Japan's Global Health Strategy in the Post–Covid-19 Era

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Issues of UHC Strategy During and After the COVID-19 Era

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Nearly two years have passed since the SARS-CoV-2 novel coronavirus (COVID-19) was first detected in Wuhan, China. To combat the ongoing COVID-19 pandemic and prepare for the risk of future pandemics of new infectious diseases, countries throughout the world are rapidly developing new national strategies and global initiatives. However, universal health coverage (UHC), which the Japanese government has long advocated as a possible cornerstone for solving various health issues including infectious diseases, has still not been viewed as a priority in terms of pandemic preparedness and response. This paper explores how we should view UHC both during and after the COVID-19 era, looking back at the changes in policy discourse on UHC, especially since the 2016 G7 Ise-Shima Summit, and taking into account what we have learned from COVID-19.

How have UHC and its associated concepts evolved over the last five years?

UHC is defined as ensuring that "all people have access to the health services they need, when and where they need them, without financial hardship. It includes the full range of essential health services, from health promotion to prevention, treatment, rehabilitation, and palliative care."[1] In 1961, Japan created its own version of UHC when it established a universal health insurance coverage system that ensures all citizens have access to good quality health services without fear of financial hardship. The system has contributed to the country's economic growth as well as to today's longevity society.[2]

In 2016, the World Health Organization (WHO) presented a new framework that combines the United Nations Sustainable Development Goals (SDGs) along with the concepts of UHC,[3] health systems strengthening (HSS), and global public health security (GPHS),[4] as shown in Figure 1. Subsequently, in 2019, a Political Declaration was adopted at the UN General Assembly High-Level Meeting on UHC. That declaration gave a broader meaning to UHC, which had hitherto been regarded merely as one of the SDG targets (SDG target 3.8), by redefining it more broadly as being not only fundamental for achieving SDG 3 but also essential to attaining the SDGs as a whole (hereinafter, "UHC broadly defined"). At the same time, in addition to disease-based approaches, many concepts were reorganized under the umbrella of UHC, including primary health care (PHC) and GPHS. Moreover, 165 countries and 10 relevant organizations around the world agreed on specific commitments to achieving UHC with milestones set for 2023 and 2030.
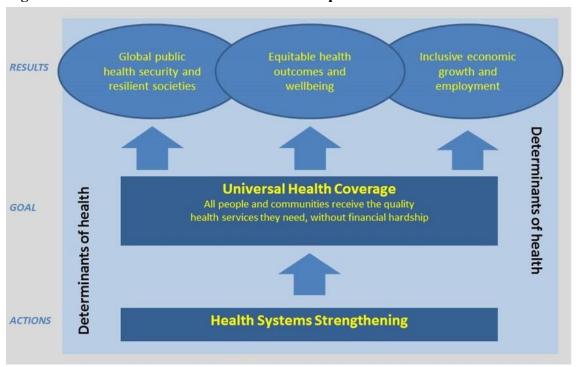
Figure 1. A new WHO Framework for UHC as part of the SDGs

Source: Denis Porignon, "Health Systems Governance for UHC: From Global Policy to Operations in Countries," WHO, 2016 (slide presentation).

Status and issues related to UHC, GPHS, and HSS

Prior to the COVID-19 pandemic, what were the policy debates concerning UHC, GPHS, and HSS?

In discussions of UHC, the emphasis was on initiatives to ensure access to health services and financial protection (indicators for SDG target 3.8). In terms of GPHS, the focus was on prevention, detection, and response, which were considered the core capacities related

primarily to infectious disease measures under the International Health Regulations (IHR), as well as health systems capacity and technology in each of those phases. And for HSS, the provision of clinical services through the enhancement of the six building blocks of the WHO Health Systems Framework was the main emphasis. The concepts do, however, have some commonalities. For example, UHC and GPHS are similar in that they both aim to avoid potential health and associated economic risks, and both involve the perspective of human rights protection. And while there are differences—for example, the risks to be avoided are at the individual level for UHC and at the group level for GPHS, and priorities are set from a domestic standpoint for UHC and mainly from the standpoint of supporting other (low-income) countries for GPHS—nonetheless, it has been pointed out that the objective should be to produce synergies among them rather than continuing to pursue separate policies and initiatives for each concept.(5) Similarly, it was argued that although HSS contains many UHC-related elements, it should be redefined in such a way that helps strengthen GPHS as well, for example, by embedding the IHR core capacity requirements.(6) In other words, arguments were made even before the pandemic for the importance of creating a framework whereby the three concepts of UHC, GPHS, and HSS are organically linked. Furthermore, looking at the respective evaluation frameworks for these three concepts, it was also pointed out that the UHC and GPHS frameworks were lacking in terms of the perspective of assessing initiatives to address the social determinants of health (particularly gender and ethnicity) and vulnerable populations.(7)

In light of these concerns, endeavors have been made to create a framework that organically links UHC, GPHS, and HSS. One such attempt was a concept analysis. A group of researchers mapped the elements contained in UHC, GPHS, and HSS, and having identified the commonalities and differences between them, concluded that the elements shared by the three concepts are health personnel, access to pharmaceuticals, and health financing and protection against financial risk. They asserted that strengthening these elements first should make it possible to create a comprehensive framework covering UHC, GPHS, and HSS.[8] Another method proposed was to analyze it using evaluation frameworks: it was posited that concurrently implementing the IHR Joint External Evaluation (JEE), which is a GPHS appraisal tool, and the Service Availability and Readiness Assessment (SARA), a tool to monitor systems and conditions for providing health services, would allow evaluators to identify the elements linking the three concepts and would enable the creation of a comprehensive framework covering all three. Lastly, another possibility raised was to use case study analyses to examine the outcomes and evaluation axes of the individual projects deemed to have succeeded in organically linking UHC with GPHS, which could serve as a reference for how to create a comprehensive framework covering UHC, GPHS, and HSS.

In spite of these endeavors, it was frequently noted that the fact that no synergies have been created between UHC, GPHS, and HSS is likely because there are self-interests of individual nations at play, meaning that the varying intentions of each donor country cause international cooperation to be fragmented and compartmentalized, which results in a lack of synergy. In addition, some are of the opinion that, given the problem of low- and middle-income countries'

dependency on foreign aid, international organizations, as neutral actors, must level the balance of power.

UHC issues brought to light by COVID-19

What UHC-related issues have newly come to light during the COVID-19 pandemic?

First, it must be stressed that achieving UHC is an urgent goal. This is evident from both the critical role that UHC is reported to be playing in combatting COVID-19,[9] and the fact that the importance of UHC has been reiterated by both the UN Secretary-General and the WHO Director-General during this crisis.

Meanwhile, as has been pointed out for some time, it has become clear that, as seen in Japan's experience, achieving UHC in a narrow sense through HSS does not result in the strengthening of GPHS or the creation of a healthy society through those systems. Therefore, what is needed first, both during and after the COVID-19 era, is to rebrand UHC broadly defined as something like "UHC for Wellbeing," with the aim of emphasizing how it is related to GPHS. As part of this undertaking, it is also critical that the pertinent concepts—most notably HSS, PHC, and social determinants of health—be reorganized and redefined.

In regard to the concept of HSS, some have argued in recent years that systems should be built in such a way to help improve health across the entire life course because that in turn will help to both strengthen UHC and combat pandemics. This way of thinking is familiar to Japan, which has become a super-aged society ahead of the rest of the world and is now promoting a community-based integrated care system. In addition, the fact that the UHC/Life Course Division was one of the three new UHC-related units created at the WHO as part of its 2019 organizational restructuring suggests that this is a domain in which Japan can exert its leadership. The significance of human security should also not be forgotten. In fact, the connection between the COVID-19 pandemic and such developments as the fall in the birth rate and increases in unemployment and suicides has been noted in Japan and elsewhere,[10] reminding us once again of the importance of multisectoral, multistakeholder collaboration.

Furthermore, to put the rebranded UHC concept into practice, it is essential to secure specific commitments with a focus on the relationship of UHC to GPHS in particular, and to develop the necessary evaluation criteria and the framework for monitoring and evaluation. Although it is expected that UHC broadly defined—as agreed to in 2019 by 165 countries and 10 relevant organizations around the world—and its related numerical targets and other commitments, are all expected to help strengthen GPHS, they do not necessarily focus on GPHS. UHC monitoring under UHC2030, an international public-private partnership that promotes UHC, currently uses evaluation criteria that correspond to UHC in the narrow sense—namely, SDG targets 3.8.1 and 3.8.2. The planning and actions taken to attain UHC are not governed by binding international rules but rather are left fundamentally to the discretion of individual countries, which makes it all the more important to have specific commitments and to establish criteria for monitoring and evaluation.

Finally, to make those commitments a reality, initiatives must be implemented that promote fundamental financial reform and a balanced mobilization of resources. As noted above, the dependency on foreign aid of low- and middle-income countries and the highly fragmented foreign aid regime that reflects the varying intentions of donor countries may particularly exacerbate the decoupling between UHC and GPHS. In Japan, meanwhile, the friction between national and local governments was exposed by the COVID-19 pandemic. Going forward, there will be a greater need than ever to bolster coordination mechanisms at the local, national, regional, and global levels, as well as to continue measures to increase public spending on health, with a special emphasis on PHC, by at least 1 percent of GDP or more, in accordance with national contexts and priorities, as agreed upon in the 2019 Political Declaration on UHC, and to create a system whereby the funds raised are allocated in a balanced way in line with local needs.

Notes

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(2) Ezoe S, "UHC shuryuka ni muketa kokusai doko to Nihon no torikumi—Kokuren Sokai UHC haireberu kaigo wo chushin toshite" [International trends and Japan's efforts toward mainstreaming UHC: With a focus on the UN General Assembly High-Level Meeting on UHC], in *Global Health Governance* [in Japanese], written and edited by Shiroyama H (Tokyo: Toshindo, 2020), 135–65.
(3) In this paper, the UHC concept prior to the High-Level Meeting on UHC is referred to as UHC in the narrow sense.
(4) In this paper, GPHS is defined as the concept of global health security that reflects the all-hazard approach in line with the revised IHR. Global health security herein means health security that targets threats beyond the national borders and focuses on actions and preparedness at multinational, regional, and global levels.
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