

Health Professional Meeting (H20) 2019
Road to Universal Health Coverage

REPORT

June 13th & 14th 2019
Hilton Tokyo Odaiba



The banner features the JMA logo on the left and the WMA logo on the right. The central text reads "Health Professional Meeting (H20) 2019" and "Road to Universal Health Coverage". Below this is a stylized illustration of the Tokyo skyline with the word "TOKYO" in large, colorful letters. The "O" is red, "K" is blue, "Y" is green, and the second "O" is teal. The skyline includes the Tokyo Skytree, various skyscrapers, a red car, and a train. At the bottom, it states "Physician pre-conference to the G20 Summit 2019 in Japan" and "June 13th & 14th 2019, Hilton Tokyo Odaiba, Tokyo".

Health Professional Meeting (H20) 2019
Road to Universal Health Coverage

Physician pre-conference to the G20 Summit 2019 in Japan
June 13th & 14th 2019, Hilton Tokyo Odaiba, Tokyo



Japan Medical Association

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PROGRAM

Health Professional Meeting (H20) 2019 Road to Universal Health Coverage

Day 1, Thursday June 13th

Moderator: **Mari Michinaga**

Executive Board Member, JMA, Vice-Chair of Council, WMA

Greetings

Yoshitake Yokokura, *President, JMA, Immediate Past President, WMA*

Leonid Eidelman, *President, WMA, Immediate Past President, Israeli Medical Association*

Congratulatory Messages of Guests

Guests of Honor

Her Imperial Highness the Crown Princess

Shinzo Abe (*Video message*)

Takumi Nemoto (**Yasuhiro Suzuki**, *Chief Medical & Global Health Officer, MHLW*)

Keynote Addresses

Session Chair: **Miguel Jorge**, *President-Elect, WMA, Member of the Executive Committee, Brazilian Medical Association*

Keynote 1/ Health Inequities and Social Determinants of Health

Sir Michael Marmot, *Professor of Epidemiology, University College London, Past President, WMA*

Keynote 2/ Towards Universal Health Coverage - What we need? -

Naoko Yamamoto, *Assistant Director-General, UHC/Healthier Populations, World Health Organization (WHO)*

Response/ Defining Roles and Functions in Primary Health Care Teams

Mukesh Haikerwal, *Past Chair of Council, WMA, Past President, Australian Medical Association*

Session 1: Viewpoints on How to Achieve UHC

Session Chair: **Osahon Enabulele**, *Chair of Socio-Medical Affairs Committee, WMA, Past President, Nigerian Medical Association*

Speech 1/ Patients Perspective Towards Attainment of Universal Health Coverage

Ellos Lodzeni, *Board Member, International Alliance of Patient's Organizations*

Speech 2/ Health Workforce: Strategic investments on the road to UHC

Giorgio Cometto, *Coordinator, Health Workforce Department, WHO*

Speech 3/ What is the Role of Medical Professionals for Achieving UHC?

- Lessons learned by The Global Fund and the globe -

Osamu Kunii, *Head, Strategy, Investment and Impact Division (SIID) The Global Fund to Fight AIDS, Tuberculosis and Malaria*

Speech 4/ UHC: Medical Association Perspective

Jacqueline Kitulu, *President, Kenya Medical Association*

Speech 5/ Universal Health Care in India

Ravindra Wankhedkar, *Treasurer, WMA, Immediate Past President, Indian Medical Association*

Comments

Oscar D. Tinio, Past President, Philippine Medical Association

Chukwuma Oraegbunam, Chair, WMA Junior Doctors Network, Nigeria

Batool Al-wahdani, President, IFMSA, Jordan

Panel Discussion

Day 2, Friday June 14th

Moderator: **Mari Michinaga**

Executive Board Member, JMA, Vice-Chair of Council, WMA

Summary of the First Day

Otmar Kloiber, Secretary General, WMA

Session 2: Health Security and UHC

Session Chair: **Masamine Jimba**, Professor, Department of Community and Global Health, Graduate School of Medicine, The University of Tokyo

Speech 1/ Trust - Health Security and UHC -

Takao Toda, Vice President for Human Security and Global Health, JICA

Speech 2/ The ICRC and Universal Health Coverage

David Maizlish, Head of Delegation ad interim, ICRC Delegation in Japan

Speech 3/ Ensuring UHC Leaves No Patient Behind

Clara van Gulik, International Medical advisor, MSF Japan

Speech 4/ Health Systems Resilience: A foundation for universal health coverage and health security in Thailand

Walaiporn Patcharanarumol, Director of International Health Policy

Program, Ministry of Public Health, Thailand

Discussion

Session 3: Political Dimension of UHC/PHC, Role of Medical Professions

Session Chair: **Hiroki Nakatani**, Executive Board Member, WHO, Project Professor at the Global Research Institute at Keio University

Speech 1/ Building Success with a Strong Professional Workforce. Country example.

Walid Ammar, Director General, Ministry of Health Lebanon

Speech 2/ Beyond UHC: The future of health systems

Kenji Shibuya, Professor and Director, University Institute for Population Health, King's College London

Speech 3/ Why Universal Health Coverage Needs Political Will, Tough Decisions and Commitment?

David Barbe, Past President, American Medical Association

Speech 4/ Is Primary Health Care an End in Itself or a Step on the Way for Comprehensive Healthcare Systems? Primary care teams should be led by whom?

Otmar Kloiber, Secretary General, WMA

Speech 5/ Primary Health Care for UHC

Mihoko Kashiwakura, Head of Japan, Bill & Melinda Gates Foundation

Speech 6/ Social Common Capital and Healthcare

Marie Urabe, CEO, Uzawa International Foundation

Comment/ **Chaand Nagpaul**, Chair of Council, British Medical Association

Discussion

Session 4: Shared Responsibilities, Individual Obligations towards UHC

Session Chair: **Takeshi Kasai**, *Regional Director, World Health Organization, Western Pacific Region (WPRO)*

Speech/ Introduction of UHC in Japan and How Physicians and JMA Responded during its Early Phase

Yoshitake Yokokura, *President, JMA, Immediate Past President, WMA*

Comment 1/

Teniin Gakuruh, *WHO Representative for Seychelles, AFRO*

Comment 2/ Shared Responsibilities, Individual Obligations

Frank Ulrich Montgomery, *Chair of Council, WMA, Immediate Past President, German Medical Association*

Panel Discussion

Yoshitake Yokokura, *President, JMA, Immediate Past President, WMA*

Frank Ulrich Montgomery, *Chair of Council, WMA, Immediate Past President, German Medical Association*

Yasuhiro Suzuki, *Chief Medical & Global Health Officer, MHLW*

Kunihiko Hirabayashi, *Regional Advisor and Chief of Regional Health and HIV Section, UNICEF East Asia and Pacific*

Takao Toda, *Vice President for Human Security and Global Health, JICA*

Pem Namgyal, *Director, Programme Management, SEARO*

Teniin Gakuruh, *WHO Representative for Seychelles, AFRO*

Yue Liu, *Coordinator, Division of Health Systems, WPRO*

Adoption of “Memorandum of Tokyo on Universal Health Coverage and the Medical Profession”

Session Chair: **Frank Ulrich Montgomery**, *Chair of Council, WMA, Immediate Past President, German Medical Association*

Adjournment

Yoshitake Yokokura, *President, JMA, Immediate Past President, WMA*

Leonid Eidelman, *President, WMA, Immediate Past President, Israeli Medical Association*

Greeting

**Yoshitake Yokokura, President, Japan Medical Association
Immediate Past President, World Medical Association**

It is my great pleasure to say a few words at the opening of the Health Professional Meeting (H20) 2019.

Today, in the presence of Her Imperial Highness the Crown Princess, it is my privilege to start the international meeting co-organized by the JMA and WMA under the theme of promotion of Universal Health Coverage.

In the modern era where borderlessness rapidly progresses with the advance of globalization, the cross-border unity of physicians worldwide has been increasingly important in preparation for the spread of infectious diseases and the occurrence of natural disasters. This requires the efforts to build a new system toward the new era.

In October 2017, in the inaugural address of the 68th President of the World Medical Association in Chicago, I expressed my intention to make all-out efforts to improve the health level of people of the world and contribute to global health by disseminating universal health insurance of Japan as UHC to the world which pushed Japan's healthy longevity to the world top level.

In December of the same year, the Japanese Government held the "UHC Forum 2017" in Tokyo with the World Bank, WHO, UNICEF and other important organizations. In this forum, the concept of "Promotion of UHC" which is one of the "Sustainable Development Goals (SDGs)" based on the pledge of "leave no one behind" by the UN, was supported by global health leaders and became a global movement.

Based on the movement, I as WMA President concluded an MOU with WHO Director General Dr. Tedros on promotion of UHC and emergency disaster preparedness. In the agreement, the areas of cooperation are the realization of UHC, in particular the promotion of understanding of the concepts and active participation focused on the roles of physicians and their professional organizations, and respect of medical ethics by all the people through addressing social determinants of health.

This meeting is organized to globally expand the practice of the memorandum contents. I consider it a good opportunity for the WMA, its member associations, JMA, WHO Headquarters, its regional offices, relevant international organizations, NGOs, patient groups, academia, and health authorities. I hope that practical discussions on specific measures and activities in promoting and accelerating UHC will contribute to efforts in developing countries.

At this meeting, we will adopt the "Memorandum of Tokyo on Universal Health Coverage and the Medical Profession" that clarifies the role of physicians in promoting UHC, and will send recommendations to the G20 Osaka Summit later this month.



The G20 Finance Ministers' Meeting held earlier adopted a policy recommendation in which they recognize the importance of UHC, strengthen of health system by measures to secure financial resources, and foster the economic growth of the development countries. Furthermore, the global movement to promote UHC will be more visible with the High-Level Meeting on UHC to be held for the first time at the UN General Assembly in September this year.

On May 1st of this year, Emperor Naruhito ascended to the Chrysanthemum Throne in Japan, and the imperial era of "Heisei" was replaced by "Reiwa". "Reiwa" means "Beautiful Harmony", and it seems to symbolically express the peaceful future that not only Japan but the whole world seeks.

Through this meeting, I do hope that we will see the further progress of UHC under "Beautiful Harmony," with the continuing support and efforts of all the participants.

Greeting

**Leonid Eidelman, President, World Medical Association
Immediate Past President, Israeli Medical Association**

Dr. Yokokura, colleagues and friends, good afternoon. Thank you for organizing and participating in the Health Professional Meeting (H20) devoted to the road to Universal Health Coverage.

It is a great honor for all of us that Her Imperial Highness the Crown Princess is present at this important event today.

During his tenure as President of the World Medical Association, Dr. Yokokura considerably promoted this initiative. Without a doubt, UHC will only be achieved via collaboration of all players throughout the healthcare sector. What can we do as physicians to ensure the success of achieving universal healthcare for all by 2030? What is the role of National Medical Associations? During this meeting we will debate and discuss viable solutions so that physicians and their medical associations can foster affordable quality healthcare for all. I know that all of us here are instrumental in making this goal possible, together we can.



It is hard to believe, but over 50% of the world's population DON'T have access to all the critical health services they need. The United Nations Sustainable Development Goal 3 is to guarantee healthy lives for all, this includes a lofty target of achieving Universal Health Coverage by 2030. Making sustainable Universal Health Coverage is a priority for global politics.

"Kaihoken", the Japanese Universal Health Insurance System, which means "healthcare for all", serves as emblematic proof that providing care for everyone is the right thing to do. The system is a model of excellency and a role of Japan Medical Association is crucial. The Japan Medical Association wields tremendous influence over public health policy keeping the well-being of the country's patients and physicians at the forefront. We admire the countless Japanese physicians that are enthusiastic about promoting high level healthcare universally.

The World Medical Association supports all measures to foster Universal Health Coverage, all discussions and means on all levels and in all forums. Achieving Universal Health Coverage is one of our top goals.

Thank you, Dr. Yokokura, for deepening the WMA's relationship with the WHO, specifically on matters connected to Universal Health Coverage. Your constructive relations with the Japanese government helped vastly.

I believe that yourself and Japan Medical Association will continue to champion Universal Health Coverage.

Congratulatory message Her Imperial Highness the Crown Princess

It is a great pleasure for me to meet all of you, who are working unceasingly for people's health, at the "Health Professional Meeting 2019, Road to Universal Health Coverage." I would like to extend my welcome to participants from abroad. I hope you will have a memorable stay in Japan.

I would like to express my deep respect to all of you who have been working in various parts of the world on this very important issue, to enable everybody to use basic health services when they need, at an appropriate cost.

During the latter half of the 20th century, the promotion of Universal Health Coverage made a great contribution to the development of Japan. The process leading to its introduction, however, was a history of long struggles to overcome various difficulties.

Until the middle of the 20th century, Japan had serious health problems, with high rates of tuberculosis incidence and infant mortality. In order to improve the situation, the Tuberculosis Control Law was enacted in 1951, and comprehensive measures for prevention and treatment of tuberculosis were carried out collaboratively between public organizations and the private sector. Also, Mother and Child Health Handbooks were introduced so that families and health professionals could share necessary information in the continuum of care for all expectant mothers and children. Through efforts by the whole country, starting with these measures, the rates of tuberculosis incidence and infant mortality rapidly declined and Universal Health Insurance was realized in 1961, resulting in great improvements in people's living conditions. Now, with the population aging, health professionals in various organizations including the Japan Medical Association are cooperating to support the health of all Japanese people.

Speakers and panelists at this conference are those who promote and support Universal Health Coverage working for organizations such as medical associations, the World Health Organization, patients' organizations and NGOs. Young doctors and medical students, who support the future of medical services, are also attending the conference. I am sure that the two days of the conference will offer precious opportunities for the participants to share their knowledge, discuss Universal Health Coverage from diverse viewpoints, and think about ways to promote it appropriate for each country or area. I hope for the further success of the participants.

In closing my address, I wish that your efforts will be fruitful in helping to create a world in which all people can enjoy a healthy and happy life.



Congratulatory message

Shinzo Abe, Prime Minister of Japan (Video message)

Good afternoon, ladies and gentlemen.
I am Shinzo Abe, Prime Minister of Japan.

Dr. Yokokura, President of the Japan Medical Association, Dr. Eidelman, President of the World Medical Association and distinguished guests. I would like to congratulate the holding of the Health Professional Meeting 2019.

For many years, Japan has placed emphasis on the global health agenda from the perspective of human security. Particularly, the promotion of Universal Health Coverage (UHC) is an essential element to realize a society that leaves no one behind, the core principle of the Sustainable Development Goals.

Japan has been leading the global discussion at many occasions, such as the G7 Ise-Shima Summit in 2016 and the UHC Forum in 2017. Global health will be an important agenda at this year's G20 Osaka Summit as well. I look forward to having an active discussion with G20 leaders as the chair.

In addition to political leadership, contributions from medical doctors and other health professionals who actually provide health services, as well as contributions from their professional organizations, are indispensable for the achievement of UHC.

I welcome that such stakeholders are attending today's meeting from all over the world and will discuss how medical doctors and their professional organizations can contribute to the achievement of UHC. I truly appreciate that such a meeting is being held in this year of the Japanese G20 Presidency.

Dr. Yokokura served as the President of the World Medical Association (WMA) from 2017 to 2018. Under his leadership, WMA signed the Memorandum of Understanding (MoU) with the World Health Organization (WHO), which further strengthened WMA's activities.

I hope that the WMA will further develop and contribute to the achievement of UHC under the leadership of Dr. Eidelman, the current President, and Dr. Jorge, the President-elect.

Finally, I sincerely wish that all of you engage in an energetic discussion and the meeting to be concluded successfully.



Congratulatory message

Yasuhiro Suzuki, Chief Medical & Global Health Officer

On behalf of Takumi Nemoto, Minister of Health, Labour and Welfare

Dr. Yoshitake Yokokura, President of Japan Medical Association, Dr. Leonid Eidelman, President of World Medical Association, distinguished guests, I would like to congratulate you on the holding of the 2019 Health Professional Meeting in the presence of Her Imperial Highness the Crown Princess.

It is a great honor for me to speak at this remarkable event, which is attended by leaders of medical associations from across the world, representatives from international organizations, academia, and other related organizations.

We greatly appreciate this meeting's purpose: the promotion of Universal Health Coverage (UHC). For many years, we have emphasized a global health agenda, and the promotion of UHC is central to achieving the core principal of Sustainable Development Goals (SDGs), "no one left behind."

Japan is serving as the G20 chair this year. Global health, including UHC, will be one of the important topics of the Summit on June 28th and 29th in Osaka. In addition, alongside the Summit, we will host the first joint session between Finance Ministers and Health Ministers in the history of G20 to discuss sustainable health finance. We will also host the Health Ministers' meeting in October in Okayama City to further discuss how to solve global health challenges, including UHC.

As for the history of UHC in Japan, in 1961, when Japan was still a developing country, we established a universal health insurance system, which greatly contributed to the economic growth and social stability of the country. Through substantial contributions by medical doctors and other health professionals and professional organizations, this system is maintained today, in the face of a super-aging society, and we must continue our efforts to ensure its sustainability in the future. I assume that Dr. Yokokura will present a more concrete story of Japanese experiences in the meeting, and I sincerely hope that this meeting facilitates the sharing of Japanese and other countries' experiences and boosts stakeholders' efforts toward the achievement of UHC around the world.

In addition to medical association leaders from around the world, many representatives from international organizations such as the World Health Organization (WHO) as well as members of academia are attending this meeting. Norm-setting by international organizations and research and study by academia are crucial for the achievement of UHC. I believe that this meeting will strengthen the cooperation between these important stakeholders and medical professional organizations.

Finally, let me congratulate you again on the convening of this meeting; I am confident that it will engender fruitful discussion and a positive outcome.



Keynote Addresses

Chair: Miguel Jorge

President-Elect, WMA

Member of the Executive Committee, Brazilian Medical Association



[Keynote Speech 1]

Health Inequities and Social Determinants of Health

Sir Michael Marmot

Professor of Epidemiology, University College London
Past President, WMA



Health crisis is social crisis

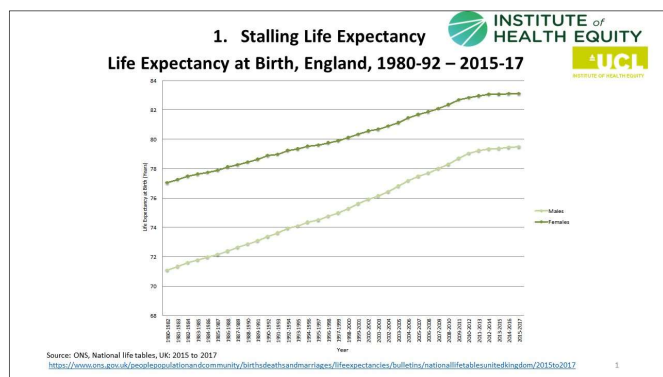
If we want to achieve not just healthcare coverage, but better health for our populations, we need to be taking action on the social determinants of health.

The first line of my book, "The Health Gap", was "What good does it do to treat people and send them back to the conditions that made them sick?" It is precisely for this reason that Dr. Tedros, Director General of WHO, set up a new division of healthier populations and it reflects his understanding of the 3 billion, that we need not just emergency care, not just universal health coverage (UHC), but action on environment, on social determinants of health.

When I was President of the World Medical Association, I produced a guide on how doctors and other health professionals can be engaged in this agenda. We emphasized five areas:

- education and training,
 - seeing the patient in a broader perspective, working with individuals and communities,
 - the health sector as employer, and indeed, the whole health system as having an impact on the communities in which it works,
 - working in partnership, and
 - the workforce as advocates.
- Doctors, nurses should advocate on behalf of the patients and the populations that we serve.

Figure 1



We have been monitoring what's been happening in different countries on health and health equity, and there are no grounds for complacency. Historically, in England, as in most rich countries, life expectancy has been increasing by about one year every four years since 1921, since the end of the Great War. One year every four years. Quite remarkable and it has gone on for 90 years. Then in 2011 that stopped (**Fig. 1**). What had been an improvement of one year every four years slowed down, for men and women. This year's data showed that in England the life expectancy improvement more or less stopped. It declined for men in Northern Ireland, for men and women in Scotland and in Wales (**Fig. 2**).

This is a health crisis! As health is telling us something fundamental about how well our societies are meeting the needs of their citizens, this is not just a health crisis, this is a social crisis.

Not only have we seen declines in part of the United Kingdom but increases in inequalities. **Figure 3** shows life expectancy at birth by deciles of deprivation. For men life expectancy was not improving in the least affluent deciles. For women it was declining. Life expectancy stopped improving; inequalities are getting bigger. We have no grounds for complacency in any country.

In the United States, life expectancy has now declined 3 years in a row (**Fig. 4**). They have a big increase in unintentional injuries, which include accidental drug overdoses: 63,600 deaths in 2016, and 70,000 in 2017. The opioid crisis is not just malfeasance on the part of the pharmaceutical industry, although it is that, but these deaths are not randomly distributed. The fewer the years of education, the higher the mortality. So, the inequalities from poisonings, suicide, and alcohol, so-called deaths of despair, follow the social gradient, and that gradient is getting steeper.

Another way to see the increase in health inequalities in the United States is to examine life expectancy at 50, by decile of income and by year of birth. Among people born in 1920 – who will be 50 in 1970 – there is a clear social gradient in life expectancy: the higher the income, the greater the life expectancy. But over a 30-year period, from year of birth 1920 to year of birth 1970, life expectancy hardly increased for men in the bottom 10% of the income distribution. It increased a bit more for the next 10%, a bit more for the next 10%, and so on. For people at the highest income level it increased dramatically. The social gradient got steeper, the inequalities got bigger.

That's men. For women, life expectancy declined for the bottom 10% of income, for the next 10%, for the 3rd decile. For the bottom 30% of income for women life expectancy declined. It improved markedly for women in the highest income deciles. The inequalities got dramatically bigger.

Progress in overcoming six areas of social determinants of health

This is a health crisis, and it is also a social crisis. What can we do? I chaired the WHO Commission on Social Determinants of Health. Following that I was invited by the British Government to conduct an English review of health inequalities with the aim of 'translating' the recommendations of our global report for one country. I was then asked by the European Region

Figure 2

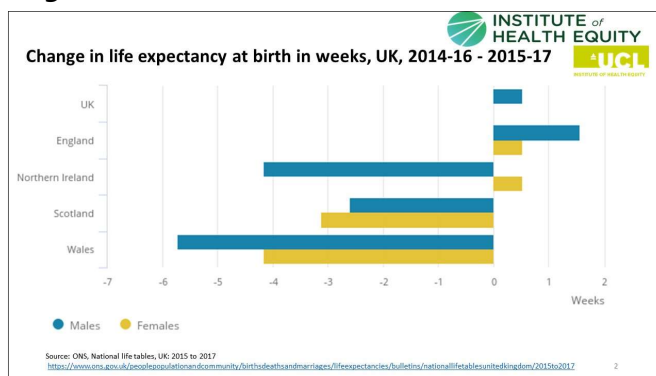


Figure 3

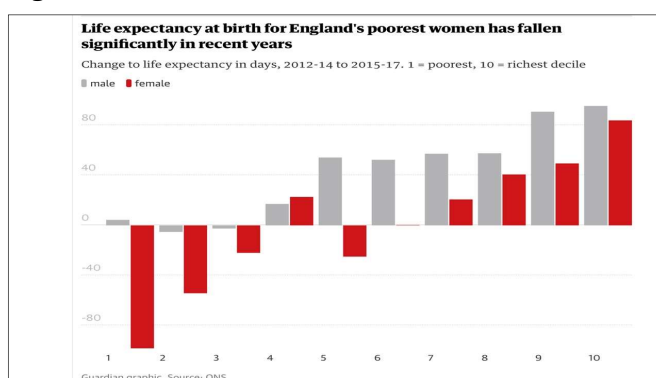
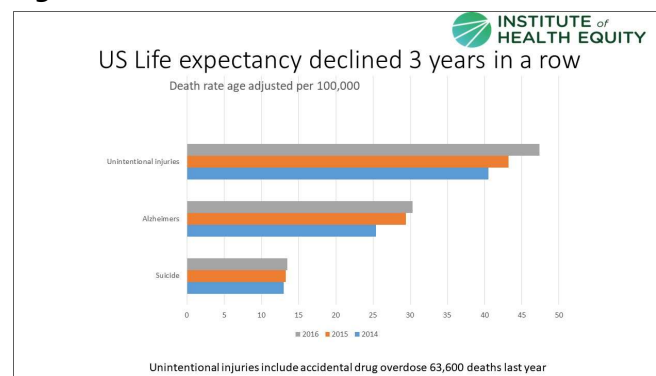


Figure 4



of WHO to conduct a European review of social determinants and the health divide. In my English review I said there are six areas where we need to act, in addition to UHC:

- Early child development,
- education and lifelong learning,
- employment and working conditions,
- everybody should have at least the minimum income necessary for a healthy life,
- healthy and sustainable places in which to live and work, and finally,
- taking a social determinants approach to prevention.

The report of the Commission on the Pan-American Health Organization on Equity and Health Inequalities in the Americas will be published on the 1st of October this year. We are calling the report “Just Societies: Health Equity and Dignified Lives.” In this report, we made a statement that if we take the action that makes it possible for everybody to lead a life of dignity, then health will improve, and health equity will be enhanced.

In this report, we plotted on the x-axis gross domestic product per person, adjusting for purchasing power. On the y-axis life expectancy (**Fig. 5**). If a country is poor, Haiti for example, and its income increased a bit so it got to the Bolivia level, it’s likely that life expectancy would improve. If Bolivia became a middle-income country like Brazil, then life expectancy would probably improve further. But when we get to an income of Costa Rica, around \$17,000, adjusting for purchasing power, and go all the way out to the United States at \$60,000, there is no relation between national income per person and life expectancy. Getting rich for a country, once you reach that threshold, is not the solution to better health. It’s how the money is spent on social determinants of health, and on UHC.

Coming back to my six domains of recommendation from England, give every child the best start in life, one way of doing that is relieving child poverty. For this analysis, poverty is defined as living in a household at less than 60% median income. In the Nordic countries, in Denmark, Iceland, Norway, child poverty is at 9%, 10%, 11%. In the Republic of Korea 11%. In the United Kingdom it’s just under 20%. In the United States it’s 29%, just below Mexico (**Fig. 6**).

This is entirely preventable. In a rich country no child should grow up in poverty. And the Nordic countries and Korea show that it can be around 11%, and in the US it’s 29%. When the health ministers get together with the finance ministers in G20 summit, maybe they should be discussing child poverty. Not just financing of UHC, but how to pull a lever to reduce child poverty is crucial. This will have a dramatic impact on improving health and reducing avoidable health inequalities.

UNICEF publishes a measure in adolescence, homicide age 0 to 19, and bullying. The United States ranks right at the bottom. I don’t know the answer to the question, why does Hong Kong or Japan do so well with respect to life expectancy, but I know where to look. I can see where the US is doing badly. In another measure of health in childhood and

Figure 5

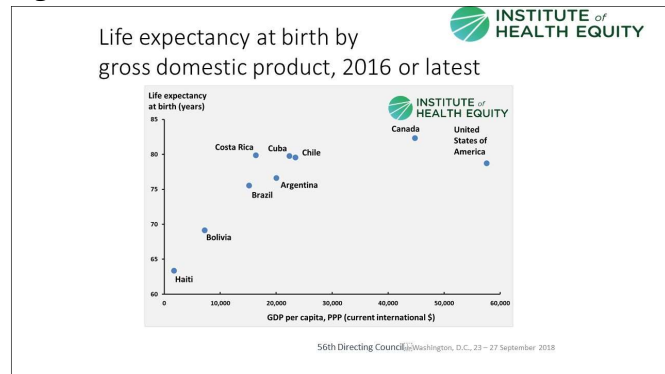
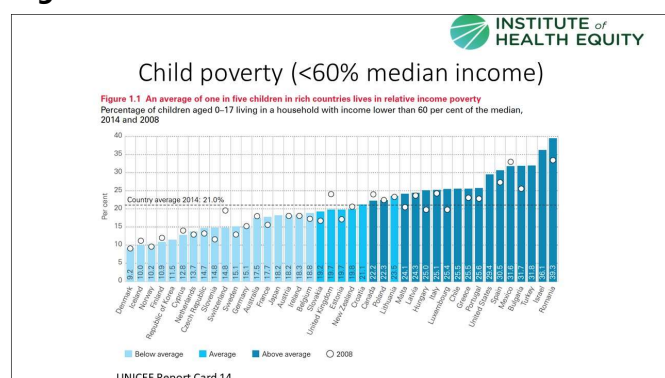


Figure 6



adolescence, neonatal mortality, suicide ages 0 to 19, mental health of 11 to 15-year-olds, drunkenness and fertility, again, the US ranks near the bottom.

For education and lifelong learning, the Program of International Student Assessment (PISA), the standardized test at age 15 on mathematics, literacy, and science, is worth looking at. Finland always does the best in Europe. The highest scores, and a comparatively shallow social gradient. The UK does worse than Finland at every level, and a steeper gradient. The US has got an even steeper gradient. It's really not good to be in the bottom quartile of income in the United States. If we look at Macau, China, we can find strong performance and narrow inequalities.

Relevant to healthy standard of living for all, an egregious wealth gap returns to the United States (**Fig. 7**). The percent of net personal wealth held by the bottom 90% of Americans is back down to 27%. The percent of net personal wealth held by the top 1% is back up to 39%. So, 1% of Americans have considerably more wealth than the bottom 90% of Americans. That is not cost free. That dramatic inequality in social conditions translates into dramatic inequalities in health.

If we look at social spending as a percent of GDP, Sweden ranks number one, then Denmark, France, Finland, Austria, and the United States ranks 23rd on social spending. On healthcare spending, the US ranks top. Their 2009 figures show it was 14%, now it's over 17%. At that time, for life expectancy, Japan was the number one. Social spending has a stronger correlation with life expectancy than does healthcare spending.

When there's high income inequality, there is less social mobility (**Fig. 8**). If we look at the correlation between income of adult children and the income of their parents, then the greater the inequality, the Gini coefficient, the less social mobility. The smaller the Gini coefficient, the less inequality. So, in Denmark, Norway, Finland, Sweden, it doesn't matter so much who your parents were or what your parents earned to your own income. But in the US, which is about halfway along, and Brazil is at the very unequal end, and it really matters who your parents are. If your parents are rich, you are likely to be rich. If your parents are poor, you are likely to be poor. So, the Nordic countries have actually understood about social mobility. Among those rich countries, the USA has among the least social mobility.

How about healthy and sustainable places and communities, and strengthening the role and impact of ill health prevention? We talk about advising people about healthy living. In England there is a regular programme of monitoring child obesity. For year 6, age 11, there is a clear social gradient in obesity prevalence by deprivation levels: the more deprived the area the greater the prevalence of obesity. While some commentators are tempted to blame adults for their irresponsible behavior in getting fat, you can't blame poor children for eating badly. It's not their fault. And yet we see this dramatic social gradient in childhood obesity. In fact, the rise of

Figure 7

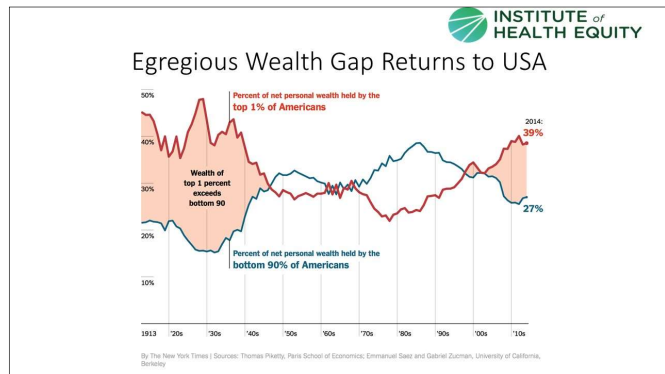
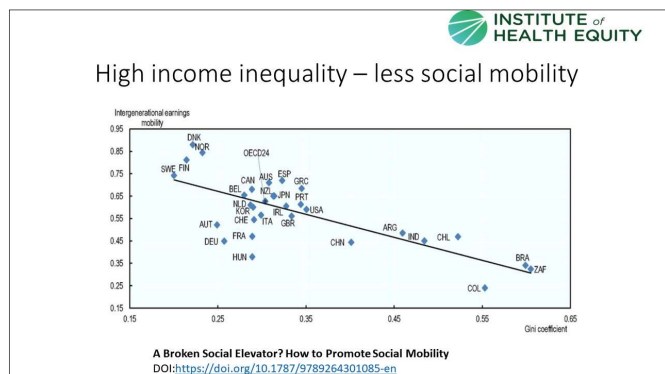


Figure 8



childhood obesity has more or less stopped in children from more privileged backgrounds, but it's continuing to increase in children from less privileged backgrounds. The effect is that inequalities are increasing.

We tell people, "feed your families healthy food." If people in the bottom 10% of household income in England followed the healthy eating advice, they would spend a 74% of household income on food. If they bought healthy food, how are they going to pay the rent? If they paid the rent, how are they going to heat their apartment? Housing is a food issue. Income is a food issue. And we can't blame poor people for not eating healthily when they would have to spend 74% of their household income on food just to eat a healthy diet (**Fig. 9**).

Coming back to the US, the more guns there are around, the more likely are people to use those guns to kill themselves, or to kill other people (**Fig. 10**). There are more suicides from guns than there are homicides. People use guns to kill themselves, as well as others. And children are involved in accidental shootings. One way to improve health is to get rid of firearms.

Do something, do more, do better

In our European review, where we were dealing with countries at a very low level of social development, we said if you are a poor country do something on social determinants of health. If you're in the middle of the development, do more. And if you're a rich country, do it better. There's something for everyone. Do something, do more, do better.

If I can do the unpardonable and quote myself, at the end of our PAHO Equity Commission report, we said at the heart of the Commission's purpose is ensuring the right of all people in the Americas. In this region too, to lead lives of dignity and enjoy the highest attainable standard of health, we call on all governments to act.

Figure 9

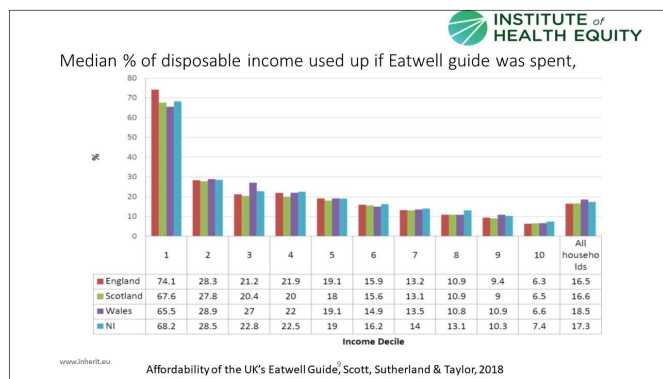
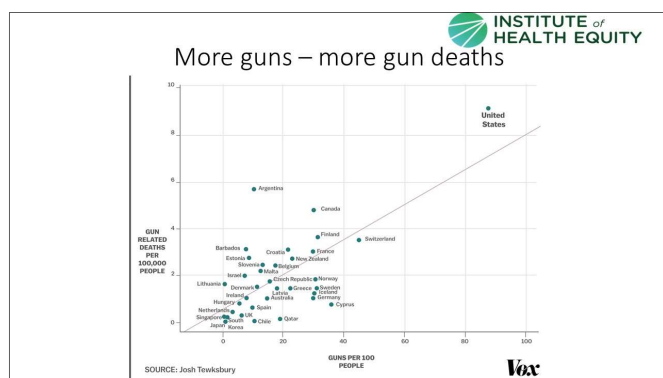


Figure 10



[Keynote Speech 2]
**Towards Universal Health Coverage
- What we need?**

Naoko Yamamoto

Assistant Director-General, UHC/Healthier Populations,
World Health Organization



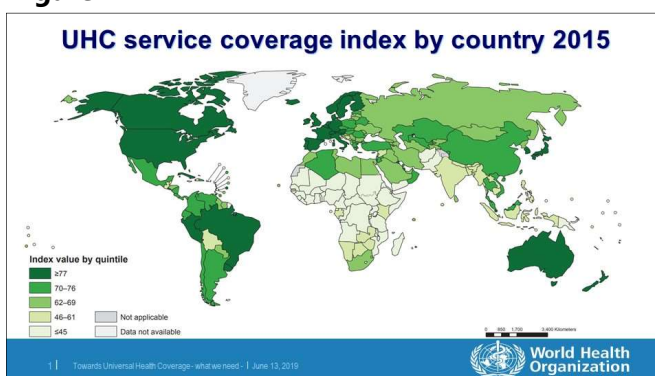
Introduction

The realization of Universal Health Coverage (UHC) by 2030 is one of the sustainable development goals of the United Nations agreed upon by the leaders of various countries in 2015. This is also an important theme of the G20 Summit that will be held in Osaka 2 weeks from today. What is necessary for the realization of UHC? In my view, there are five requirements.

Five requirements for UHC

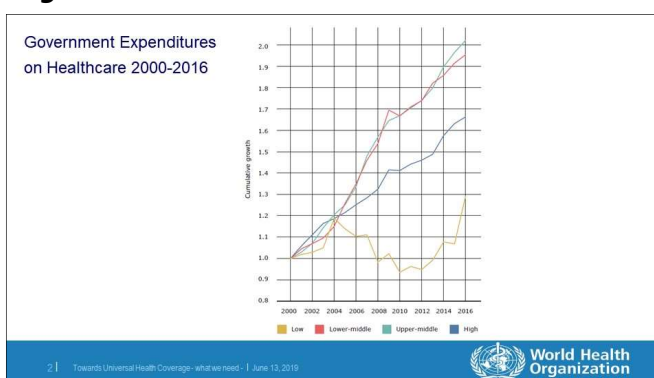
First, we need political leadership. The importance of achieving UHC has thus far been confirmed, and commitments have been made for it, in various settings of international politics and dialogue. Japan has also made contributions to realize this goal through the G7 Ise-Shima Summit and TICAD VI (Sixth Tokyo International Conference on African Development) in 2016. The status of UHC achievement varies among nations. It is necessary that commitments made in the international arena be connected to the actions in individual countries (**Fig. 1**).

Figure 1



Second, fund infusion into the field of healthcare and its effective utilization are essential. An analysis of government expenditures (public funds) on healthcare since 2000 showed that middle-income countries have sustained sharp growth surpassing that of high-income countries (**Fig. 2**).

Figure 2



Dependence on external sources for spending on healthcare is limited in middle-income countries (**Fig. 3**).

When government expenditures in the healthcare field rise, the coverage of healthcare services improves. However, the funds spent to achieve the same level of coverage vary considerably among nations. Making efficient use of funds is a key element to success in this area (**Fig. 4**).

Third, where should the financial resources be used? The most important element is human-resource for health. It is estimated that there is a shortage of 18

million health workers worldwide needed to provide basic health services. On the other hand, 40% of medical facilities have no clean water, and medical waste is not appropriately disposed of also in 40% of medical facilities.

It is necessary to share knowledge on the efforts of various countries regarding the issues of maintenance and uneven distribution of medical facilities, the roles of private and public sectors, migration issues, optimal circumstances for team healthcare, etc.

Fourth, great importance should be placed on primary health care (PHC). PHC is efficient and effective, and enhances the fairness of healthcare delivery. Last year, 40 years after the Declaration of Alma Ata was issued, participants who gathered at Astana, Kazakhstan from various parts of the world confirmed that PHC is the core of UHC realization.

PHC is an essential public health function involving health promotion, disease prevention, primary care, water, and hygiene, and is provided at the community level with participation of local residents (Fig. 5).

The fifth factor is assuring optimal utilization of innovative technology. This opens the highly desirable possibility of leading to the development of effective and inexpensive therapeutic agents based on innovation, provision of evidence-based healthcare services, improved access via digital technology, and so on.

Expectations for medical associations

Finally, I would like to mention my expectations for medical associations.

First, I believe that participation of medical associations in various fields such as the environment, education, food, and nutrition, beyond the healthcare field, and their advocacy and support of activities placing a high value on human health will be of great help in changing society.

Second, medical associations have the responsibility of finding evidence, as well as effective policy planning and implementation based on the evidence collected.

Third, physicians have the team leader role in healthcare venues, and national medical associations play a role in cultivating human resources and career path building in their own countries.

The fourth is improvement of healthcare quality and promotion of people-centered care. I appreciate the work that national medical associations are doing to enhance patient safety.

Figure 3

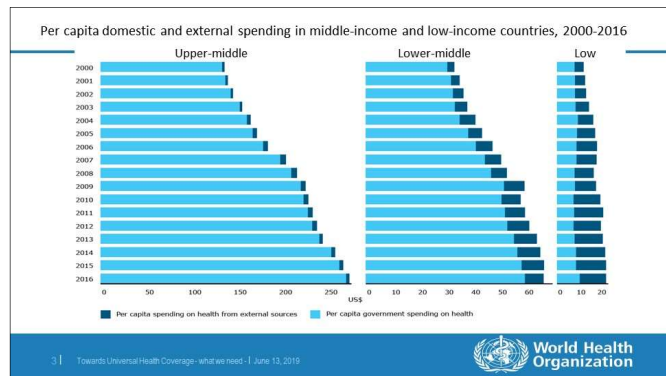


Figure 4

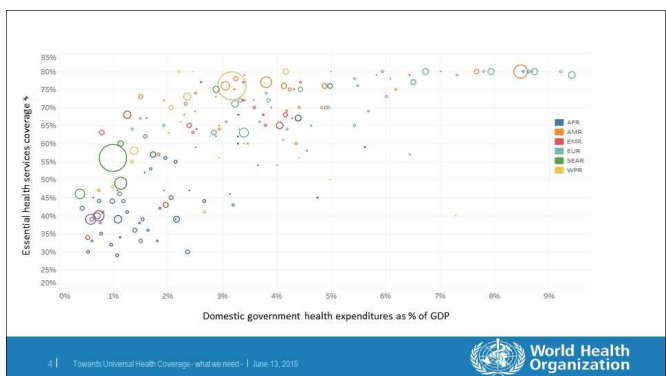


Figure 5



The fifth expectation is making contributions to fields that require further research, education, and practice, such as rehabilitation, palliative care, geriatric medicine, and food safety.

My sixth expectation is that actions to manage emerging infectious diseases and disasters. The threat is increasing under the influences of climate change and other factors.

Finally, let me underscore how indispensable the cooperation and participation of physicians from medical associations are for creating an environment where people have basic knowledge of health and make efforts to develop communities allowing healthy living.

Health is a human right, making its universal provision a form of social justice, reflects solidarity, and serves as the basis of development, societal progress, safety, and peace. I anticipate that this H20 will send a strong message to world leaders at the G20.

[Response]

Mukesh Haikerwal

Past Chair of Council, WMA, Past President, Australian Medical Association

Once the keynote speeches were completed, Dr. Mukesh Haikerwal, a past President of the Australian Medical Association, a past Chair of Council of the WMA, specified some of the roles and functions of a primary care team in which several medical professionals work together as a single unit. The Australian healthcare system has been recording high performance levels because in this system, primary care forms the core of general practice. This system makes a difference in the country's healthcare practices by providing continuous care as part of general practice. Further, it has significant capacity to provide preventative healthcare; however, prevention efforts did not attract sufficient attention among physicians. One of the challenges faced by the system is the provision of better support to preventative care and to link it to health promotion. Further, the improved access to psychological services has significantly reduced Australia's healthcare burden by enabling general practitioners to concentrate on general medical practice. Moreover, Dr. Haikerwal emphasized the importance of providing team-care, which is the responsibility of not only general practitioners or nurses but also nutritionists, dietitians, physiotherapists, and so on, as a single unit. Collaboration is key in the provision of care to patients.

Session 1

Viewpoints on How to Achieve UHC

Chair: Osahon Enabulele
Chair of Socio-Medical Affairs Committee, WMA
Past President, Nigerian Medical Association



Introduction

The estimated half of the world's population is said to still lack full coverage of essential health services with about 100 million people pushed into extreme poverty by having to pay for healthcare (according to the World Health Organization). Dr. Osahon Enabulele highlighted the significance of Universal Health Coverage (UHC) against such a situation.

The panel session featured five panelists and three commentators. The panelists were Mr. Ellos Lodzeni, Board Member, the International Alliance of Patients Organizations (IAPO); Dr. Giorgio Cometto, Coordinator, the WHO Health Workforce Department; Dr. Osamu Kunii, Head of Strategy, Investment and Impact Division of the Global Fund to Fight AIDS, Tuberculosis and Malaria; Dr. Jacqueline Kitulu, President, Kenya Medical Association; and Dr. Ravindra Wankhedkar, Treasurer, World Medical Association (WMA), Immediate Past President, Indian Medical Association.

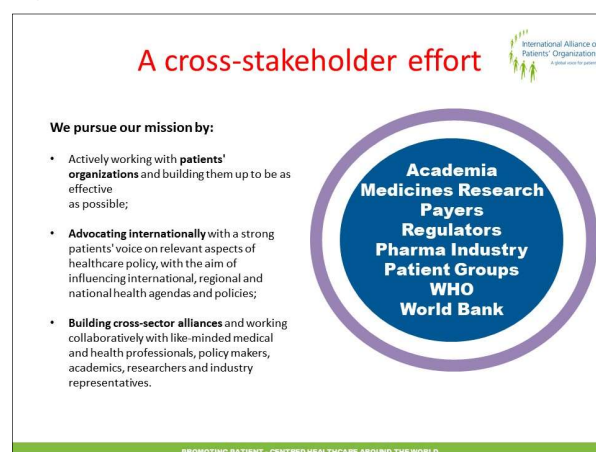
The commentators were Dr. Oscar D. Tinio, Past President, Philippines Medical Association; Dr. Chukwuma Oraegbunam, Chair, WMA's Junior Doctors Network (JDN); and Ms. Batool Al-wahdani, President, International Federation of Medical Students Associations (IFMSA).

Presentations

Having laid the basis for the panel session, the session chair proceeded to call on each of the panelists to respectively make a 15minute presentation on the outlined thematic areas.

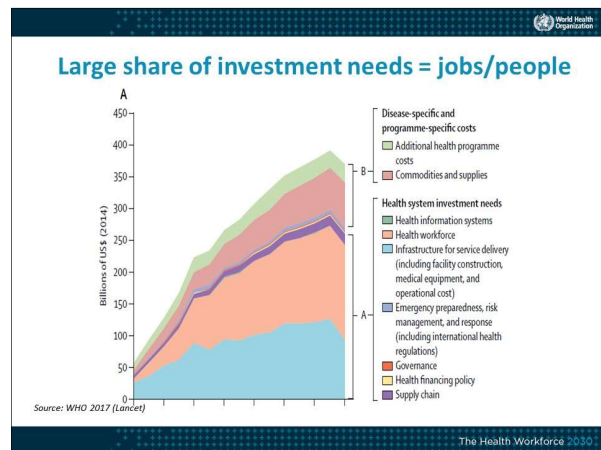
First to speak was Mr. Ellos Lodzeni who made a presentation on "Patients Perspective Towards Attainment of Universal Health Coverage". He advanced the view that high out-of-pocket expenses by vulnerable patients posed a great threat for achieving UHC, and that lives could only be saved by increasing equitable, universal access to quality and affordable essential medicines and medical supplies. He further averred that financial and technical strengthening of patient organizations was needed to ensure transparency, accountability and monitoring of the delivery of health services at all levels. He therefore called on stakeholders to provide sustainable funding towards strengthening patient centered Primary Health Care delivery systems and to strive towards safe Universal health which puts patient safety first (**Fig. 1**). He assured that the IAPO was ready to work with the WMA and its members across the world to realize UHC for the benefit of Patients.

Figure 1



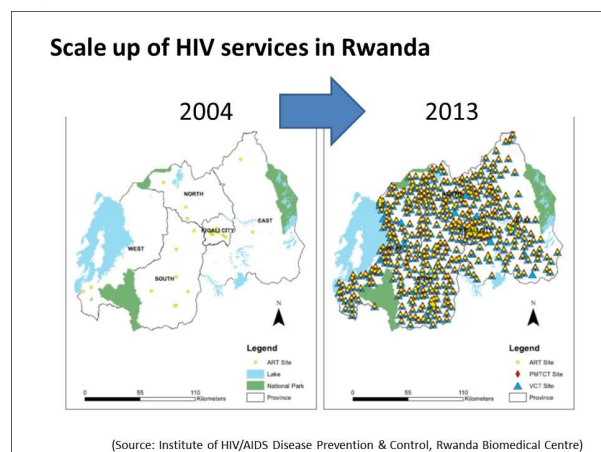
Speaking on “Health Workforce: Strategic investments on the road to UHC”, Dr. Giorgio Cometto, affirmed that the progressive realization of UHC depended on availability of health workers, and that the expansion and transformation of the health workforce is an investment that would pay a triple dividend consisting of improved health outcomes; enhanced global health security, and economic growth through the creation of employment opportunities. He however stated that there was a substantial mis-match in the health labour market at global and national levels, and that the biggest challenge to address these imbalances was to ensure adequate public-sector investment for education and employment of health workers. He asserted that professional associations could play a pivotal role to support the required policy and investment decisions which should be designed and implemented in a comprehensive and cost-effective manner (Fig. 2).

Figure 2



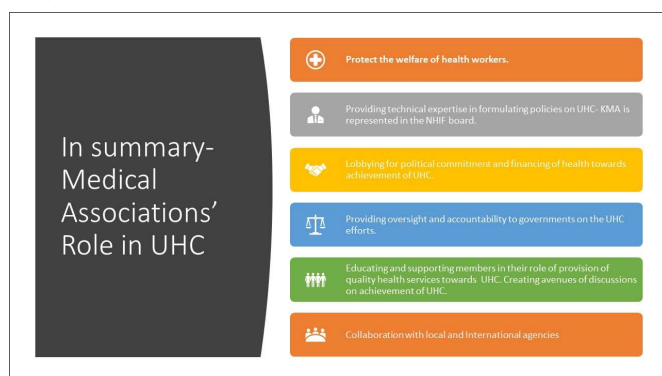
In his presentation on the “Role of Medical Professionals for Achieving UHC - Lessons learned by the Global Fund and the globe”, Dr. Osamu Kunii, informed the session that the role of medical professionals was very critical for UHC, and that more proactive engagement and strategic approach was needed in countries which have a long way to achieving UHC (Fig. 3). He stated that medical associations could help the government develop and implement robust national plans and strategies to improve equitable access to effective, efficient and quality health services, increase domestic financing and reduce out-of-pocket payment, and build resilient and sustainable health systems.

Figure 3



Speaking on “Medical Association’s Perspective”, Dr. Jacqueline Kitulu, informed the session that any effort at advancing UHC would require addressing the need for adequate and well-trained workforce, preventive and promotive health, sustainable health financing mechanisms and strategic purchasing using public funds. She stated that UHC should be tax-funded, public-led and patient-centered, with public-private partnerships in place (Fig. 4).

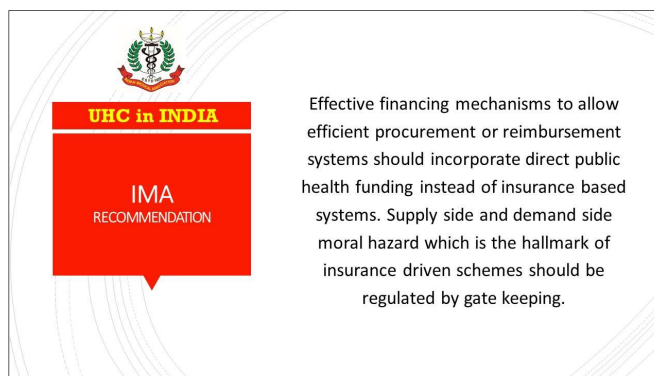
Figure 4



In his presentation on “Universal Health Care in India”, Dr. Ravindra Wankhedkar, informed the session that the Indian Medical Association works for synergies between private and public sectors, provides inputs into health governance, and helps in service delivery, particularly in fragile populations. He asserted that health service delivery should focus on deployment of highly skilled

health workers. He harped on the need for effective financing mechanisms to allow for efficient procurement or reimbursement systems which should incorporate direct public health funding instead of insurance-based systems. He also said that the supply side and demand side moral hazards which was the hallmark of insurance driven schemes, should be regulated by gate keeping (**Fig. 5**). In his view, UHC mechanisms should focus on comprehensive outpatient care without restricting its role in providing secondary and tertiary inpatient care.

Figure 5



Comments

Dr. Oscar D. Tinio, a past President of the Philippine Medical Association, enunciated the elements that play a key role in the delivery of healthcare in various countries. These elements are financing, accreditation, the development of standards and incentives for healthcare facilities, the delineation of the roles of key agencies and stakeholders, the provision of equitable access to all, and human healthcare resources. Subsequently, he explained how the medical associations of different countries should work together to realize the same objective, that is, achieving UHC. Nowadays, the Philippines Medical Association has been focusing on the provision of primary care, rather than specialist care. Moreover, on February 20, 2019, in the Republic of the Philippines, President Rodrigo Roa Duterte signed a new law to achieve UHC in the country, thereby, Philippines joined the group of countries where UHC is realizing.

Dr. Oraegbunam, Chair of WMA-JDN, highlighted the undisputable need to ensure quality healthcare and affordable access to healthcare for all by mentioning the deplorable healthcare conditions of some low- and middle-income countries. The presence of poor-quality healthcare systems is the main reason for the excessive mortality rates of different diseases worldwide. On a positive note, he proudly recollected the features of the Nigerian National Health Insurance Scheme that was launched in June 2005. The scheme aimed to put an end to the prohibitively high out-of-pocket expenditure. Efforts to realize this scheme are currently underway, and similar efforts have been implemented in other low- and middle-income countries. Finally, he appreciated the endeavors of the UK National Health Service and cited it a good UHC model that can be emulated by other countries.

Ms. Batool Al-Wahdani, President of IFMSA, stated some key ideas to reverse the trend of UHC realization in some countries. She believes that UHC can be realized once the system becomes inclusive for all, rather than implementing specific measures to manage marginalized populations. According to her, one of the key barriers to ensuring equitable access to healthcare services is the healthcare workforce crisis. This crisis is caused by not only the limited information on UHC provided to medical students in their training facilities, but also the lack of incentives and decent working conditions for healthcare professionals. Further, she opined that health professionals should work together in interprofessional collaborative efforts. To ensure a positive outcome for this meeting, she expects different leaders in the room to exemplify those who can undertake appropriate investments to realize UHC.

Discussion

The highlights of discussion are summarized as follows:

- 1) The session reaffirmed the need to strengthen existing commitments of governments, non-governmental bodies/ non state actors, including WMA, National Medical Associations (NMAs), and health professionals, to UHC.
- 2) The session also affirmed the need for NMAs, physicians and other health professionals, to get actively involved in the policy and political decision-making process of their respective countries and localities.
- 3) The session affirmed the need for NMAs, physicians and other health professionals, to strengthen their advocacy for UHC, including seeking ways to put it on the political agenda of their respective countries and localities.
- 4) The session identified corruption as a major barrier to the attainment of UHC in many countries of the world and therefore affirmed the need for zero tolerance to corruption. Importantly, the session called for greater transparency in resource utilization and the institution of comprehensive strategies to extirpate corruption and its conduits.
- 5) The session emphasized the need to integrate the voices of patients in conversations on UHC and build collaborations with patient organizations and populations.
- 6) The session observed the critical nature of the current global health workforce deficit of 80 million with low- and middle-income countries, particularly Africa (where there is a massive shortage of health workforce), being worst hit. Recognizing the prime place of the health workforce in driving progress towards the achievement of UHC, the session affirmed the need to develop more comprehensive policy sets to take care of the issues of health workforce development, particularly in terms of production of medical doctors and other members of the health workforce in various countries of the world. Additionally, the session emphasized the great need to incentivize and motivate medical doctors and other health workers, especially those who work in Primary Health Care settings.
- 7) The session also identified as germane, the quality care component of UHC, but nevertheless decried the suboptimal nature of the quality care component of UHC in most low- and middle-income countries. The session therefore called on governments, non-governmental bodies/ non state actors, including the WMA, NMAs, physicians and other health professionals to be more focused on the quality care component of UHC. Additionally, the session called for greater investments in the quality care component of UHC, as well as regular quality assessments and strengthening of health regulatory frameworks and laws.
- 8) Recognizing the great importance of private health institutions and hospitals in the pursuit of UHC, the session called for greater government support to the private health sector, particularly in terms of easy access to credits, grants and reduction of tariffs on hospital equipment and consumables, as well as effective regulation.
- 9) Expressing great worry over the high out-of-pocket expenditures that have increasingly led to catastrophic health expenditures and limited access to healthcare amongst several populations in low-and middle-income countries, the panel session called for institution of effective, efficient and sustainable financial risk protection mechanisms as well as greater financial investments in health systems across the world.



Session 2 Health Security and Universal Health Coverage

Chair: Masamine Jimba

Professor, Department of Community and Global Health,
The University of Tokyo



Introduction

Disasters and disease epidemics are major threats to the on-going efforts to achieve Universal Health Coverage (UHC). If UHC is realized, it can be a strong foundation to overcome such threats. This session addressed two major issues about human security and UHC; controlling health threats can be a contributor to achieving UHC, and how UHC can be a key to overcoming such devastating health threats.

In this session, we invited four speakers from different agencies; Dr. Takao Toda, Vice President for Human Security and Global Health, JICA, Mr. David Maizlish, Head of Delegation ad interim, ICRC Delegation in Japan, Dr. Clara van Gulik, International Medical Advisor, Médecins Sans Frontières (MSF) Japan, and Dr. Walaiporn Patcharanarumol, Director of International Health Policy Program, Ministry of Public Health, Thailand.

Presentations

Dr. Toda of JICA highlighted the importance of “trust” for responding to health threats such as natural disasters and disease epidemics as it can build resilient social systems among individuals, local communities, and countries. He introduced JICA’s experiences with disaster in different countries: Indian ocean earthquake and tsunami in 2004 in Indonesia, Great East Japan earthquake in 2011, Ebola outbreak and medical staff training in Democratic Republic of the Congo (DRC) in 2018. In addition to these response activities, JICA also has given technical support for Expanded Program on Immunization (EPI) and polio vaccine supply in Pakistan since 2006. Similar support has been given to community health workers in Ghana and Bangladesh (**Fig.1**). For all these activities, “trust” was the key as it contributed a great deal for overcoming devastating health threats toward achieving UHC.

Mr. Maizlish of the ICRC mentioned that their sole mission is to aid and protect victims of armed conflict and other situations of violence. He described the long history of ICRC’s systemic support to fragile health systems damaged by armed conflict, and then called upon the international community to strengthen efforts to support healthcare systems amidst crises, and caution against increasing constraints on access to healthcare, including emergency hospital care due to politicization of humanitarian aid. In particular, he urged the international community to address both mental health and non-communicable diseases in conflict settings. More importantly, to provide such services, he argued that no UHC is possible until access to healthcare is protected and he emphasized that the attacks on health facilities and healthcare professionals

Figure 1



must stop (Fig. 2). Finally, he urged that all parties inflicting conflict and violence to allow for neutral and impartial treatment of all victims without restricting access to healthcare.

Dr. van Gulik of MSF mentioned that they witness people who struggle to access healthcare, been denied or lack it. If each person can realize UHC to access quality medical care based on their health needs, doctors can ensure that no patient is left behind. Amidst the global health narrative of achieving UHC, doctors need to ensure patient-centred discussions. Doctors need to actively discourage harmful policies, such as the reintroduction of user fees (Fig 3). She emphasized that life-saving emergency response is always a priority; preventive and preparedness strategies can be improved complimentarily. Health system strengthening should be invested on, along with disease-focused services. To promote UHC, the importance lies in keeping medical care protected, and criminalizing medical colleagues for providing care to patients should be condemned because saving lives should not be a crime.

Finally, according to Dr. Patcharanarumol of Thai Ministry of Public Health, their health systems have undergone a continuous process of change over the last five decades. UHC in Thailand was successfully implemented nationwide during 2001-2002. This achievement is attributed to health-system's resilience, in turn, fostering the resilience of the systems, despite frequent changes of Health Ministers: 13 Ministers in the last two decades. The paradigm shift also has taken place from a focus on disease and health facility to general health and wellbeing protection for all. This includes protecting households from financial hardship and impoverishment due to medical care costs. Within the era of UHC, the Thai health systems were able to fairly and effectively respond to many major public health crises, like the tsunami in 2004, the nationwide severe flood in 2011 and the advent of MERS CoV in 2015 (Fig. 4). The dynamics and interaction of various groups and institutions within and outside the health sector also contributed to the sustainability of effective UHC policy and health systems resilience.

Figure 2

The ICRC's Health Activities

- The ICRC calls for all governments and donor agencies to consider healthcare in humanitarian settings as part of a comprehensive and sustainable health approach
- Urges the international community to address both mental health and psychosocial support and non-communicable diseases in conflict settings
- Encourages preparedness measures to meet the threat of disease and epidemics in conflict-affected environments
- Calls for the impartial delivery of services, including areas not controlled by State governments

Figure 3

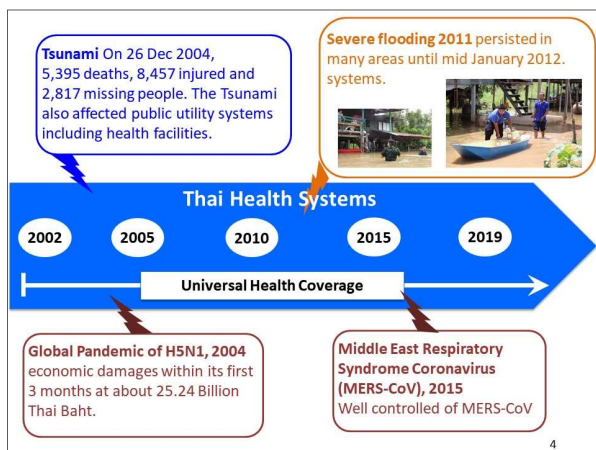
Taxing the Ill: How user fees are blocking universal health coverage MSF report December 2017

User-fees in low resource, conflict, crisis or emergency settings:

- exclude, deter, delay people from seeking care
- reduces the quality of health services or medical care
 - vulnerable to abuse and misuse, such as withholding care or holding them captive until they pay for the cost of treatment
 - poorly remunerated healthcare workers are prone to sacrifice quality of care by opting for treatments or services that generate the most profit
 - health facilities underused, efficiency reduced: in terms of optimal use of health workers, avoiding expiry of drugs
- exacerbates poverty and disease burden
- delays the detection of epidemics and outbreaks

UHC Plans need to prioritise concrete measures to avoid negative effects of user fees.

Figure 4



Discussion

During the discussion session, two main issues were raised.

1. Emergency as a chance to strengthen UHC: An emergency situation often gives us an opportunity for building a health system or strengthening UHC. Humanitarian crisis is a chance for development practitioners improve on the key factors of UHC in the current systems, such as the improvement of logistic and supply chain, the necessity of capacity development and robustness of the system. The discussion addressed what efforts have been made by institutions, like MSF and ICRC, to strengthen UHC in emergency situations.

2. Integration of UHC and emergency: Discussion questions were raised concerning how UHC and emergency response activities are integrated, where UHC is well developed and implemented, like in Thailand.

1. Emergency as a chance to strengthen UHC

Responses for the first question were given by MSF, ICRC, and Thai Ministry of Public Health. Dr. van Gulik of MSF explained their situation in the Philippines where they work in collaboration with the government, and they managed to improve the emergency logistics supply. As the Philippines have been focusing on emergency preparedness, challenges remain because of their middle-income country status. In more resource limited settings in Africa, capacity building is crucial, such as the training and supervision of human resources and the collaboration with government and local authorities. In the DRC, MSF just has a permanent supply chain system and massive warehouses in the capital, Kinshasa. Due to the high number of emergencies, MSF must work closely with the government by showing how MSF can effectively operate. As it is beyond the task of one external agency, MSF calls out to development organizations to work near the people, in different parts of the countries, to help create a sustainable system.

In armed conflict countries, ICRC must work under very fragile public health systems. ICRC is working to support existing and developing community ownership over healthcare through mobilizing assets within the system, which proved to be more sustainable over time. They also are equipped with a cadre of highly trained medical logistics specialists who work specifically on these programs for logistics of supply chain and cold chain management.

2. Integration of UHC and emergency

In Thailand's context, UHC and emergency response integration was demonstrated when the country was hit by the flood in 2011. The peritoneal dialysis (PD) solution was delivered to patients through the post office and sent directly to the patients' home. This system resulted in a more efficient supply chain. In addition, the 1-3-3-0 call center has been effective hotline to receive questions and complaints from the public.

Although UHC in the country is functioning well, UHC and health security activities are not always integrated. A lack of integration still remains among the UHC scheme with the control department in health security, as well as in the national health system with the surveillance program.

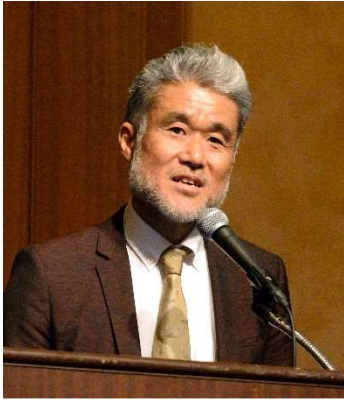
Summary

This session had a reoccurring theme of "leaving no one behind" and "leaving no patient behind". However, we need to consider how it is integrated in our daily practices. MSF and ICRC spoke about their actions in conflict areas where patients are never left behind. A system level action, in addition to an individual level action, is also necessary for leaving no one behind.

The discussion centered around opportunities after disasters in the African countries. Disasters often leave detrimental effects, but it also gives a chance to improve and better the health systems or UHC.

UHC and health systems can be strengthened, even with an unstable political situation. Thailand proved that even with 13 Health Ministers heading the Ministry of Public Health in the last 20 years, UHC now belongs to the people. When a political system is very fragile, the importance lies in how we can create a health system which is less affected by politics. However, the answer is it is possible when people realize that UHC belongs to them.

Lastly, as health professionals, we tend to think about trustful relationships between us, the health professionals, and the patients. However, Dr. Patcharanarumol highlighted that "trust" can also mean the importance of trust in the health facilities, trust in the health system, or trust in UHC. "Trust" is a key to maintaining UHC after achieving it, but also people's trust to the system is indispensable. Therefore, "trust" is possibly the answer to how UHC can be a key to overcoming devastating health threats.



Session 3

Political Dimension of UHC/PHC, Role of Medical Professions

Chair: Hiroki Nakatani

Executive Board Member, WHO
Project Professor, Keio University, Global Research Institute



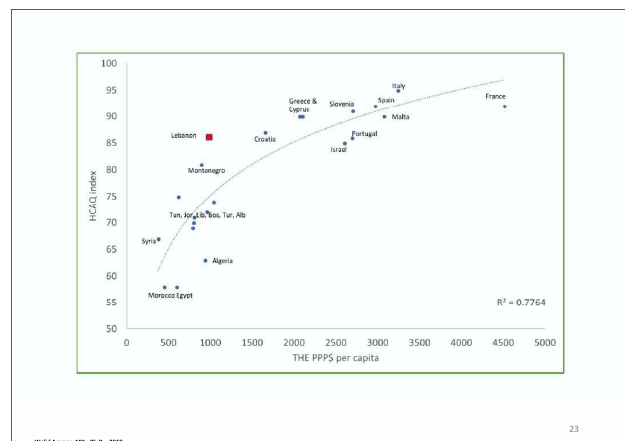
Introduction

UHC/PHC is not only a technical challenge, but its progress depends on political process unique to the context of each country and health system. Medical professions have a crucial role to play in health policy. In this session, six distinguished speakers presented from six different angles; national government, global health academia, National Medical Association, World Medical Association, philanthropic organization and socio-economic think-tank. After a short presentation from each speaker, the floor was open for discussion.

Presentations

The first presenter was Dr. Walid Ammar, Director-General, Minister of Health, Lebanon. The title of his presentation was “Building success with a strong professional workforce: the case of Lebanon”. He first recalled the epoch-making Alma-Ata meeting of PHC in 1978 and highlighted the uniqueness of the new paradigm followed by identification of subsequent implementation shortfalls. Then, he pointed out the unique challenges since the Alma-Ata meeting, such as change of geopolitical landscape, advancement of technology, proliferation and diversity of health professionals, increased demand of the population, increased incidence of emergencies, and as a consequence, more migrants and stronger private sector. Based on the above background, Dr. Ammar used

Figure 1



Lebanon as a case study of how a country can achieve relatively high performance in healthcare access and quality index (**Fig. 1**). The task started from understanding the people's legitimate expectation and the country's health systems, and confirming the people-centered approach. This process succeeded to identify critical strategic areas such as mitigating fragmentation in service delivery and financing as well as engagement of key stakeholders including the Ministry of Public Health and medical professions. Attempts have been made to deploy medical professionals as key and quality providers of PHC in Lebanon.

Professor Kenji Shibuya, University Institute of Population Health, King's College, London, was the second presenter. He spoke on the topic “Beyond UHC: the future of health systems”. Professor Shibuya provided the future outlook of health systems under the following four subheadings: 1. Let us talk about the real stuff; 2. UHC is not the end, but a never-ending journey; 3. system transformations: from health systems to social systems; and 4. doctors: the forefront of the future health systems. The real stuff often reveals painful experience, such as Mexico, which

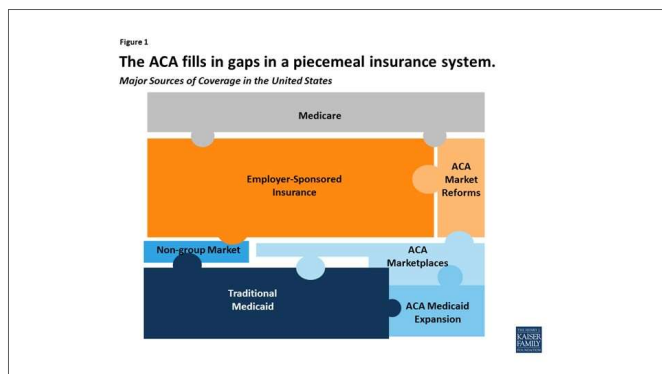
was poorly rated in WHO's ranking of health systems in 2000. With regards UHC, four tsunamis are hitting us today. They are (1) population ageing, (2) chronic diseases, (3) explosion of health technologies, and (4) globalization. Surviving these enormous challenges require system transformation. Based on this concept and adopting essential strategic orientation, Japan and the UK have formulated action plans: "The Japan Vision: Healthcare 2035" and "Improving the Health of the Public by 2040", respectively (**Fig. 2**) This transformation requires new technologies, new partners, as well as transformation of life science and education. Lastly, Professor Shibuya emphasized the roles of doctors as the forefront of future health systems.

Figure 2



Next, Dr. David Barbe, Past President of American Medical Association (AMA), spoke on "Why Universal Health Coverage Needs Political Will, Tough Decisions and Commitment". Dr. Barbe illustrated the efforts of the AMA in the recent hot debates on healthcare reform; whether to continue or repeal the Affordable Care Act (ACA, so-called "Obamacare") in the US. He stated that the mission of the AMA is to promote the art and science of medicine and the betterment of public health. This leads the association to "advocate for health insurance coverage for all Americans, in the setting of pluralism, freedom of choice, freedom of practice, and universal access for patients."

Figure 3



Notably, the AMA supports the ACA with the goals to (1) expand health insurance coverage for the uninsured, (2) making health coverage more affordable, (3) prevent denials of care and coverage, including those of pre-existing health conditions, and (4) investments in prevention and wellness initiatives. The percentage of uninsured persons was as high as 17%, but declined after the ACA was signed on 23rd March 2010. Thus, ACA is filling the gaps of fragmented insurance schemes as illustrated in **Fig. 3**. However, the new administration is eager to repeal the ACA. Therefore, AMA forms a broad alliance to fight against the erosion of patient protection by repealing ACA. This is an example of new activities for a national medical association to uphold the mission and values for the interest of patients and families it serves.

The fourth presenter was Dr. Otmar Kloiber, Secretary-General, World Medical Association (WMA), who discussed the topic "Is Primary Health Care (PHC) an end in itself or a step on the way for comprehensive healthcare systems?" Dr. Kloiber posed the question: Who should lead the primary care teams? He

Figure 4

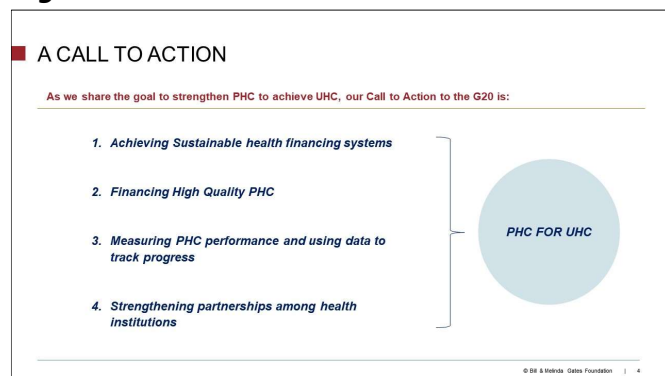
Conclusions

- We wholeheartedly share most of the aims especially the ubiquitous provision of Primary Health Care (PHC) and the strive for Universal Health Coverage (UHC).
- Making this a reality depends on the actions of the donors, their willingness to invest in proper PHC as a core element of UHC is unclear.
- PHC's success will depend on the availability of physicians and other health professionals, their appropriateness and sufficiency of treatment options. Thus PHC has finally to be complemented by secondary and tertiary care.
- Patients deserve that medical decisions about their care are taken on the highest professional level.

reviewed the outcome of the Alma-Ata Conference in 1978, in which health was declared as a human right and PHC was declared as an essential tool to realize such noble objective. But, what to do and who should do it remained unclear, which stimulated many discussions. However, the HIV epidemic highlighted a critical shortage of doctors, and attempts to shift tasks from doctors to less trained personnel began. Under such circumstances, the Global Conference on Primary Health Care was held at Astana in 2018, which heightened again the ongoing debates on who should deliver PHC. There are growing discussions globally on the expanded roles of nursing professions and community health workers. Therefore, Dr. Kloiber called on medical associations to engage more actively in the ongoing debate on who to deliver PHC, as illustrated in his summary slide. (Fig. 4)

The fifth speaker was Ms. Mihoko Kashiwakura, Head on of Japan, Bill & Melinda Gates Foundation (BMGF) who presented "Primary Health Care for UHC". The BMGF is the world's largest health philanthropic organization, and its global health program seeks innovative, ambitious, and scalable solutions to address health problems that have a major impact in developing countries. In this context, the Foundation sees that PHC is critical to achieve UHC and a priority for the Foundation. Ms. Kashiwakura stressed that the sustainable actions in four areas, as shown in Fig. 5, deserve the highest political commitments at the forthcoming G20 meeting hosted

Figure 5

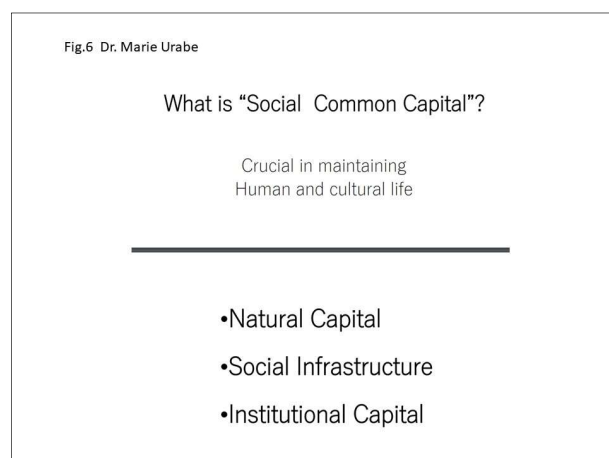


by Japan. Particularly, she pointed out that governments of low- and middle-income countries must increase spending on PHC, since currently they are spending only 36% of their health budgets in this area. Also, strategic information for investment is lacking. To facilitate informed policy decision, the Foundation works with partners to develop PHC Performance Index (PHCPI) which is displayed as Vital Signs Profile (VSP). It provides a snapshot of the strength of a PHC system across four dimensions: financing, capacity, performance and equity. She concluded her presentation by emphasizing the importance of strengthening partnership among health institutions.

The last speaker was Dr. Marie Urabe, CEO, Uzawa International Foundation. Her presentation was entitled "Social Common Capital and Healthcare". Dr. Urabe started her presentation by

referring to her father late Professor Hirofumi Uzawa who was initially a cutting-edge researcher in mathematical economics, but later became the most forceful advocate of "Social Common Capital (SCC)". The concept of SCC is "a natural environment and social infrastructure that enables the people living in a country or a specific region to enjoy a prosperous economy, develop a superb culture, and maintain in a sustained and stable fashion a society that is attractive on a human level". She explained that three elements constitute SCC: natural environment, social infrastructure and institutional capital. This concept was initially

Figure 6



applied to air pollution caused by automobiles, which damages the natural environment and the social infrastructure, with high social cost. In the same manner, Professor Uzawa extended the concept of SCC to medical care. Dr. Urabe emphasized that the idea of SCC is very relevant to advance health both globally and nationally in the era of SDGs (**Fig. 6**).

Comment

Following the six speakers' presentations, Dr. Chaand Nagpaul, Chair of Council in the British Medical Association, described the National Health Service of the United Kingdom as a visionary system that was inspired by social conscience and implemented to ensure that the state safeguards the health of all its citizens. He explained the three core values of the Service: being universally accessible by ensuring equitable access, providing low-cost services, and prioritizing clinical needs. Further, he clarified how the National Health Service is funded by general taxation. Patients are not charged once they access the services, and the state directly pays doctors and, thereby, ensures pay protection and provision of good working conditions. This system fundamentally builds trust between patient and doctor. Finally, on behalf of the international civilized medical community, he exhorted all the participants to strengthen the United Nations' efforts to realize UHC worldwide by 2030.

Discussion

Then the panel moved to a question and answer session. One participant from Africa commented that the political will on health is likely demonstrated by the number of doctors in the Parliament. In his own country, the number of Parliamentarians with a medical license is proportional to the health budget.

Another participant asked two questions, one for Dr. Ammar regarding the key factors to improve healthcare access and quality index even under very harsh conditions of a country in conflict, and another for Dr. Barbe regarding the involvement of AMA members particularly close to legislative bodies. In response, Dr. Ammar pointed out the importance of the development and implementation of accreditation and performance indicators. Dr. Barbe responded that the debate over ACA and the polarization between political parties in the US has led to a big divide between AMA members.

The last person also raised two questions. One was for Dr. Nagpaul regarding the burnout of UK physicians, and he responded that insufficient resource allocation was problematic. Another question was for Dr. Urabe regarding whether there were some examples of countries implementing the SCC concept. Dr. Urabe responded that Scandinavian countries could be examples at country level. However, there may be many smaller models in various countries which we are not aware of.

After such rich presentations and discussions, the Chair adjourned the meeting with appreciation to all presenters and participants.



Session 4

Shared Responsibilities, Individual Obligations towards UHC

Chair: Takeshi Kasai

Regional Director, World Health Organization,
Western Pacific Region (WPRO)



[Speech]

Introduction of UHC in Japan and How Physicians and JMA Responded during its Early Phase

Yoshitake Yokokura

President, JMA, Immediate Past President, WMA



The healthcare system in Japan began in 1927 with an insurance program for large corporation employees. Then the public health insurance program started in some municipalities from around 1940 and during the wartime, and the number of insured persons increased. However, the healthcare system was devastated in the post-war confusion in 1945.

In December 1956, the Ministry of Health and Welfare resubmitted the revised National Health Insurance Act. The revised Act aimed to strengthen the government control on the health

insurance program in general and suppress the healthcare expenditure by restricting medical practice of physicians.

Health insurance unions were established in April 1961 in all municipalities enforcing all citizens to join, including those who cannot afford for whom the healthcare assistance program was made available. As a result, the health insurance in Japan as Universal Health Coverage (UHC), in which all citizens are covered by insurance, was achieved.

Near the end of the 20th century, the progress of population aging led to the rise in the long-term care needs, such as the increase in the number of the elderly who need care and the extension of care periods. JMA insisted that long-term care is part of healthcare and that the elderly care should be supported by the society as a whole, and the Long-term Care Insurance Act was enacted in December 1997, which enforcement started in April 2000.

As population aging advances, the social security expenditure is expected to rise in the areas of both medical care and long-term care. Meanwhile, the pressure to cut down on insurance benefits in the name of growth strategy and deregulation will likely increase from the standpoint of financial retrenchment.

Japan faces aging society, but the national health insurance program as UHC must be firmly maintained. The opinions that JMA state on government policies are based on the criteria of

whether it contributes to safe healthcare for the public and whether it allows to maintain UHC through public health insurance. With this in mind, we will continue making proposals toward the most appropriate healthcare system in which medical practitioners can provide sufficient care to the patients.

[Comment 1]

Teniin Gakuruh

WHO Representative for Seychelles, AFRO

After the presentation by Dr. Yokokura, Dr. Teniin Gakuruh, WHO Representative for Seychelles, was invited to make comments by Session Chair Dr. Kasai. In her speech, Dr. Gakuruh emphasized some of the major issues the African region faces including the Polio and Ebola outbreak, and how some of the affected countries responded to the emergencies. She also gave a positive note by mentioning how in Seychelles, a reformulated constitution enshrined free education, and primary health care, amongst other social determinants of health. Through these, Seychelles has met MDGs and had even been recognized globally as having the potential to meet the SDG targets. She purposely mentioned those specific examples to stimulate the discussion regarding the role of doctors for delivering UHC. In that regard, she stated that the role of doctors needed to be refocused. Dr. Gakuruh expressed the possibility of such refocus by not only improving curative, and providing leadership for primary health care, but also by supplying guidance in public health emergencies, including serving in the front line. She concluded her speech by expressing the distressing reality of how doctors serving in the front line made them become the main casualties in such health emergencies.

[Comment 2]

Frank Ulrich Montgomery

Chair of Council, WMA, Immediate Past President, German Medical Association

Following Dr. Gakuruh, Dr. Frank Ulrich Montgomery, Chair of Council, WMA, Immediate Past President of German Medical Association, made comments on the "Shared Responsibilities, Individual Obligations". Professor Montgomery focused on UHC financing, and some issues with healthcare professionals. He mentioned about the successful social health model that affluent countries follow. However, he cautioned about being careful when advising other countries concerning reaching the goal of UHC, as one sole model might not be as productive for all. He moved on to discuss about the importance of education and how the facilities who are responsible for coaching specialists have to assess a training for both primary and secondary physicians as well. He also included that while physicians should learn what they want, following the liberal approach, the facilities should help by giving some directives. His next point focused on work-life balance applied in the healthcare system. He brought out the necessity to adapt with the new generations' needs and also pinpointed the imperativeness of teamwork between physicians and nurses. His last point encompassed the retention of healthcare professionals. He shed light on early retirement due to discontent from bureaucracy and over-working. In some cases, violence against uniform was also a major cause along with migration. He concluded by stating the need to have all healthcare professionals work in a safer environment.

[Panel Discussion]

Introduction

The Panel Discussion was held under the theme of “Joint Accountability towards Universal Health Coverage (UHC)” with the following panelists: Dr. Yoshitake Yokokura, President, JMA, Immediate Past President, WMA; Dr. Frank Ulrich Montgomery, Chair of Council, WMA, Immediate Past President, German Medical Association; Dr. Yasuhiro Suzuki, Chief Medical & Global Health Officer, MHLW; Dr. Kunihiro Hirabayashi, Regional Advisor and Chief of Regional Health and HIV Section, UNICEF East Asia and Pacific; Dr. Takao Toda, Vice President for Human Security and Global Health, JICA; Dr. Pem Namgyal, Director, Programme Management, SEARO; Dr. Teniin Gakuruh, WHO Representative for Seychelles, AFRO; and Dr. Yue Liu, Coordinator, Division of Health Systems, WPRO.

The Chair Dr. Kasai sought views on the following three questions:

- 1) Sharing their initiatives and approach to achieve UHC
- 2) Challenges and Opportunities for UHC
- 3) Solutions and suggested actions to advance UHC

1) Sharing their initiatives and approach to achieve UHC

Dr. Kasai invited Dr. Suzuki, Dr. Hirabayashi, Dr. Toda, and Dr. Pem Namgyal, to respond to the first question, initiatives and approaches to UHC. Dr. Suzuki recounted Japan’s long history on moving toward UHC including how TB programs supported UHC in terms of accessibility, quality and financial protection. Dr. Kasai noted Japan’s leadership journey on UHC at the global level.

Dr. Hirabayashi outlined UNICEF’s mandate to protect child rights and needs in progressive realization of UHC. Key to UNICEF’s work includes: a) focus on equity; b) enhance service quality ; c) social determinants of health; d) support health system capacity development, particularly sub-national to community level (emphasis on coordination and links with other sectors / systems incl. education, water, sanitation, social protection, and pro-poor cash transfer programs); and, e) work for and work with children and young people, partnering with and empower wider stakeholders or professions (medical doctors and pharmacists, and nurses and midwives, the civil society like NGOs, but also private sector). Private sector engagement on child-friendly policy (e.g. extending maternal leave etc) to improve UHC with equity the overarching approach is a focus for joint work on addressing social determinants is important on the UHC journey.

Dr. Toda reiterated JICA’s focus on human resource development and frontline service quality in multi-sectoral approaches for the last half century. Service quality and management system improvement are key in the context of diversification of health needs including non-communicable diseases, mental diseases, and increasing patient demands. Dr. Toda also raised the importance of prevention and health promotion and patient-centered care in frontline work with local communities. Humanization of service delivery supports technically and financially efficient and effective and mutual learning among health professionals.

Dr. Namgyal, on behalf of WHO SEARO noted WHO South-East Asia Region comprises one quarter of the world’s population in 11 countries and UHC as a flagship focus including essential medicine and human resources for health was adopted to address the low density of health professionals per population. Following WHO revised estimates to have 44.5 per 10,000, the SEARO is at present approximately 27 per 10,000. Essential medicines costs are high in many countries and SEARO member countries are taking very innovative measures. For instance, Indonesia where an insurance scheme has reached 70% of their population. India’s insurance scheme (Ayushman Bharat), aims to cover 50 million families (500 million people), or 50 per cent of India’s of 1.2 billion. Several smaller countries (Bhutan, Maldives, DPRK, Timor-Leste etc) feature systems where health services are free and provided.

2) Challenges and Opportunities for UHC

Dr. Kasai posed the next question to Dr. Yokokura, Dr. Toda, Dr. Hirabayashi, Dr. Montgomery and Dr. Liu.

Dr. Yokokura raised the importance of 'trust' between patients and medical professional touching on the introduction of medical accident report systems in Japan. Dr. Toda noted human resources, facilities to address diversification and increasing challenges of the diseases burden, and geographical disparity of human resources internationally and domestically as key challenges. Retaining health professionals in-country and increased expectations vis-à-vis medical services, based on globalization of expanded internet communications are also challenging health systems. Dr. Toda viewed the use of less aggressive lower maintenance and cost along with mobile technologies that could be scaled up (e.g. tele-education, tele-medicine systems) with global focus as opportunities. Japan's human-centered approach is also being adapted to other country contexts.

The Chair noted that some countries are experiencing rapid economic growth driving societal change as both a challenge and opportunity. Dr. Hirabayashi reiterated equity of access and quality as key priorities in meeting healthcare needs of children and families for UNICEF including promoting education based on data and evidence as a key to addressing challenges such as access to information (e.g. immunization). Out of pocket costs and expenditures also pose challenges for issues such as immunization, antenatal care, and pneumonia. The opportunities include strong political ownership and stewardship, medical professional engagement and collaboration across agencies (WHO & UNICEF).

Dr. Liu outlined the fundamental importance of medical doctors and a well-trained and motivated workforce to achieve UHC. Many countries in the region are addressing challenges of how to ensure coverage to remote and rural areas in a context of increasing urbanization. Touching on China's health reforms including motivating the health professional workforce and benefits that can be obtained through adopting systems approaches to achieve UHC.

In emphasizing the importance of prevention, Dr. Montgomery canvassed the issues of training, retaining and incentivizing medical health professionals, particularly to return to countries of origin rather than to remain in advanced economy countries. One of the opportunities might include strengthening in-country training and measures to ensure ethical recruitment of professionals.

3) Solutions and suggested actions to advance UHC

The Chair requested panelists discuss one area or opportunity to achieve UHC, including Dr. Suzuki, Dr. Hirabayashi, Dr. Montgomery, Dr. Namgyal, Dr. Gakaruh and Dr. Liu, noting mention of new technology, training and data and evidence. Dr. Suzuki identified the importance of harnessing new technology and data to increase productivity in low resource settings. Dr. Hirabayashi noted possibility for UNICEF support for more sophisticated utilization for not only indicator-based data management, but also treatment, referral and the service driven type of data management as innovative idea can be jointly developed. This should include the voices of researchers, health workers, and particularly young professionals.

The Chair noted that the rapid development of new technologies also presented a degree of challenge to synchronize innovations with frontline practice. This was reiterated by Dr. Montgomery in emphasizing training and educating physicians in evidence-based medicine, identifying those based on higher-technology should also represent value for money. Dr. Suzuki considered cost implications associated with introduction of new innovations and technologies. In reflecting on high-level commitments such as Alma-ata, MDGs, SDGs and Astana, Dr. Namgyal urged that this point in time reflects a huge opportunity for UHC. Importantly, as there is collaboration and cooperation particularly in areas of health professional retention and health workforce allocation to rural and hard to reach population groups. Issues of the importance of good governance and stewardship were reiterated in the context of human resource development planning.

Panelists also considered the challenges associated with service delivery equity in an environment of increasing privatization noting the attribution of incentives as a key challenge in equitable service delivery. The Chair noted that these can sometimes be exacerbated by the rapidity of economic development when advancing UHC. As key take-home messages, Dr. Hirabayashi reiterated the importance of including young professional voices, tomorrow's leaders, those in the frontline in efforts to achieve UHC. Dr. Liu reminded that a systems approach with UHC as the foundation was key to addressing challenges and harnessing new opportunities, complemented by working together as highlighted by Dr. Namgyal. The importance of the role of the medical professional doctor was noted by Dr. Gakuruh. Dr. Toda re-emphasized the people-centered approach, including the ownership of data in child and maternal health.

Dr. Kasai closed the meeting with a quote, "If you wanted to go quickly, you go alone. If you wanted to go far, you go together", in urging countries continued progress towards UHC before formally thanking participants and closing the discussion.



Health Professional Meeting (H20) 2019 - Road to Universal Health Coverage was held for two days, June 13-14 with an attendance of over 220 people from 38 countries including 8 from the African region.



Keizo Takemi
Member of the House
of Councillors



Taro Aso
Finance Minister



Takumi Nemoto
Health Minister



Memorandum of Tokyo
on
Universal Health Coverage and the Medical Profession

At the Health Professional Meeting (H20) 2019 in Tokyo, the World Medical Association and the Japan Medical Association welcome the efforts by the World Health Organization, national governments, intergovernmental and United Nations agencies as well as other organizations to foster the development of healthcare systems providing Universal Health Coverage (UHC).

We notice that UHC means “that all people and communities can use the promotive, preventive, curative, rehabilitative and palliative health services they need, of sufficient quality to be effective, while also ensuring that the use of these services does not expose the user to financial hardship.” (WHO definition of UHC)

UHC is a tool to overcome inequities in the health systems themselves.

UHC is for people, but also by people.

Human resources for healthcare in many countries are scarce. We urge all in responsible positions to invest in the education and retention of health professionals to make UHC possible.

This must include quality education, opportunities for continuing professional development and most important safe, dignifying and attractive working and living conditions for those who provide healthcare to their communities and patients.

The WMA encourages physicians and their associations in all parts of this world to play a profound role in the advocacy for and the realization of UHC.

From the side of the medical profession, there should be no hesitancy in embracing the concept of UHC, including a strong engagement for the development of quality primary care as the core part of a comprehensive health system.

We welcome the recent attention that G20 Finance Ministers¹ give to the development of UHC as a contribution “to human capital development, sustainable and inclusive growth and development, and prevention, detection and response to health emergencies, such as pandemics and anti-microbial resistance, in developing countries.”

We express our expectation to the G20 Summit that this inspires the way to improved and sustainable investments in healthcare system not only in G20 countries but also and most importantly in other economies, which still invest insufficiently in their healthcare systems, irrespective of the reasons for such shortfalls.

¹ https://www.mof.go.jp/english/international_policy/convention/g20/communique.htm
https://www.mof.go.jp/english/international_policy/convention/g20/annex8_1.pdf



Health Professional Meeting (H20) 2019
Road to Universal Health Coverage

