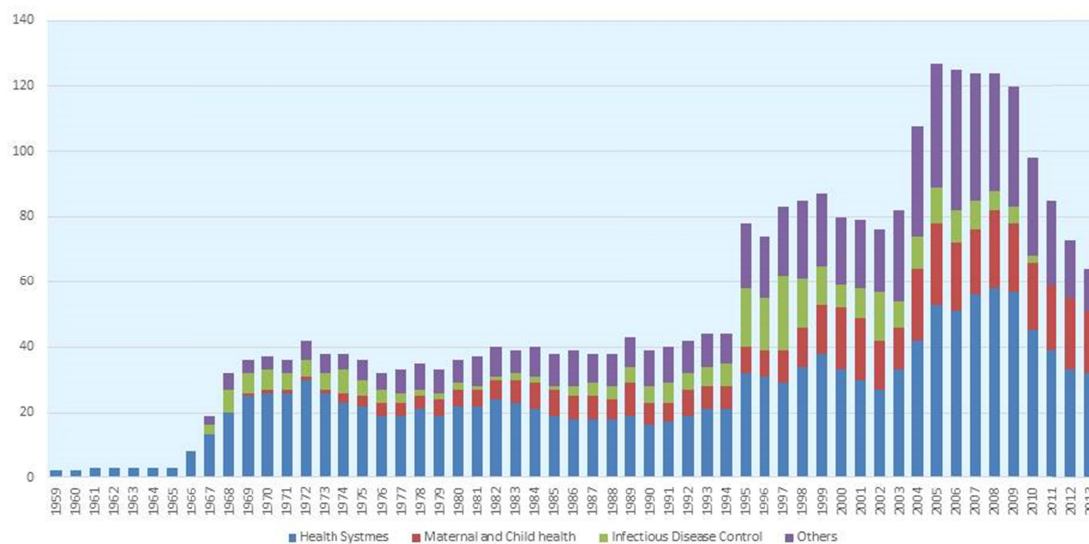
	1920-1959 (1940)*	1960-1975 (1970)*	1975-1989 (1980)*	1990-1999 (1990)*	2000 and after
General trends	Quantitative amplification of national and regional public health leaders Training of practitioners involved in PHC, such as maternal and child health and infections control	Development of human resource 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 trainees⁶. 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



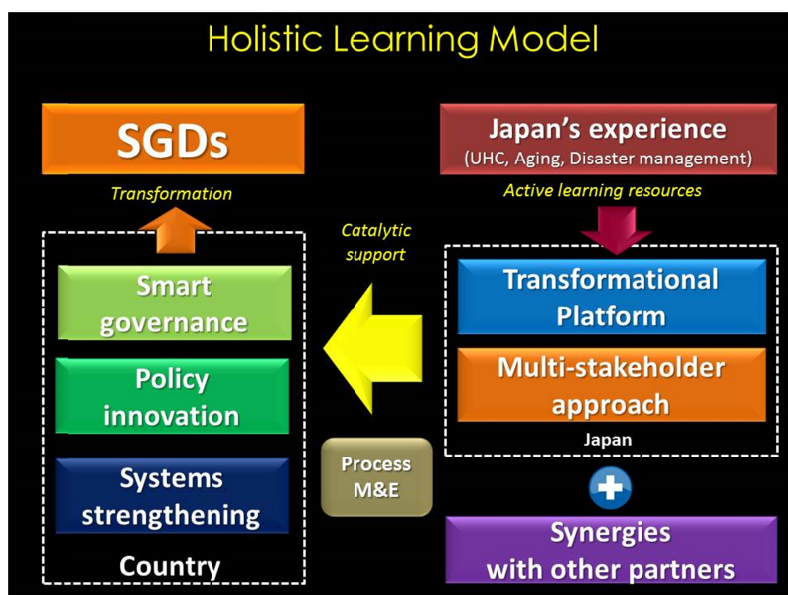
Although the introduction of history and lessons-learned from Japan’s experience on achieving universal health coverage are currently incorporated in many other training programs, those contents tend to be theoretical and merely introductory. Moreover, like other training programs provided by other agencies 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



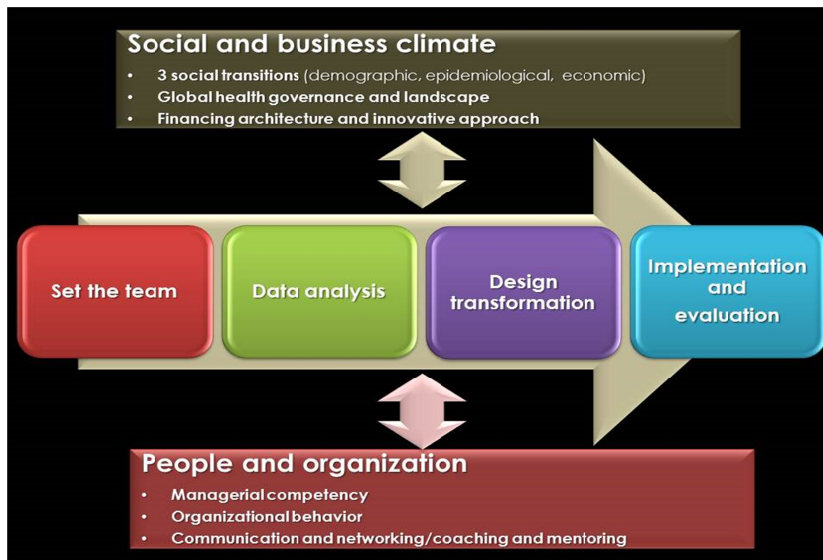
The process evolved in accordance with the theory of adult education⁸ and related educational reform agenda⁹. The learning process here to facilitate the integration and transformation of present systems becomes the means by which the government can deal critically with reality and articulate how the people can participate in the transformational process of the entire world¹⁰.

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).

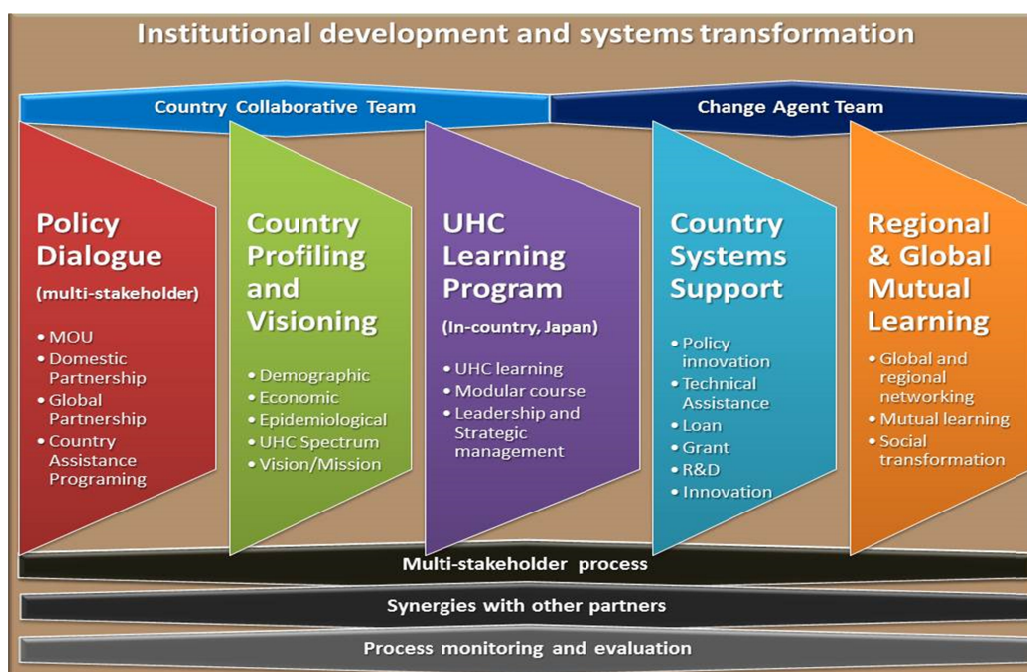
Figure 6: Organizational development



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

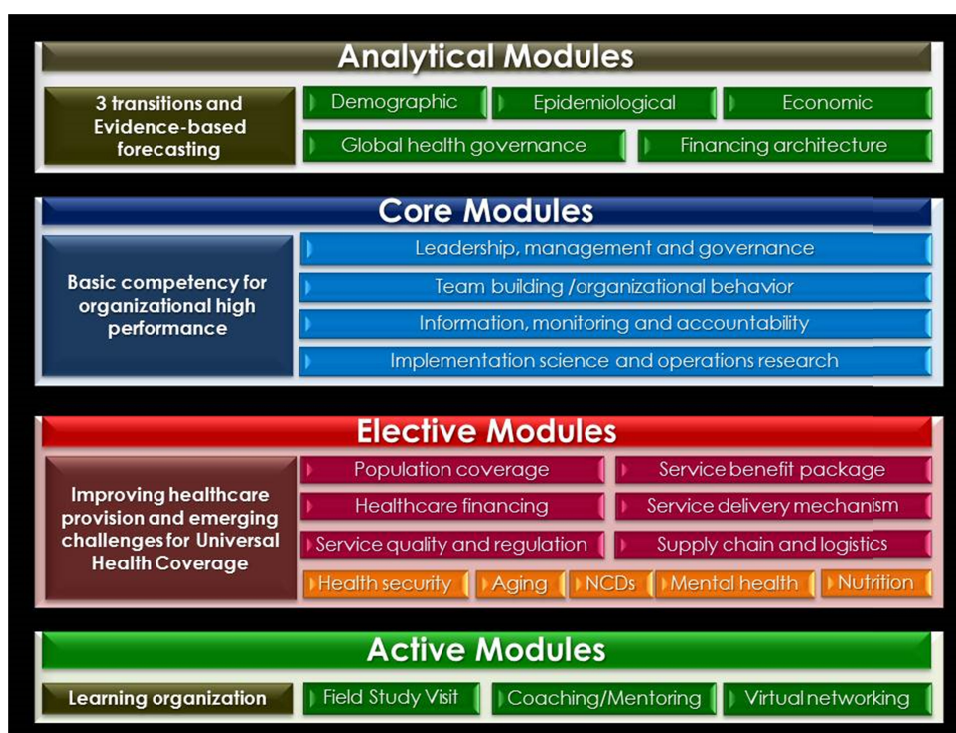
This platform has progressive sequences for institutional development and health systems transformation. At the initial engagement, the platform provides opportunities for policy dialogue with multi-stakeholder engagement. It is encouraged that an official agreement is reached through a Memorandum of 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.

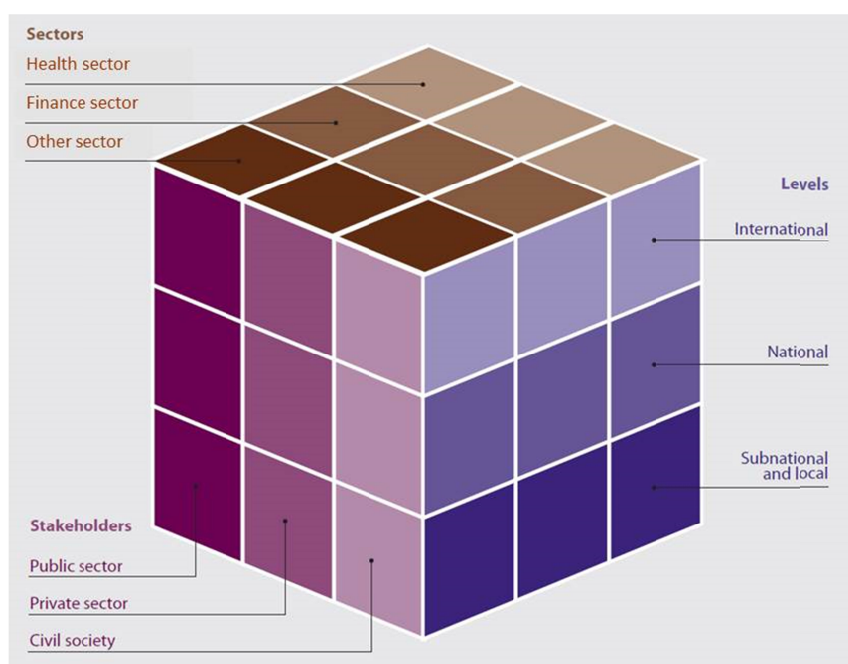
The platform is also supported by integrated efforts by other development partners and global initiatives. Since the Government of Japan became a signatory to the Global Compact of the International Health Partnership plus¹² in 2015, efforts on the aid effectiveness and harmonization should be mainstreamed 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 approach¹³ (see Column (3) Synergies with other global partners).

Multi-stakeholder approach

The multi-stakeholder approach¹⁴ 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 21¹⁵ adopted by the Earth Summit in 1992 and became an instrumental backdrop for the development of the SDGs¹⁶. 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



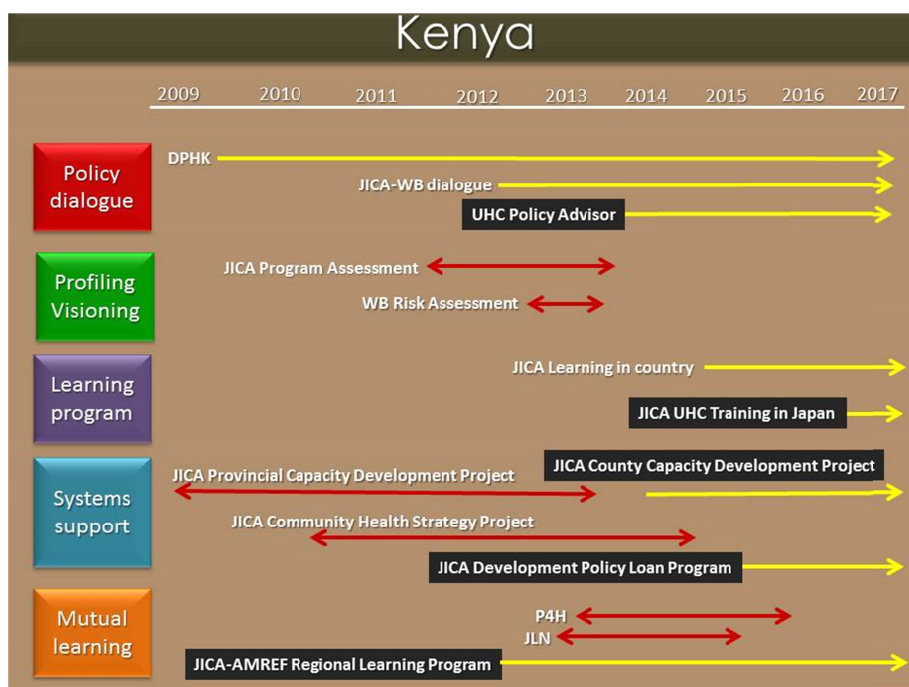
Solutions are often as complex as the problems, and all stakeholders have ideas about possible solutions and need to be part of them. The challenge is providing them with the fora to bring their wisdom to the table effectively and equitably¹⁷. Hence, multi-stakeholder approaches should enhance democracy 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

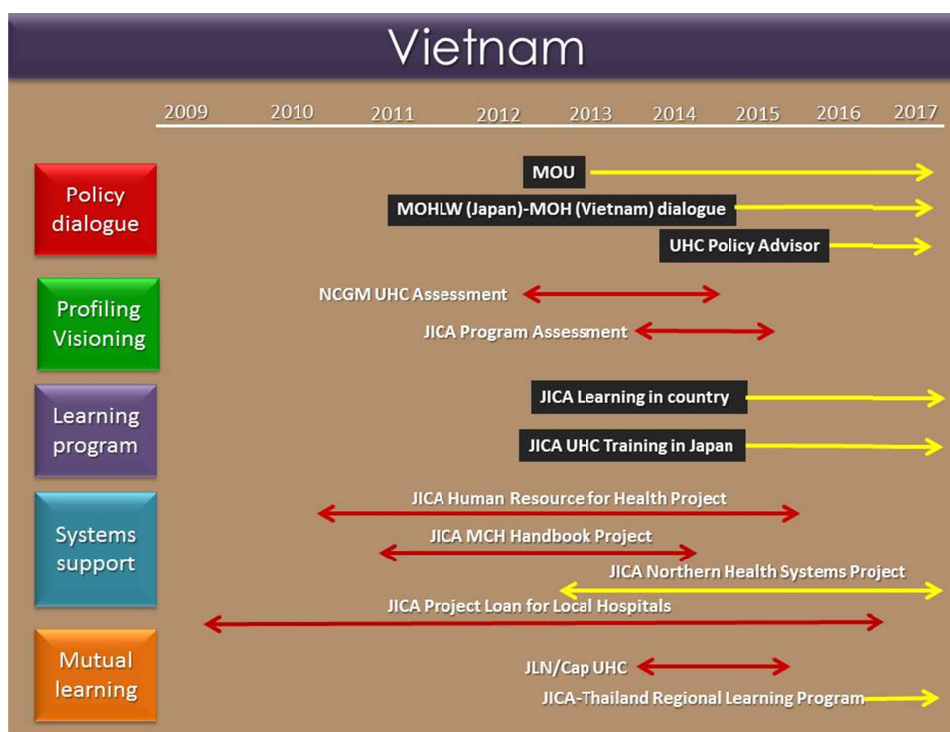
dispatching experts to the Ministry of Health. To develop local health managers for their managerial capacities in the devolution process and expand the provision of essential health services at the community level, JICA initiated seamless and dynamic interventions in the country such as the Project 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 continue¹⁹. (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 modalities²⁰. (Figure 11)

Figure 11, Holistic Learning Process in Vietnam



5. Conclusion

In the era of the SDGs, global governance is facing many challenges in power fragmentation, systemic complexity, and uncertainty. The rapid development of economic globalization and deepening interdependence of cross-border activity prove the relative absence of governance mechanisms capable of effectively tackling global public policy issues²¹. Across policy domains, there is an increasing presence of public and private actors engaged in core governance functions and generating much more uncertainty over predicaments.

Indeed, global governance for health is not just a matter of pandemics. It is a matter of global well-being and of the future of mankind. The relationship between good governance and well-being is significant and it is said that “the effects of good government remain as the single most important variable explaining international differences in life satisfaction in the full global sample, while international differences in per capita incomes are frequently insignificant²²”.

This is why we need to cherish the important aspect on “learning” and “transformation” in building smart governing systems. Japan has rich active learning resources and can lead the global community in building new governance mechanism through providing transformative platforms, in which all the stakeholders can engage in the process of defining and implementing solutions. This article articulates Japan’s new direction for global health cooperation, which signifies multi-stakeholder engagement in the holistic learning process to transform individual countries as well as the globe. Active learning resources in Japan explore experiential and substantial knowledge to tackle new global challenges posed by inequitable and unsustainable patterns of development. It is truly expected that Japan should show leadership to promote global movements through emerging dialogues and transformative processes toward realizing the SDGs. Commitment is never too late, even if starting today.

UHC Profiling and Spectrum approach

The Japan–World Bank Partnership Program on Universal Health Coverage articulated 11 country case studies and categorized countries representing a range of income levels and health systems. Group 1 countries are still setting national policy agenda for moving towards UHC; group 2 countries have made substantial progress toward UHC but still face substantial gaps in coverage; group 3 countries have recently achieved many UHC policy goals but face new challenges in deepening and sustaining coverage; and group 4 countries have mature health systems with UHC but still need to adjust their national policies to meet changing circumstances (Table 3).^{23,24} Even low-income countries with limited service coverage (typically belonging to group 1 above), according to the Japan-World Bank report, can start building institutional capacity, learn from the experiences of other countries, and adapt innovative approaches toward attaining UHC.

The guidelines for Japan’s Strategy on Global Health Diplomacy issued by the Government of Japan in June 2013 proposes a framework for differentiating UHC support in accordance with the status of development of developing countries focusing particularly on the physical, social and financial barriers to accessing health care.

In order to visualize and operationalize the framework, we have conducted a data-based categorization of countries that Japan put particular emphasis on collaborating with in the field of health: 12 developing countries with which Japan’s Ministry of Health, Labour and Welfare (MHLW) signed memorandums of understanding (MoU) for bilateral collaboration (Cambodia, Lao PDR, Viet Nam, Myanmar, India, Turkmenistan, Turkey, Bahrain, Brazil, Mexico, Iran and Qatar), other ASEAN member states (Thailand, Philippines, Indonesia and Malaysia) and four African countries (Kenya, Ghana, Senegal and Zambia). We also included notable developed countries (Japan, UK, USA, France and Sweden) as references.

Countries were scatter-plotted by indicators of health service access, namely % of deliveries by skilled birth-attendants (%SBA) and another one of health social security and financial protection, % of out-of-pocket payment among total health expenditure (%OOP). %SBA was used because it varied widely across different developing countries and was thus considered sensitive to physical and social barriers of access to health services

Figure 1 shows the result of the scatter-plotting. It identifies four groups of countries: (1) countries with poor service access and medium OOP% (Kenya, Lao PDR, Senegal and Zambia);(2) those with medium service access and high OOP% (India, Myanmar and Philippines); (3) those with good service access and medium OOP% (Indonesia, Mexico and Viet Nam); and those that generally attained UHC (Bahrain, Qatar, Thailand and Turkey).

Figure 1 OOP% and deliveries attended by SBA

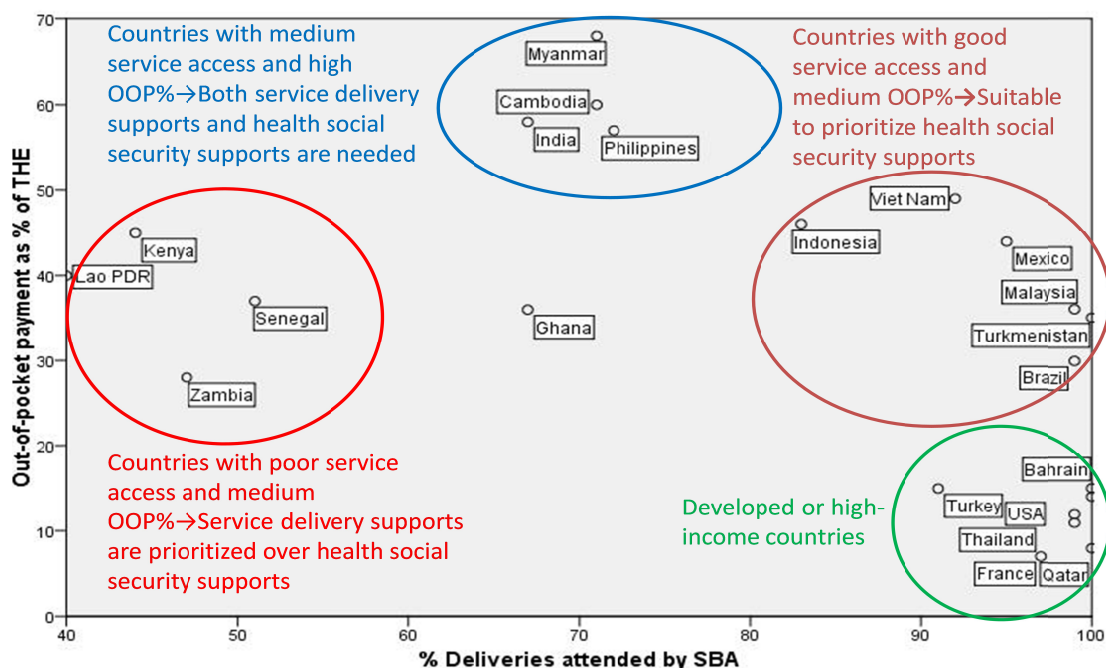


Table 1 presents a framework of differentiating UHC support, as originally proposed by the guidelines for Japan’s Strategy on Global Health Diplomacy, reflecting country categorization based on the above analysis. It provides a practical direction for how to formulate support toward UHC according to where different countries are in health development. For different country categories, different foci of Japan’s UHC supports can be set as following:

- Countries with poor service access and medium OOP% (corresponding to Group 1 in the Japan-WB study): UHC supports should focus on expanding health service coverage among the poor and vulnerable populations. However, designing and introducing health social security in the mid- to long-term should be considered. For this category, public financing including grant-based official development assistance (ODA) and development loans (where appropriate) will be the key financing mechanisms for support.
- Countries with medium service access and high OOP% (a subset of Group 2 in the Japan-WB study): UHC supports should focus both on further expanding health service coverage and establishing a health social security scheme. As in the case of the above category, public financing will be the key financing mechanism.
- Countries with good service access and medium OOP% (a subset of Group 2 in the Japan-WB study): UHC support should focus on establishing a health social security scheme. Considering their middle-income country profiles, public financing should be effectively linked with private financing (e.g. ODA to support institutional development for risk-pooling health financing schemes, while private companies provide technical solutions in the field of information and communication technology (ICT) to operationalize it).
- Countries that have generally attained UHC (corresponding to Group 3 in the Japan-WB study): UHC support should focus on maintaining and improving established health social security schemes. Given their quasi-developed status, public financing will only play a catalytic role, and private entities will play the major role.

Country profiling with other indicators derived by new data platforms such as the Primary Health Care Performance Initiative (PHCPI) and those of demographic and epidemiological transitions will enable further elaboration of the UHC support strategy. However, in actual project formation, country-by-country approaches with careful policy dialogue will be required.

Table 1: Framework of differentiating UHC support in accordance with the status of health development with country categorization by coverage of skilled birth attendants and degree of health social protection*

Category	Profiles	Case country	Focus of Japan's supports	Note
1	Countries with poor service access and medium OOP%	Kenya, Lao PDR, Senegal and Zambia	Expanding health services coverage among the poor and vulnerable population (consider designing and introducing health social security in mid to long-term).	Corresponding to Group 1 in the Japan-WB study
2	Countries with medium service access and high OOP%	India, Myanmar and Philippines	Further expanding health service coverage AND establishing health social security scheme.	Corresponding to Group 2 in the Japan-WB study
3	Countries with good service access and medium OOP%	Indonesia, Mexico and Viet Nam	Establishing health social security scheme.	Corresponding to Group 2 in the Japan-WB study
4	Countries that generally attained UHC	Bahrain, Qatar, Thailand and Turkey	Maintaining/improving health social security scheme.	Corresponding to Group 3 in the Japan-WB study

Note: *Measured by % of out-of-pocket payment among total health expenditure (%OOP)

Synergies with other global partners

The World Bank in collaboration with Harvard University has offered training on “Health Sector Reform and Sustainable Financing” since 1996 and restructured its course focusing on UHC from 2013. The eight day course offers lectures and discussion on how to improve health system performance to meet UHC goals. While its focus is on health financing, it also covers political economy, health systems management and human resources, and equity aspects were covered in an optional session. While the course provides substantial time for discussion and group work using county cases, it tends to limit country specific questions and answers, as the course targets participants from different countries, and less represented countries have to join larger country teams for group work.

The WHO commenced an “Advanced Course on Health Financing for Universal Health Coverage for UHC for low and middle income countries” in 2014, based on its health financing course (Barcelona course) targeted to European countries. The five-day course specifically focuses on function of health financing—revenue collection, pooling, and purchasing—and requires advanced knowledge and experience in health systems. Again, as this is a global course, it faces similar challenges of being able to dive deep into country specific challenges.

There are several other technical expertise and learning networks concerned with UHC. P4H, the Social Health Protection Network, has since 2014, starting with a team of six African countries, designed three regional modules for in-country support that focus on practical expertise required to implement UHC-related leadership reform, situation analysis, management, and commutation. Cap UHC (Capacity building on Universal Health Coverage), hosted by Thailand provides tailored workshops based on county needs and specific request to offer practical solutions based on the experience of Thailand. The Joint Learning Network (JLN) with 22 member countries offers different types of learning opportunities, aiming to bridge theory and practical implementation of reforms through a knowledge portal, with occasional face-to-face meetings.

In general, the majority of the trainings and learning opportunities provided have focused more on health financing aspects with less focus on service delivery. While global trainings offers theories plus group work, they face limitations in practically answering the countries’ specific needs. P4H focuses on practical skills rather than health financing theory, and Thailand custom makes trainings based on the participating country’s needs and its own experiences (Table 2).

In May 2015 Japan signed the global compact under the International Health Partnerships Plus (IHP+)²⁵. Japan’s ODA has been encouraged to promote aid effectiveness both at the country and global levels according to the Paris Declaration and Busan Partnership Agreement. Those global collaborative works have to be incorporated into Japan’s new ODA schemes to promote more synergetic effects in country assistance programs.

Table 2 Global UHC training program and collaborative

	World Bank	WHO	P4H	CapUHC (1)	CapUHC (2)
Title	Health Systems Strengthening and Sustainable Financing: The Challenge of UHC	Advanced Course on Health Financing for Universal Coverage for low and middle income countries	Leadership for UHC: Supporting Leaders to Deliver Result	- Capacity Building - experience sharing of Thai case study (2015-2017)	(Tailor-made) Workshop
Duration	8 days in December, 2013 * 5 days training was held as a short version for Asian region in March, 2014	- First: 5 days in September, 2014 - Second: 5 days in June, 2015	As a total, 12 months mixing attendance based learning (3 modules) and practice sessions with on-the-job application phases.	- Third in 2012: 6 days in November, 2013 - Training in 2015: 5 days in August	2-6 days (duration is not fixed as the training is tailor-made according to the needs and levels of trainees)
Venue	- 2013: Tokyo, Japan - 2015: Washington, USA (unfixed)	- 2013: Tunis, Tunisia - 2014: Barcelona, Spain	- Module 1: South Africa - Module 2: Kenya - Module 3: Turkey	Bangkok, Thailand	Bangkok, Thailand
Number of Trainees and Target Members	73 members from 23 countries participated in the training in 2013. Many of them were from ministries and educational institutions such as universities.	About 50-60 members are expected to participate in each training. 55 members from 27 countries attended in the second training. Major targets are policy makers, advisors and analysts in the health and social sectors, senior managers of service provider organizations and health insurance funds, and other relevant actors in government	39 trainees from 6 countries (Kenya, Ethiopia, Nigeria, Uganda, Zambia, South Africa) participated in 2014. Many of them were at director level in ministries of health, labor or finance. Others are in leadership positions in national health or social insurances, as well as civil society organizations.	25- 30 members from low and middle income countries are expected to participate in each training. First in 2012: 12 members from 4 Asian countries Second in 2012: 36 members from 7 Asian countries Third in 2012: 35 members from 7 Asian countries Many were from ministries of health and health insurance bureau.	Participants are encouraged to apply as a group of at least 3 people from same country for effective group discussion using participants country experiences as inputs in program learning activities.
Contents	The course provides opportunities to analyze the best design of health systems and financing according to the country's respective condition ● Definition	●	The followings are the main objectives of the course. ● Defining the resources in and the challenges of UHC work, e.g. values and trade-offs ● Analyzing the UHC	The followings are introduced as the contents of the annual international training course on UHC in 2005, 2006 and 2007. ● Introduction of Thai UC scheme	The workshop will be suitably designed according to the needs and levels of participants (policy level and technical level) with the selected contents. ● Overview of Thai

	<ul style="list-style-type: none"> ● Different strategies ● The Flagship framework ● Ethics and the political economy ● quality, efficiency and access ● Financing options ● Paying and reimbursing providers ● design of benefit packages ● Setting priorities and controlling expenses ● Health promotion and prevention in making UHC feasible ● Improving performance in the public sector ● The private sector: contracting and regulation ● Leadership for implementing change 	<p>reform environment, e.g. interests, allies, and sources of opposition</p> <ul style="list-style-type: none"> ● Gaining skills to build effective alliances and broker consensus and commitment ● Applying modern management techniques in implementing a UHC change project ● workshops and on their job site, in which they are finally expected to come up with actual plan of their collective action. 	<ul style="list-style-type: none"> ● Calculation and adjustment of government budget requirement for Thai UC Scheme ● Application of close-end budget provider payment methods i.e. capitation and DRG with global budge in Thai UC Scheme to public and private health care providers ● Quality assurance and people's satisfaction, ● Monitoring and evaluation system ● Information System to support the movement of UC Scheme 	<p>Health system and UHC</p> <ul style="list-style-type: none"> ● Population coverage expansion ● Policy process towards UHC ● Policy implementation ● Design of benefit package ● Effective purchasing and provider payment methods ● Capitation, DRG ● Intelligence of health systems ● Heath information systems ● Monitoring and evaluation of outcome ● Governance of insurance fund ● Field visit to various organizations ● Quality of healthcare
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Remarks	<p>The course gives more weight on health financing and includes practical contents related to leadership, governance and political analysis.</p> <p>It applies 5 control nobs framework as flagship model to analyze countries' UHC and health systems.</p>	<p>The focus is on policy and strategic decision making, rather than the details of how to implement reforms. As this is an advanced course, participants are expected to have extensive and relevant work experience and knowledge of health financing policy, and previous training in health systems and policy</p>	<p>The course has unique structure having attendance based workshops and on-the-job application phases in between. Another characteristic is to target country team consisting of members from different background (government, social health insurance body, CSO etc).</p>	<p>The course provides opportunities of concrete learning from Thai UHC experiences and covers not only health financing but wider range of topics than other UHC training.</p>	<p>Remarkable point is that the contents can be arranged in a way to fit to the needs and levels of participants.</p>
Other Notes	<p>The flagship course started in 1996 and provided the opportunities to learn about health systems strengthening. Topics related to UHC have been included in the course since 2012.</p>	<p>The course on health financing started in 2011. UHC have been focused in the course since 2013.</p>			
Source	<p>http://wbi.worldbank.org/wbi/event/challenge-universal-health-coverage2013-global-flagship-course-health-system-strengthening-</p>	<p>http://www.who.int/health_financing/hfcourse/en/</p>	<p>http://p4h-network.net/global/cpd/ http://health.bmz.de/events/In-focus/Leading-the-way-to-Universal-Health-Coverage/LeadershipTwoPager_v2.pdf</p>	<p>http://www.ihppthaigov.net/capuhc/images/Activity_2012-1_Workshop_27_Feb-3_March_2012.pdf http://www.ihppthaigov.net/capuhc/images/Activity_2012-2_Workshop_23-28_July_2012.pdf http://www.ihppthaigov.net/capuhc/images/Activity_2012-3_Workshop_19-24_Nov_2012.pdf</p>	<p>http://www.ihppthaigov.net/capuhc/images/brochurecapuhc%20a4.pdf</p>

Group 6 - Challenges in global governance

The members of the Group 6 have worked on the issue of Global Health Governance based on lessons learnt from the Ebola responses. Two papers were produced - one on the analysis of broad global health governance issue and the other more focused on the PPPs (Public Private Partnerships) especially of research and development (R&D) during an emergency.

The first paper, Global Health Governance: Analysis and Lessons Learned from the Ebola Virus Disease Outbreak and the Identification of the Future Response Options, written by Hideaki Shiroyama, Yasushi Katsuma and Makiko Matsuo, aims at providing a broad analysis of the process of the Ebola response and present options for responding the potential future outbreaks.

The paper revealed that although much criticism was directed towards the shortcomings of WHO responses (i.e. delayed PHEIC, lack of leadership, lack of coordination mechanism at 3 levels etc), issues were not limited to the issues of WHO itself but also the issues concerning the affected countries (i.e. fragile health system, reluctance of the government etc) as well as the lack of utilization of existing UN frameworks (UNDP, OCHA, UNICEF, WFP etc) at the country/regional and international level).

The paper present following response options for the future possible global health crisis. To enhance response capability during the emergency, paper makes four points. First, it proposes to introduce a multi-staged framework as opposed to binary PHEIC decision making. Second, it supports the recent WHO decision to put in place integrated programme for emergency. Third, it explored cross-sectoral coordination patterns in accordance with the situation categories and emphasized the importance of the role of "switching function". Fourth, it supports the movement of building the financing mechanism for the emergency (i.e. WHO contingency fund for emergency and World bank's Pandemic Emergency Facility). In addition, in order to prevent the health crisis, the paper considers it important to strengthen health system under normal conditions. For that purpose, it is strongly suggested that the IHR core capacity be implemented. Countries and international organization including those beside health sectors (i.e. trade, development and aiding framework etc) should all cooperate to engage in building frameworks to support IHR implementation. There should also be a comprehensive funding mechanism for health system.

The second paper, Public-Private Partnerships for Strengthening Global Health, is written by Sayako Kanamori, Jonas Kemp and Charlotte Sauter.

One of the major lessons learned from the recent Ebola outbreak and its response is the importance of developing an effective and efficient global research and development (R&D)

framework during an emergency.

In this paper, we performed an analysis based on the 7-S Framework, which evaluates how well the resilient global R&D framework can be developed to effectively counter infectious disease threats: (1) structure; (2) style and skill; (3) stakeholders and staff; (4) shared value; (5) strategy; (6) system; and (7) size. Based on the analysis, we propose four recommendations.

Firstly, the World Health Organization (WHO) should lead in establishing an independent Pandemic Product Development Committee (PPDC), supervised by the Technical Governing Board (TGB). The PPDC should remain independent primarily to promote private-sector involvement. The committee should include public health/ regulatory and R&D experts of major pharmaceutical manufacturing countries and representatives from each WHO regions, with a size of less than 15 members respectively. The TGB should be comprised of representatives from the UN Family, regulatory agencies, industries and research organizations.

Secondly, the PPDC should work to define priorities, map global R&D progress, raise and manage the budget including gap analyses, and draft a pandemic-preparedness plan that illustrates R&D's role, responsibility, and operations during an emergency.

Thirdly and the most presumably important, the PPDC should focus to lead design-institutional arrangements on various regulations for R&D, including approval, during an emergency. Given the fact that it is extremely important to swiftly counter pandemics, it is reasonable to redesign existing protocols and frameworks: especially during clinical trials, manufacture, and approval of medical products as these three phases often require the most time and investment.

Lastly, the PPDC should work to secure and deploy a minimum of US \$1 billion per year, which is relevant to half of the annual budget for global PDPs, to implement operations described above.

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- ¹ Japan International Cooperation Agency Team (*Yoshiharu Yoneyama, Ikuo Takizawa, Maki Ozawa, Tomoko Ono*)
- ² National Center for Global Health and Medicine Team (*Chiaki Miyoshi, Hitoshi Murakami*)
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