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＜ Practice Report ＞

Sharing Japan's experiences for the development of universal health coverage (UHC): a practice report from the UHC leadership course for Asian countries

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Abstract

Introduction: Universal Health Coverage (UHC) is a system ensuring people to receive medical care at an affordable cost and is promoted by UN and WHO as a goal to be achieved by all member countries. As the first country to have achieved UHC in Asia, Japan provides technical assistance for Asian countries to achieve UHC as part of its international health diplomacy.

The "Social security system strengthening towards Universal Health Coverage (UHC) in Asia" course was organized by the Japan International Cooperation Agency (JICA) in collaboration with the National Institute of Public Health (NIPH) and was provided in three years (FY2013-15).

Contents: The participants were young bureaucrats responsible for the development of UHC in their countries. The course intends to provide technical knowledge and skills useful for UHC through a case study of Japan's experiences. The course also emphasizes practical aspects of the UHC operation to be learned from on-site visits.

The course is a two-week course, in which the first half is devoted for didactic lectures to provide basic understanding about Japan's UHC system and the last half is devoted for site visits to the three essential components of health insurance: insurer, provider and claims review/reimbursement organizations (CRRO). In the end of the course, participants summarize what they learned to make them lessons for realizing UHC in their countries. Those lessons range from health economics to balance the patients' copayment and its inflationary effects on health expenditures to political negotiations to win supports from providers (such as favorable taxation on doctors' income derived from health insurance).

Achievement: In three years, a total of 39 participants from nine countries completed the course. The course was continued in FY2016 after expanding target countries from Asia to include Africa. Monitoring of the activities of the participants and the developmental process of UHC of participating countries will be next challenges to the future.

keywords: universal health coverage, health insurance, health economics, Nagase-effect, international health diplomacy

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I. Introduction

Universal Health Coverage (UHC) is defined by WHO as "ensuring that all people have access to needed health services (including prevention, promotion, treatment, rehabilitation and palliation) of sufficient quality to be effective while also ensuring that the use of these services does *not* expose the user the financial hardship (italic author)[1]". The emphasis is on the financial security as well as provision of health services. The financial security is increasingly important because of the escalating cost of health services and the need for integrating with social security system of a country.

Achieving UHC is listed as one of the targets to be achieved by 2030 in the Sustainable Developmental Goals (SDGs) adopted by the UN general assembly in September

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2015[2]. The target 3.8 specifies that "Achieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all".

Japan pledges to provide assistance to achieve UHC by sharing its experiences on national health insurance system as its national policy[3]. To provide training on both practical and theoretical aspects of administering health insurance system, an international course targeting government experts was started in 2013. The course invites government experts responsible for UHC in respective countries and provides intensive two-week course to share practical and theoretical aspects of Japan's experiences of UHC.

II. UHC leadership course targeting government experts of Asian countries

The author have been involved in the Japan's UHC strategies by serving as a coordinator of a two-week course for governmental experts responsible for UHC in Asian countries. It is organized by the Japan International Cooperation Agency (JICA) in collaboration with National Institute of Public Health (NIPH) since 2013. Its purpose and mission were defined as "capacity building for senior policy makers on health security in Asian countries through sharing Japan's experiences and the analysis of issues in each participating country" according to the JICA's proposal.

The participants were invited from Asian countries and a total of 37 participants graduated from the course.(Table 1)

The course is designed to provide participants with both practical and theoretical experiences of Japan combining both lectures and on-site visits. In this article, the author summarizes the contents of the course, which should be shared internationally for the development of UHC.

III. Contents of the course

The course starts with an introduction of the history of Japan's UHC as well as enabling factors in realizing it. Then the course proceeds with practical elements to achieve, administer and maintain UHC including the following three components: 1) contracting with providers as to the price, and scope of coverage, 2) financing (premium collection), and 3) claims review and reimbursement. Participants learn not only from lectures but also from on-site field visits to observe the day-to-day activities to run Japan's health insurance system.

The course also emphasizes theoretical aspects of UHC such as health economics. The key concept proposed by WHO is expressed in the form of "UHC cube[4]" consisting of three dimensions: 1) population coverage, 2) extent of services covered and 3) cost covered (i.e., % of cost sharing). Ideally, all three dimensions are 100% but such system will not be financially sustainable. If UHC is defined by 100% population coverage, policy makers must make some compromise in 2) and/or 3). Such compromises always involve dilemma: one has to protect households from financial catastrophes while at the same time controlling the total expenditure at an affordable level. Japan's experiences pro-

Table 1 List of participants of UHC course

	2013(10 participants)	2014(11 participants)	2015(16 participants)
Bangladesh	Director General, Health Economics Unit, Ministry of Health and Family Welfare	Deputy Director, Health Economics Unit, Ministry of Health and Family Welfare	Director, Health Economics Unit, Ministry of Health and Family Welfare
Cambodia		Deputy Director, Planning & Health Information, Ministry of Health	Chief of Bureau, Department of Planning & Health Information, Ministry of Health
Indonesia	Planner, Directorate for Health and Nutrition, National Development Planning Agency Assistant Deputy of Social Security, Deputy of Social Protection and Housing People, Ministry for People's Welfare	Deputy Director, Center for Budget Policy, Ministry of Finance	Junior Policy Formulator, Central Government Expenditure, Ministry of Finance Branch Manager, Branch Office, BPJS Kesehatan
Lao	Deputy Director, National Health Insurance Bureau, Ministry of Health Deputy Director, State Authority of Social Security, Ministry of Labour and Social Welfare	Deputy Chief of Informal People Health Insurance Division, National Health Insurance Bureau, Ministry of Health Vice Head of Administration, National Health Insurance Bureau, Ministry of Health	Head of Bureau, Health Insurance Bureau, Provincial Health Office Deputy Director, PR Division, National Social Security Fund Office
Myanmar	Deputy Director, Medical Department, Social Security Board, Ministry of Labour	Assistant Director, Medical Department, Social Security Board, Ministry of Labour, Employment and Social Security Director, Health Information Division, Department of Health Planning, Ministry of Health	Director, Social Security Board, Ministry of Labour, Employment and Social Security Assitant Director, Department of Medical Serivices, Ministry of Health
Philippines	Senior Manager, Corporate Marketing, Philippine Health Insurance Corporation	Senior Manager, Non-formal Sector, Philippine Health Insurance Corporation	Department Manager III, Sickness, Maternity & Disability Benefits Administration Department, Social Security System Senior Manager, Corporate Communication Department, Philippine Health Insurance Corporation
SriLanka	Director, International Health, Ministry of Health Medical Officer, Planning Unit, Ministry of Health	Regional Director of Health Services, Health Department, Kurunegala, Ministry of Health Medical Officer, Regional Directorate of Health Services, Monaragala, Ministry of Health	Deputy Director General (Planning), Management, Development and Planning Division, Ministry of Health Regional Director of Health Serivces, Department of Health Services, Monaragala, Ministry of Health
Thailand	Director, Regional Office, National Health Security Office	Assistant Director, Regional Office, Chiang Mai, National Health Security Office	Deputy Director, Regional Office 12, Songkla, National Health Security Office Director of Health Insurance Group, Office of the Permanent Secretary, Ministry of Public Health
Vietnam			Head of Division, International Cooperation, Vietnam Social Security Head of Division, Planning and Finance Department, Ministry of Health

Table 2　Typical schedule of the 2014 course

Note that field visits (shown as shaded area) are intentionally scheduled in the second week to allow participants to obtain background knowledge in the first week of the course

DAY		9:30-50	AM(10:00-12:30)	PM(13:30-16:00)	PLACE
2014/11/10	MON		Briefing by JICA	・General orientation, ・Scope, structure and objectives of the course (incl. WHO strategies toward UHC) ・Presentation by participants (self introduction)(Okamoto, Horii)	TIC
2014/11/11	TUE	presentation by participants	Japan's health care system (Okamoto)	**【Visit MHLW, Bureau of Health Insurance 】** Health insurance system and social security system in Japan	TIC, **MHLW**
2014/11/12	WED		Quality management of health care in Japan (Taneda, teleconference with WPRO)	Japan's Health insurance system (Fee schedule, claims review & processing etc.)(Okamoto) **【field visit】** The role of health care facility in national health insurance sytem (Claims preparation and submission of a provider etc.)	TIC, **Cross Hosp**
2014/11/13	THU		Japan's public health system　(incl. strategies for health service in remote area)(Sone)	Financing and sustainablity of health insurance (Okamoto)	NIPH
2014/11/14	FRI		Factors contributed to realisation of universal health coverage in Japan (Shimazaki)	【Discussion】Factors contributed to realisation of universal health coverage in participants countries' context	TIC
2014/11/15	SAT	※Weekend break (Get together party was held in the evening of 14th Nov)			
2014/11/16	SUN				
2014/11/17	MON	**Moving by bus**	**【Field visit】** The role of municipality in national health insurance and long-term care insurance (incl. coordination system between medical service and community health etc.)	**【Field visit】** financial management and claims processing in hospital (Ogano municipal hospital, President Sekiguchi)	**Ogano town**
2014/11/18	TUE	presentation by participants	Fee schedule and drug prices setting (Okamoto)	Economic evaluation of drugs and products (Health technology assessment)(Fukuda)	NIPH
2014/11/19	WED		Strategies development toward UHC(Kumakawa)	**【Field visit】** The role of federation in national health insurance system (Claims review and processing)	**NIPH, Saitama NHI Federation**
2014/11/20	THU		JICA's strategies toward UHC in Asia (Nakamura)	Preparation for action plans (Okamoto, Horii)	NIPH
2014/11/21	FRI		presentation of action plan	・presentation of action plan (cont.) ・synthesis ・closing ceremony	NIPH

legend: TIC:Tokyo International Center, NIPH: National Institute of Public Health, MHLW: Ministry of Health, Labour & Welfare

vide some answers: strong price control and meticulously designed cash benefit.

1. Factors in realizing UHC in Japan

Japan achieve UHC in 1961, the first among Asian countries and it is necessary to review factors which made it possible because some of them may be generalizable to other countries while others may not.

One factor was the presence of resident registration system maintained by municipal governments. The registration was initiated as far back in 1870 for assessment of tax. Such registration system would be necessary for municipality-based health insurance programs.

Another factor which cannot be overlooked was the absence of private health insurance. Private health insurance usually covers the rich only and the industry tends to resist to the introduction of public health insurance, as amply evidenced by the U.S. in its struggle to achieve UHC. If both private and public health insurance coexist, the rich population will "opt-out" from public health insurance system thereby reducing the financial sources[5].

Fortunately, Japan had no large private health insurance when UHC was achieved. The absence of opposing or competing stakeholders was an enabling factor for Japan's UHC. However, in many Asian countries today, private health insurance companies (many of them are from developed countries) already dominate the market, thereby hindering the development of UHC in those countries.

2. Practical elements of UHC

1) Price control and contracting with providers

Japan's UHC is characterized by "uniform" fee schedule and price regulation of drugs, dictated by the central government. Such strong and centralized control over the prices and scope of coverage is a key factor explaining how Japan has been able to control the national health expendi-

ture at an affordable level.

The national uniform fee schedule includes nearly 15000 items meticulously defining not only clinical procedures but also professional fee for evaluation and management such as initial consultation fee. The national drug price list includes over 20000 items each assigning price tags for different dosage and formulae.

However, such uniform fee schedule and drug price list are by no means compulsory. Participation in health insurance practice signifies a contractual arrangement between providers (hospitals, clinics and pharmacies) and the government (MHLW), in which providers promise to obey the rules and regulations (including prices and scope). The contract implies prohibition against balance billing, i.e., providers must accept the fee schedule and price list as their full charges and any balance billing other than legally required copayment is prohibited (there are some exceptions such as room surcharge for private and semiprivate rooms).

Participation is voluntary but nearly 100% of hospitals and clinics participate. Most of non-participating providers are providers not covered by health insurance such as cosmetic surgery or prevention. The high participating rate of Japan's providers owes much to the taxation system, which favors health insurance practices to practices out of health insurance. Such taxation system was introduced in 1954, in which 72% of the revenue from health insurance were deducted from taxable income as expenses unconditionally even if the actual expenses were much smaller. The 72% expense rule was advantageous for doctors under Japan's sharp progressive tax rate (highest marginal tax rate was 86% before 1983). The system was often criticized being dubbed "discriminatory taxation favoring doctors", however it is certain that the very taxation system contributed to UHC in Japan (the 72% rule was reduced in 1979 in response to criticism but still remains as of today).

Reciprocally, the MHLW retains an authority to cancel the contracts in case the contracting providers commit fraud and abuse. Every year, quite a few providers have their contracts cancelled due to fraud and abuse.

2) Financing and premium collection

Participants learn about financing mechanism of Japan's health insurance from an on-site visit to Ogano town with population of 13,162 (2012, % of elderly was 32%). The informal sector of population is the most difficult segment of population to be covered under the UHC due to the difficulty of premium collection. Japan's National Health Insurance (NHI) Act requires all municipal governments (there are approximately 1700 cities, towns and villages) to operate community-based health insurance program called municipal NHI to ensure residents of informal sector to be covered by health insurance. Each municipality develops budgets, sets a premium schedule and collects premium. Unlike formal sector (employed population), for whom premiums can be withheld from their pay checks, municipality must collect premiums directly from residents. Municipal officers will have to visit residents who do not pay premium and sometimes they must resort to legal actions to secure necessary revenue. To ensure sustainability, the national government amply subsidizes the NHI program with massive subsidy. In fact, the government subsidy accounts for larger share of the revenue than premiums contributed by residents.

Ogano town also serves as a show case of integrated community care. The "integrated" means ensuring medical services and non-medical services such as domestic services be provided to the disabled elderly in a well-coordinated manner. Municipal governments operate not only NHI programs but also the Long-term Care Insurance (LTCI), which was established in 2000. Because Ogano town also operates its own public hospital, Ogano NHI Central Hospital (95 beds, staffed with 5 full-time doctors), it provides a

アジア9国から病院など視察

小鹿野、JICA研修で

アジア9カ国の行政官15人が、小鹿野町の町立小鹿野中央病院や町保健福祉センターを視察し、保険制度や地域包括ケアシステムを学んだ。

アジア各国では、保険制度が整備されておらず、国民が平等に治療を受けられない国も多い。国民が最低限の医療を過度の負担なく受けられる「ユニバーサル・ヘルス・カバレッジ」の制度整備が求められている。

視察は国際協力機構（JICA）による研修で、カンボジアやインドネシアなどの9カ国から保険制度立案に関わる課長級職員が参加。参加者たちは現場を見て回り、病院の診療費請求や町の保険料徴収の仕組みなどについて理解を深めた。保健・福祉・医療が一体となった地域包括ケアシステムの説明も受け、メモを取りながら熱心に聞き入っていた。（桜井和憲）

現場を視察するアジア9カ国の行政官ら＝小鹿野町小鹿野の町保健福祉センター

Fig. 1 local newspaper reporting the site visit to Ogano town (Saitama Shinbun dated 24 Nov. 2015)

favorable condition for effective integration of medical and LTC services. Participants were invited to observe care conferences through which hospital nursing staff and LTC service providers collaborate to achieve integrated care. (Fig. 1)

3) Centralized claims review and prompt reimbursement

One of the enabling factors that made Japan's health insurance universal was the centralized clearing house of health insurance claims and the monetary fund to ensure prompt payment to providers.

Japan's health insurance system is by no means a single payer: it consists of over 3000 fragmented insurers. It would be a nightmarish situation if a provider (doctors, hospitals and pharmacies) has to submit paper claims to thousands of insurers every month. Japan established centralized clearing houses in each of 47 prefectures in the early post-war period. The clearing houses of health insurance claims reduced clerical burden of providers considerably: each hospital or clinic must submit their bulk of claims only to one place.

Another important factor for health insurance operation is how to detect and prevent fraud and abuse. If such fraud and abuse are left unchecked, the financial integrity and trust from both providers and patients will be compromised. The centralized clearing houses also function as claims review and processing organization (CRPO). Claims review can be a politically touchy issue because it may infringe upon doctors' professional freedom. The NHI Act commissions claims review to the tripartite committee whose members are appointed by providers, insurers and prefectural governors in equal numbers. Also, the CRPO serves as a monetary fund regularly collecting "deposits" from insurers. Thanks to the fund, the providers will receive payment in a prompt and timely manner soon after review (an officer of a CRPO boasted that no single claim has ended up in default in a half-century history of Japan's health insurance). The role of CRPO in 1) eliminating clerical burden of providers, 2) fair "peer" review and 3) reliable and timely reimbursement, has been a key factor in achieving Japan's UHC.

Participants visit Yamanashi Prefectural Federation of NHI (PFNHI), one of the CRPOs established in each of 47 prefectures. The participants observe how computerized claims are reviewed on-screen assisted with preliminary screening by administrative staff of the CRPO.

3. Theoretical aspects of UHC

1) Economic evaluation of drugs and technologies

The course includes a lecture on health economics focusing on economic evaluation of drugs and medical technologies. When Japan achieved its UHC in 1961, the economic situation in terms of per-capita GDP was not much different from that of developing countries nowadays. However, one thing is crucially different between Japan half century ago and countries preparing for UHC today: advancement of medical technology and high prices of such technology.

Half century ago, medical technology was primitive. Doctors' clinics were equipped with stethoscope and sphygmomanometers at most. Under such primitive medical technology, Japan's policy that all available treatment shall be covered by health insurance was feasible. The national uniform fee schedule as well as the national uniform drug list serve as a pivotal role in Japan's UHC in that they dictate which pharmaceuticals are covered by health insurance at what prices. All approved pharmaceuticals and medical devices are automatically included in the coverage, limiting the role of the government only to the control of the prices. The prices of pharmaceuticals have been set primarily resource-based or market survey on whole-sellers[6].

However, such long-held policy of automatic inclusion of any new pharmaceuticals or devices are being challenged by proliferation of effective but expensive new pharmaceuticals and devices. Japan is beginning to introduce economic evaluation into the pricing of selected expensive drugs while retaining the long-held policy to automatically cover all approved pharmaceuticals and devices[7].

One of the currently debated issue is new drugs to treat hepatitis C. Hepatitis C is prevalent not only in Japan but also in many Asian countries as well and can develop liver cancer. New effective drugs have been developed but are expensive. The total drug price of Pegylated interferon (PEG-IFN) is 2.23 million yen ($18,600) and Sofosbuvir (Sovaldi®) is priced 61,799 yen per tablet with the total price amounting to 5.46 million yen ($45,500).

Faced with such price tugs, a variety of economic evaluation tools such as cost-benefit analysis (CBA), cost-effectiveness analysis (CEA) and cost-utility analysis (CUA) are being adopted in deciding which drugs or technologies should be covered at what price[8]. Countries pondering to achieve UHC will have to carefully evaluate prices and coverage to ensure financial sustainability of UHC.

2) Achieving equity through income redistribution

A crucial difference between private and social health insurance is that the latter usually (though not always) involves income redistribution functions while the former does not. Typically, social insurance collects premium based on the income while providing benefit equally. Through such income redistribution function, UHC is expected not only to ensure health care to all people, but also enhance solidarity by narrowing the gap between the rich and poor[9].

Therefore, policy makers should monitor how much

inequality exists among people and how much of them are remedied by social insurance and tax. In macroeconomics, the level of inequality is measured by Gini coefficient. Gini coefficient takes value between 0 (complete equality) and 1 (complete inequality), hence it is known as an index of inequality. In Japan, MHLW surveys income redistribution effects every three years. The trend of income inequality and redistribution effects is presented in.（Fig. 2）

Japan's Gini coefficient was lowest in the 1970s-80s and many historians believe that Japan at that time was arguably the most egalitarian society in human history as evidenced by the commonly held acclaim "all nation in middle class". More importantly, this was exactly when Japan's economy was robust. Since 1980, the income inequality has consistently widened but thanks to the redistribution effects of social security contribution and tax, the inequality after redistribution has been kept at a tolerable level.（Fig. 3）illustrates income-class specific health insurance premium contribution and health care benefit converted into monetary values. One sees that poor income people receive more than they contribute, thereby redistributing income among different income classes.

3) Protection against catastrophe while controlling cost---The Nagase effect

As for cost sharing, Japan has pioneered in predicting the effect of patients' cost sharing on the overall health

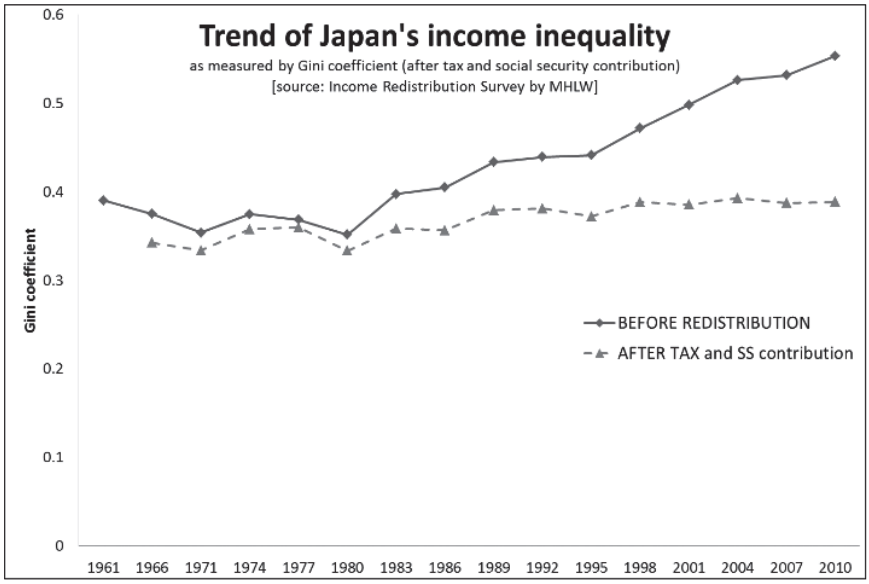

Fig. 2 Trend of Japan's income inequality

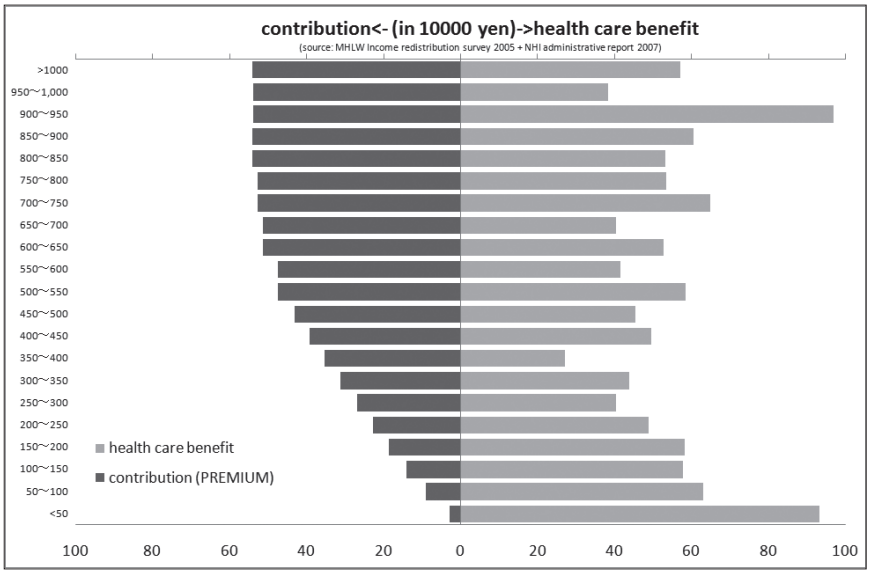

Fig. 3 Income redistriution effects of health insurance

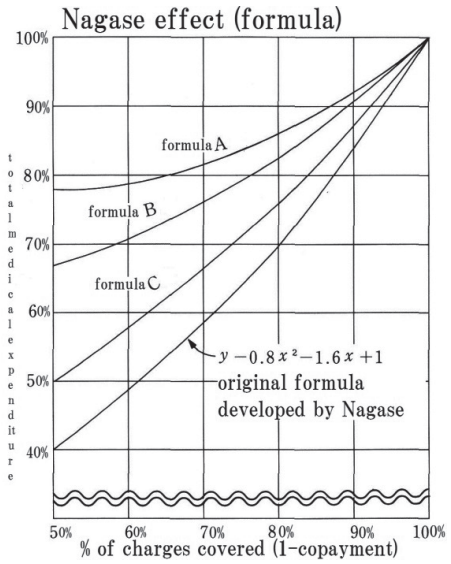

Fig. 4 Nagase effect (formula)

care expenditures. As old as in 1938, Dr. Nagase, a statistician working for the Health Insurance Bureau of the then Ministry of Health, analyzed the cost-inflationary effect of patients' cost sharing and expressed the relation in the form of quadratic equation that the total expenditure will inflate exponentially as patients' cost sharing is reduced. (Fig. 4) The equation was later called "Nagase equation" and is still used for calculating government subsidy to municipal-administered health insurance program.

Japan's health insurance typically requires 30% copayment, which is higher than international standard. However, much of the copayment will be refunded upon patients' requests from insurers. Through such combination of service benefit and cash benefit, Japan has been successful in controlling the inflation of the total health expenditure while protecting people from financial catastrophe. This provides a useful lesson for other countries to follow.

Patients' copayment (cost sharing) is one of the important actuarial concerns in designing UHC. Higher copayment will discourage people from seeking necessary care, while low or no copayment will lead to abuse or misuse of care from both patients and providers' sides thereby straining the financial sustainability of the system. The cost inflationary/deflationary effect of patients' copayment on the entire health care expenditure was therefore a major concern when Japan developed various health insurance schemes in the pre-war period. However, no actuarial evidence existed at that time to quantitatively predict the cost inflationary/deflationary relationship between copayment and the entire health care expenditures. Nagase, then an actuarial statistician of the Health Insurance Bureau of the Ministry of Health, conducted an observational study comparing different insurance schemes with different copayment rate and demonstrated that "the entire health care expenditure of an insured population (Y) will inflate with benefit rate (X, =1-copayment rate) following a quadratic equation (Y=-0.8X^2-1.6X+1)" in his seminal book "Statistics of diseases" in 1938[10]. His theory became known as Nagase effect and his formula is still in active use in Japan's health insurance system. This led to Japan's meticulously balanced combination of cash vs. service benefit. Patients' copayment is uniformly set at 30% (reduced for elderly people), a high copayment rate when compared with international standard. On the other hand, Japan's health insurance provides ample cash benefit. If the total copayment exceeds a certain limit, the excess will be refunded afterward. The amount of refund is metered to the patients' income, thereby protecting the poor patients from financial difficulties. This elaborately balanced assortment of cash vs. service benefit achieves the two conflicting goals of UHC: controlling the entire cost while protecting patients financially. The Nagase effect provides useful evidence for countries developing UHC today.

IV. Responses from participants

At the conclusion of every course, questionnaire surveys were conducted for evaluation. One of the questions is on the applicability or usefulness to their country. As shown in Table3, responses from the participants were overall positive but 25 out of 37 of them also admit that the knowledge and experiences from Japan may not be directly applied to their countries, the results of which is open to discussion.

Table 3 Results of the post self-evaluation on the training course

Do you think the knowledge and experience you acquired through the program in Japan is useful?	2013	2014	2015	total
Yes, it can be directly applied to work	3	5	4	12
It cannot be directly applied, but it can be adaptable to work	5	5	10	20
It cannot be directly applied or adapted, but it can be of reference to me	2	1	2	5
No, it was not useful at all	0	0	0	0
	10	11	16	37

V. Discussions and conclusions

It is understandable that any system of a particular country cannot be implanted to other countries per se, nor is it intended to be. The author believes that the course would have fulfilled the mission if it could make participants to extract lessons universally applicable from the particular experiences from Japan's case of UHC. Principles of health economics such as economic evaluation, cost-inflationary/deflationary effect of cost-sharing and, above all, political skills and tactics to win support (or at least avoid resistance) from stakeholders would be universally applicable skills to realize UHC in any countries.

World Bank (WB) formulates such universally applicable skills as "UHC challenge programs (UNICO)[11] ". When 24 developing countries were analyzed using UNICO, a sharp contrast was found in terms of copayment: while eleven countries had no explicit copayment with no restrictions, other countries imposed caps on reimbursement (beyond which patients will have to pay out-of-pocket)[12]. The contrast can be counter-productive: countries with caps on reimbursement jeopardize people to financial catastrophes while countries without them may face financial difficulties. Japan pioneered in reconciling these mutually contradictory targets by developing the Nagase formula and meticulously incorporating it to the copayment system. Unfortunately, such valuable experience of Japan has not been well-known among international community and the UHC leadership course provided valuable opportunities for the experts from Asian countries to learn useful experiences Japan had accumulated.

During the three years, the course graduated a total of 37 experts from nine countries. The author hope the experiences and knowledge learned from the course will contribute to the development or improvement of UHC in respective countries.

VI. Acknowledgements

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The authors declare that there is no conflict of interest regarding the publication of this article.

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＜報告＞

日本のユニバーサル・ヘルス・カバレッジ(UHC)の経験を共有する
—JICA国際研修「アジア地域におけるユニバーサル・ヘルス・カバレッジ達成のための社会保険制度強化」の報告—

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抄録

緒言：全ての人が必要とする医療を可能な経済負担で受けられる体制，ユニバーサル・ヘルス・カバレッジ（UHC）は，国連とWHOが掲げる目標であり，アジアでいち早くUHCを達成したわが国は，アジア諸国のUHC達成への支援をその国際保健外交戦略の重要な柱と位置づけている．

国際協力機構（JICA）の国際研修「アジア地域におけるユニバーサル・ヘルス・カバレッジ達成のための社会保険制度強化」は，その戦略実現の重要な方策として2013〜15年度に実施され，国立保健医療科学院は研修の企画立案そして実施等の技術面で全面的に支援した．本稿では，その概要と成果を報告する．

研修の内容：本研修はアジア諸国のUHC達成に関係する中堅職員を対象とし，わが国の医療保険制度の学習を通じて，各国に適用できるUHCのあり方に関する医療保険や医療経済の知識を習得するとともに，現地見学を通じて実務的経験を涵養することを目的とする．

本研修は 2 週間のコースで，前半の週は座学中心に，日本の医療保険制度と医療経済の基本知識を学習し，十分な基礎知識を習得した上で後半週において，医療保険システムの 3 要素すなわち，保険（支払）者，医療機関そしてその間に介在する審査支払機関の業務を実地見学する構成となっている．十分な知識を持って実地訪問をすることによって，関係機関の機能と役割，そしてその重要性の理解を深める．

後半週においては，講義と実地見学で得た知識と経験をベースに，各国でUHCを実現する上で必要となる医療経済学（患者負担割合と医療費との関連，医薬品の経済評価と薬価算定等）ならびに医師会等の利害関係者の理解と協力を得るための方策を日本の経験（審査支払への医師会の関与，保険診療への優遇税制適用等）を例に学び研修を総括する．

成果と考察：3 年間にわたって 9 か国37人が修了した．研修は2016年度より対象国をアジアのみならずアフリカにも拡大して継続している．今後は修了者の活躍や各国のUHCの達成状況等の追跡評価が必要になろうと予想される．

キーワード：ユニバーサル・ヘルス・カバレッジ，医療保険，医療経済，長瀬効果，国際保健外交戦略