Report

Strengthening Social Health Protection Towards Universal Health Coverage

UHC Open House Tokyo

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Submitted to

The Partnership Project for Global Health and

Universal Health Coverage (GLO-UHC)

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Title: **Review for site visit to Ogano town and its public hospital**
Presenter: Dr. Etsuji Okamote, The University of Fukuchiyama

Key points from presentations:

Background information

Japan has three-tiered administrative structure. The top level is central government, followed by the governments of 47 prefectures, and the local governments of 1780 municipalities at the lowest level. A municipality can be called a city, town, or village depending on population size.

The health system has a fragmented structure. The entire population is covered by multiple health insurance payers which could be categorised in 3 sectors:

Sectors/Payers	**No. of pools**	**Beneficiaries**	**Administrative bodies**	**Financing Sources**
1) The elderly aged 75 and older				
The elderly health care system	47	The elderly aged 75 and older	Prefecture governments	50% central gov. 40% cross subsidy from the other insurance plans 10% premium
2) Formal workers				
Civil Servant	78	Civil servants		
Corporate-based health insurance	1348	Employees of 1348 big companies	Each private company	50% employer 50% employee
Japan Health Insurance Association	1	Employees of all small companies	Japan Health Insurance Association (government)	~16.4% gov subsidy The rest is an equal contribution by employer/employee
3) Informal workers (poor & non-poor)				
Citizens Health Insurance (CHI)**	1780	Non elderly & non formal workers	Municipal governments	Premium and government

*some information are taken from Prof. Naoki's lecture on Day 2

** CHI or sometimes is called NHI (National Health Insurance)

Beside health insurance, Japan has also established non-medical long term care insurance (LTCI) in 2000. People aged over 40 need to pay additional premiums to this LTCI. This insurance scheme fully covers the elderly aged 65+ and partly covers the disabled people aged 40-64 whose disabilities are caused by diseases.

Citizens Health Insurance (CHI) in Ogano town

Ogano town is a municipality in Saitama prefecture. 31.7 % of its residents are within informal sector. These residents are covered by Citizens Health Insurance (CHI) managed by municipal government. The town also operates 1 public hospital. There are 3 accounts involving in the process of premium collection and provider payment in this town.

1) General account: All residents are required to pay (city) tax to General account. Other sources of revenues include central government. This account is used for government expense within the town e.g. school, civil servant's salaries, social welfare. It is also used to subsidise the other two accounts.
2) CHI account: The CHI beneficiaries pay premiums called 'CHI tax' to this account. It is used to pay for medical expenses incurred by its beneficiaries claimed by any providers in the country and to subsidise the elderly health care system and LTCI.
3) Hospital account: Hospital receives reimbursement from CHI account, Out-of-Pocket payments from its users, and subsidies from General account.

Tax rate in Ogano town in Fiscal Year 2014

In Japan, tax rate varies by municipalities and fiscal years. In FY 2014, tax rate in Ogano municipality was the lowest in Saitama prefecture and lower than national average. The collection rate was high (96.3%). Tax rates were calculated as follows:

1. CHI tax rate per household:

4.5% of income + 42% of real estate tax + 5,500 yen per person + 13,100 yen fixed price

2. Supportive contribution to the elderly health care system:

1.4% of income + 5,500 yen per person

3. LTCI rate (only for 40-64 years old):

1% of income + 7,200 yen per person

Title: **Introduction to health policy and to Japan's health care system**
Presenter: Prof. Naoki Ikegami, St. Luke's International University, Keio University

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Key points from presentations:

Three objectives in health care policy

1) Not bankrupt the patient
    - Reduce copayment
    - Reduce service not covered by public financing
2) Not bankrupt the government
    - Negotiate more budget for health
    - New sources e.g. sin tax, VAT, mobile phone use, fuel taxes
3) Provide services in publicly financed sector
    - Either private or government facilities
    - Need to balance health workers' expectations (healthcare cost = health workers' income)

Key features of Japan's health system

Population	127.3 million
Population coverage	100% (since 1961)
GDP	5.87 trillion USD
Total Health Expenditure as % of GDP	11.4%
Total Health Expenditure per capita	4,265 USD
Public expenditure as % of THE	86.5%
Life expectancy at birth	86.8 years
Physicians per 1000 populations	2.35
Nurses per 1000 populations	10.6
Hospital bed per 1000 populations	13.2
Service provision	Private sector: 82% of all hospitals, 72% of all beds, 95% of all physicians 95% Public sector: restricted to • University hospitals • Army and navy hospitals • Quarantine hospitals • Areas with not adequate private facilities
Health insurance plans	4 categories (over 3000 pools) 1) The elderly 75+ 2) Large companies + public sector 3) Small companies 4) Citizens' Health Insurance (CHI) for informal sector

Payment methods	• fee-for-service + fee schedule • All items have fixed prices and conditions for billing. • Fee schedule is revised every 2 years • there is a DRG-like system for IP but the principle of payment is as same as ffs • Global Budget is imposed but can be overspent
Co-payment	• 30% copayment for all except <7 and >75 with • ceiling for monthly copayment amount • Balance billing is prohibited • Extra billing is restricted (e.g. extra-charge rooms, new technologies being evaluated)
Benefit packages	All medicines, devices and services approved in Japan can be reimbursed.
Policies promoting Primary Health Care	• Same fee schedule throughout the country regardless of cost of living resulting in relative more income in rural areas • Fee schedule sets relatively higher fees for primary care services compared with high-tech care services • Income of specialists in big city hospitals < Income of physicians in rural facilities

Title: **Inception report presentation**

Presenters:

Bangladesh	Mr. Islam Rafiqul
Cambodia	Mr. Touch Mengleng Mr. NY Sophanith
Egypt	Mr. Khalaf Mohsen George Naoum
Indonesia	Ms. Kiswanti Utin Mr. Taufik Ahmad
Laos	Ms. Sengdara Laddavanh
Mongolia	Mr. Orosoo Batbayar Aralud Borchi Ms. Purevsuren Undarmaa
Myanmar	Mr. Soe Oo Mr. Kyi Lwin
Philippines	Mr. Tan Lester Madriaga
South Africa	Ms. Zondi Gloria Thulile Sthembile
Sri Lanka	Mr. Mahagedara Udayachandra Arunasiri E.
Vietnam	Ms. Vu Thi Nga Ms. Vu Nu Anh

Key points from presentations:

Parameters/Countries	**Ban**	**CAM**	**EGT**	**IND**	**LAO**	**MON**	**MM**	**PH**	**SA**	**SL**	**VN**
Population (million)			91.5	237.6	6.8	3	51.4	101	52.9	20.3	90.4
Population coverage				51.8%	33%	90%		92%	17.9%		81.7%
UHC target	2032			2019			2030				
THE as % of GDP	3.7%		5.7%	2.9%		6%				3%	6.7%
THE per capita (USD)	27	183	163.7	51	33			<100		127	113
Public expenditure as % of THE	23.09%		30%*	37.5%	51%	65.5%	40%		50%		
GGHE as % of GGE		12%		7.8%	3.4%		3.65%		11.5%		
OOP as % of THE	63.31%	~67%	60%*	46.9%	39%		60%	57.6%			49.3%
Life expectancy at birth			70.9		64		66.8	M69.5, F73.9	59.6	77	75.2
Maternal mortality per 100000 live births		206	33	346	197		282	114	155	30	67
Infant mortality per 1000 live births		45	12.8	32	30.1		62	21	41.7	8	15.5
Under-5 mortality per 1000 live births		54	24		66.7		72	27	56.6		
Physicians per 1000 populations			8.4				0.7				
Nurses & midwives per 1000 populations			14.8								
Service provision			Private dominant	Private dominant		Public dominant	Public dominant	50:50			Public dominant

* As of operating health expenditure (excluding investment)

Countries	Main challenges for the attainment of UHC
Bangladesh	Inadequate financing Inefficient use and allocation of resources Lack of quality and readiness of health infrastructure and health workforce Gaps in evidence and information Lack of understanding and consensus on UHC Bad governance
Cambodia	Lack of quality and readiness of health infrastructure and health workforce Direct and indirect healthcare costs remain high Low level of health literacy Only 20% of poor people receive support
Egypt	Incomplete coverage Multiple laws & systems Unrealistically low premium and contribution rate Fragmented insurance pool Voluntary enrollment No explicit benefit package Moral hazard and fraud Health workforce flow to private sector Purchase provider integration
Indonesia	High OOP Large informal sector (around one-third, many without ID cards) Inadequate quality and readiness of health infrastructure and health workforce Rising health expenditure Health workers do not satisfy with provider payment scheme
Laos	Inadequate readiness of health infrastructure Lack of informed decision to determine level of finance to providers Insurance expansion to informal sector Monitoring & evaluation of
Mongolia	-
Myanmar	Large informal sector The poor rely on private providers Primary care takes second place to hospital services Inequitable access to services Lack of health infrastructure and health workforce Questionable quality of care Lack of transparency in health budget
Philippines	Limited and uneven number of accredited facilities Unaffordable health facilities Inadequate supply of medicines

Countries	Main challenges for the attainment of UHC
	Lack of financial resources Lack of awareness of health benefits High indirect cost to access health facilities Perception of poor quality of healthcare services
South Africa	Inequities in service delivery, HWF, financing between public and private sectors and within public sector
Sri Lanka	Low government funds for health Overcrowding public hospitals Lack of resources for rural areas Negligence of preventive services Lack of evidence based decision culture HWF problems (brain drain, conflicts among professionals) Corruption
Vietnam	Weak cooperation with private health insurance Adverse selection, moral hazard Unsuitable payment method Undefined health care package High co-payment esp high-tech services Abuse of health insurance fund

Title: **Field visit – Case of quality management in hospital (incl. coordination system between medical service and community health etc.)**

Presenter: Ogano Hospital

Key points from presentations:

Ogano town is a municipality in Saitama prefecture. It has 12,600 populations of which 32% was over 65 years old (and increasing). Ogano hospital is a public hospital established in 1953. The hospital has 2 wards: 45 beds for acute/subacute conditions and 50 beds for chronic conditions. Bed utilisation is 80% and average visit per day is 160.

The visit to hospital showed patient flow for outpatient visit. There steps are:

1) Reception – where health insurance card is checked
2) Waiting area for OP department
3) Consultation – where the patient meets doctor and investigation and other examinations are performed
4) Waiting area for payment department
5) Payment – where the patient makes copayment and receives prescription
6) External pharmacy – patients can go to any pharmacy to receive medicines as prescribed.

Health Insurance Claims are submitted on monthly basis. The claim checking process starts on Day 27th of the month and submits online to Federation of National Health Insurance insurers and Social Insurance Claims Review and Reimbursement Services on Day 9th of the next month. If approved, the reimbursement will be paid within 2 months.

The hospital also has problem collecting unpaid fees. The current measure is to remind the patient about the overdue payment by phone and postcard. If one-time payment is difficult, the patient can pay in instalments. However, this measure has not been very effective. So far, the hospital does not take any legal action on patients regarding the uncollected fees.

One of challenges that Ogano hospital is facing includes population ageing which reflects higher health costs in the future coupled with reduced income due to shrinking working age group.

Title: **Field visit – The role of municipality in national health insurance system**
Presenter: Ogano Municipal Government

Key points from presentations:

The main role of municipal government in national health insurance system is to collect NHI tax. The purpose of this collection is to secure funding for health expenses for NHI beneficiaries based on a spirit of solidarity. In Japan, a municipal government can choose between two options of NHI fund raising which are NHI premium and NHI tax. In Ogano town, NHI tax is applied. The major differences of these two types are summarised in the table below.

	NHI premium	NHI tax
Time limit on imposition	2 years	3 years
Status of limitations on collection	2 years	5 years
Status of limitations on refund claim	2 years	6 years
Precedence rules on collection	National and local tax collection takes precedence over NHI premiums.	NHI tax is equal to national tax i.e. take precedence over all other claims and public dues.

Fiscal year in Japan starts in April. The amount of tax is considered in June and then the 6- term payment due dates are announced. There are 3 methods to pay tax 1) at bank/post office 2) bank transfer 3) deduct from pension. If the full payment is not made by the due date, a demand notice is issued within 20 days from the due date. The next step is urging by phone calls, letters, or visits. The final step is property confiscation. However it has never been practised in Ogano town. The collection rate was 97% in the past year.

Title: **Health system and community health in Japan**

Presenter: Professor Munehito MACHIDA, Professor for department of global health, Kanasawa university school of medicine

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Key points from presentations:

Data at a glance:

- Life expectancy: 83.7 (2015)
- Fertility rate: 1.41 (2012)
- Ageing rate is 24.1% (2015) and will be 30% in 2025
- NCDs account for 60% of all death.
- Japan has 8,480 hospitals and 100,995 clinics.
- 2/3 of hospitals are private.
- Hospital beds per 1000 population are 13.2 (OECD 4.7).
- Average length of hospital stay is 17.5 days (OECD 7.7).
- Number of physician consultation is 12.8 times/person/year (OECD 6.8).

Healthcare delivery:

Administrative organisation in Japan is decentralised into 3 levels: national, prefectures, and municipalities. Prefectures are to set medical-service zones as regional unit to coordinate and share medical resources. This is designed by prefecture governments based on local needs.

Each municipality is equal to primary medical service zone where minimum services are ensured. Multiple primary zones make a secondary medical service zone. Tertiary medical service zone (most advanced) is a prefecture size.

Medical service is regulated by Medical Service Law (1948). According to the law, hospital must have at least 20 beds. Clinics have 19 beds or less. The classification of hospitals (e.g. general, long-term, psychiatric, infectious diseases) is based on staff and facility criteria. The number of beds is regulated within secondary medical-service zone.

Apart from medical service, a total of 486 Public Health Centres are also established in prefectures and major cities. They handle mainly public health services such as infectious diseases, AIDS, TB, mental health, maternal and child health, food sanitation, environment health, planning, and health statistics.

Municipalities also have duty in health and medical service. They provides ‘direct health services’ that Public Health Centre does not handle e.g. regular health check-up, maternal & child health, health care counselling, vaccination, or oral health care.

Title: **JICA's assistance in achieving in universal health coverage (UHC) in developing countries**
Presenter: Makoto Tobe Ph.D., M.P.H. senior advisor on health financing/health systems, Japan international cooperation agency (JICA)

Key points from presentations:

UHC means "provide *all people* with access to needed health service of sufficient quality and ensure that the use of these services dose not expose the user to financial hardship". However, there are gaps in service utilization between rural and urban, rich and poor and between countries.

Vision of JICA is inclusive and dynamic development. Missions of JICA are addressing the global agenda, reducing poverty through equitable growth, improving governance and achieving human security. Assistance in UHC fits very well in JICA's vision and mission.

JICA can provide both technical and financial support in developing countries. This session presented two cases of UHC strengthening under JICA support with different models.

1) Concessional loan aid in Senegal

This project aimed to boost government efforts to provide social health insurance coverage to the poorest group. National strategy for UHC has been established in 2013; however, with high uninsured informal sector, many of which is the poorest. JICA provided both financial and technical support. Loan was disbursed only when predefined policy action are accomplished. Therefore, the government had strong incentive to support the policy actions.

2) Technical Cooperation Project in the Philippines

This project assisted pregnant women in rural areas to deliver at health facilities without financial hardship. JICA's assistance included upgrading birthing facilities in rural areas, training on basic emergency obstetric and newborn care, health facility accreditation by health insurance agency, checking health insurance enrolment status, and community campaign. One lesson learnt from this project is that pregnancy is a good change to promote insurance enrolment.

Title: **Achievement and challenges of UHC: Thailand's experience**

Presenter: Walaiporn Patcharanarumol, BSc MSc PhD. International health policy program (IHPP), Ministry of public health. Thailand

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Key points from presentations:

Background

- Thailand now an upper middle income economy (GNI per capita = 5,410 US$)
- Total health expenditure (THE) is 4.6% GDP, 254 US$ per capita, public source 80% of THE (2014), Out of pocket 11.3% of THE

Experience

Health system development has started since 1970. The hand-in-hand expansions of supply sides and health financial protection have resulted in significantly reduction of under-five mortality rate.

The history of insurance coverage expansion included targeting the poor, civil servants, compulsory enrolment of formal sector, or on voluntary basis. Although several strategies have been undertaken, there was still 30% of population remained uninsured due to adverse selection and large informal sector. The UHC policy was committed as a political manifesto during the general election in 2001. It was also at the lowest trough of the Asian economic crisis where the GNI was at 1900 USD/capita. ***Thailand has started and achieved 99% population coverage at low to middle income level.***

Now, 99% of population is covered under 3 major schemes.

- UC scheme: 75% of pop (50 million pop), tax funded, close ended budget, managed by National Health Security Office (NHSO) governed by board chaired by Ministry of Public Health
- Civil servant scheme: 7 million pop, tax funded, open ended budget, managed by Comptroller General Department, Ministry of Finance
- Social security scheme: 10 million pop, tripartite contribution (employer, employee, government), close ended budget, managed by Social Security Office, Ministry of Labour

'Triangle that moves the mountain' is the theory behind the UHC reform in Thailand. ***Synergistic power from technical capacity & evidence, social mobilisation, and political commitment was critical to successful reform.***

Achievements of the UC scheme included increased utilization with pro-poor benefit, low unmet needs, health system efficiency, and reduction of health impoverishment.

The remaining challenges are inequities among and within health insurance scheme, urbanization and financial sustainability.

Title: **Lessons and Challenges in Fund Management: Thailand's Experience**

Presenter: Dr. LALITAYA KONGKAM, Director of NHSO Regional branch 9, Thailand

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Key points from presentations:

The UC Scheme in Thailand is managed by National Health Security Office (NHSO) which are governed by 2 boards: National Health Security Board (NHSB) and Health Service Standard and Quality Control Board (HSQCB). Regional health security offices are distributed in 13 regions. The key responsibilities of NHSO include:

Fund management

NHSO is responsible for budget calculation and negotiation for the UC scheme and fund management. The UC budget per capita has increased from 1,202 baht in 2002 to 3,344 baht in 2016. NHSO employs mixed provider payment methods to ensure cost containment and quality goals. Capitation and DRG with global budget are the main payment methods for OP and IP services respectively. Some other methods e.g. P4P, project-based, fee-for-service, or lump sum payment are also used considering population's health needs. These payment methods and conditions are constantly revised. NHSO is also managed claim processing and performs coding and billing audit to identify reimbursement pitfalls and prevent fraudulent claims.

Health service quality control

HSQCB has duties to set up measurement to control and monitor health service quality. All hospitals under UCS contract must be accredited by Hospital Accreditation Institute. There is a 24/7 hot line number 1330 to address customer's inquiries and complaints.

The current challenges are improving efficiency under limited resources, long term and sustainable financing sustainability, promoting collaboration between stakeholders, preparing strategies for aging society, vulnerable groups and urbanization, harmonization of health insurance scheme, and improving quality and safety.

Title: **"Long-term care insurance system" and community-based integrated care system**
Presenter: Kenichi TANAKA, senior director, Pension benefits department, Japan pension service

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Key points from presentations:

Long-Term Care Insurance system

The change in the percentage of the population over age 65 in Japan has been rapid compared to other countries. Japan has the highest ageing population in the world resulting from increased life expectancy from the advancement of technologies coupled with low birth rate. The ratio of persons aged 65+ to persons aged 20-64 has changed from 1/5.1 in 1990 to 1/2.6 in 2010, and is expected to be 1/1.2 in 2060.

Japan has started developing the welfare policies for the elderly since 1960s. However, the welfare system and medical system for the elderly have limitations to address problems e.g. expensive fee for intensive care home and hospital, restricted choices of service, and limited long-term care facilities. Therefore, the Long-Term Care Insurance system has been introduced in 2000 with the aim to enable society to provide LTC to the elderly through diverse agents based on their own choice.

LTCI primarily insures the elderly aged 65+ and secondarily insures the 40-64 who have certificates of needed LTC. Municipalities are the insurers. The funding comprises of 50% premiums and 50% tax. This amount will cover 90% (or 80%) of the LTC costs plus 10% (or 20% if income above certain level) copayment from users.

To use LTC, the person needs to apply to municipal government then s/he will be investigated for the need of support/care. The services are categorised into 7 levels: support level 1&2 and care level 1-5. Varieties of LTC services include home-visit, outpatient day services, short-stay services, residential services, in-facility services.

Community-based integrated care system

The 21st century society is a long-living society. The elderly people may have difficulty adapting to change in living environment. The principle behind community-based integrated care is to support a person to continue his/her own way of life to embrace a happy end-of-life by living mostly at home. Therefore, health and medical care are to be provided in the whole community for the people living with disease. In

To maintain dignity and independence of the elderly people, two strategies are exercised.

1) Services that contribute to long-term care prevention e.g. train the elderly to bathe instead of help them bathing, community volunteers helping them go shopping or do physical exercising with other people in the community
2) Services that would maximize the ability to continue living at home e.g. home visit nursing, Apron service (home visit to do cleaning, cooking, laundry, or companionship)

Care management is also enhanced through multidisciplinary collaboration to help care managers make suitable care plan.

Title: **Japan's global health policy**

Presenter: Dr. Eiji Hinoshita, Director, Global health policy division, MoFA of Japan

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Key points from presentations:

Japan is the leading advocator of human security. The Japan's Global Health Policy agenda includes:

- Global health policy 2011-2015
- Japan's strategy on global health diplomacy (2013)
- Basic design for peace and health (2016); to build a society which is resilient to external factors such as public health emergencies, to establish a seamless utilization of essential health and medical services throughout life thus achieving UHC and to effectively make use of Japanese expertise

The 17 goals of SDGs are very comprehensive and applicable to all countries. The 'no one left behind' principle and the Goal 3.8 on UHC fit very well with 'Human Security' policy that Japan advocates. Japan has committed 1.1 billion USD to international health organization excluding unilateral or bilateral projects.

The Ebola outbreak in 2014 has led to a review of global health architecture on how we cope with such kind of health emergency. There were a series of review in global community since 2015, for example, basic design for peace and health, SDGs summit, PM Abe's article on the Lancet, International conference on UHC tin Tokyo, G7 Ise-Shima Summit, TICAD VI, UHC follow-up meeting in Tokyo, G20 summit, and G20 health ministers' meeting.

Some key positive movements in global community are:

- In G7 Ise-Shima, 3 key issues are health-related; reinforcing the global health architecture to respond to public health emergencies, attaining UHC with strong health system and better preparedness and prevention, strengthening response to AMR. It also gave birth to UHC2030.
- TICAD VI in Kenya, the first ever TICAD in Africa. One of the 3 priorities is 'resilient health system'. In this regard, two agreements were made: strengthening capacity for resilient Africa and promoting UHC in Africa.
- G20: Japan is also trying to put Health into G20 agenda based on the fact that health gain is also contributing to economic gain.

Title: **Economic Evaluation of Pharmaceuticals and Medical Devices under Health Insurance System in Japan**

Presenter: Dr. Takashi Fukuda (NIPH)

Key points from presentations:

In 2014, Japan spent 8.3% of GDP on Medical Expenditure which was 321,100 yen in per capita term. The trend of National Medical Expenditure has been increasing every year. Currently, all medicines listed in Japan are covered by health insurance schemes. Every drug has its fixed price set by Central Social Insurance Medical Council (Chu-I-Kyo). A new drug price is determined by value added to similar existing drug (innovative, useful, market size, children use) or costing data submitted by manufacturer if no similar drug existing. The price is then adjusted by average foreign price from France, Germany, USA and UK. These fixed prices are revised every two years.

Health Technology Assessment (HTA) has been extensively used in many countries such as UK (NICE), Australia (PBAC), Canada (CADTH), Korea (HIRA & NECA), Thailand (HITAP), and Taiwan (CDE & NIHTA). However, it has just been started in Japan and is not used to determine coverage decision. In the pilot phase started from April 2016, the evaluation result will only be used to re-determine prices of some existing pharmaceuticals and medical devices. Two main reasons that Japan does not use HTA to determine coverage decision are: 1) economic evaluation process will delay new drug entry 2) it will limit patients' access to non-cost-effective technologies. The economic evaluation methods applied in Japan are Cost Effectiveness Analysis (CEA) and Cost Utility Analysis (CUA).

Observation Form

Observer: **Dr. Patiphak Namahoot**

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1. What is your overall impression of the UHC Open House?

- In overall, it is very well organized.

2. Please describe the good points of this UHC Open House.

- Period of time, place (JICA training center and field trip), lecture topics, lecturers, activities (lecture, discussion, field trip, inter-professional activity) and number of participants are appropriated

- Dr. Naoko, Dr. Takeda and JICA's staffs are doing good jobs.

3. Please describe what should be improved for this UHC Open House.

- Should organize another field trips such as private provider, claim unit.

- The other countries which are successful in UHC and have similar context to the participant countries should share their experiences.

4. Should the JICA GLO-UHC Project create its own UHC Open House? Please share your opinions.

- I do agree because the aim of JICA GLO-UHC Project is to promote and support the Asian and neighboring countries.

- These countries can learn and get the knowledge of UHC and experience from Thailand, Japan, and the other country

5.Other suggestions for the JICA GLO-UHC Project.

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Observation Form

Observer: Ms. Woranan Witthayapipopsakul

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1. What is your overall impression of the UHC Open House?

- The course has been organized well. Within 2 weeks, we were able to understand the main features of Japan's health system that are key lessons for UHC policy development.
- It was well thought that the course leaders, Dr. Tomita & Dr. Taneda, stayed with participants at all time to provide extra clarification/explanation.
- The course brought together expertise from various experiences which has further benefited the participants to learn not only from the resource persons but also from their peers.
- Participants' active engagement to the class has been seriously emphasized e.g. recap, thank you speech, individual's presentation, Q&A. The curse leaders put their efforts to ensure that all participants express their thoughts for their own and the class's benefits.
- The course seemed to create relaxing atmosphere that stimulated ice breaking and helped people from different countries become friends so fast. One particular point was perhaps they lived in the same building which has various evening activities. I saw many classmates went sightseeing together in the evening and over the weekend. Everybody seemed to enjoy their times in Japan.
- The organizers of the course, Ms. Sadaie, Ms. Ichihashi, and Ms. Wada, have shown great hospitality for all participants throughout the visit. I think all participants appreciated their kind assistance to make sure that everybody was physically and mentally well.

2. Please describe the good points of this UHC Open House.

I think I answered this question in Question 1 already.

3. Please describe what should be improved for this UHC Open House.

- There should be more discussion time. It seemed that almost all times allocated for discussion were used for Q&A (i.e. addressing unclear points from the classes) rather than discussion (provoking ideas & exchange experience).
- A few participants were not so engaged with the class. Not sure this was because of English competency. If so, some improvements could be done during recruitment process e.g. interview. This is because the rich contents spoken in the class would mean less if the participants could only partially expose to them. Also the overall effectiveness of the course would be decreased if it was rather one-way communication.
- There might be something that could be improved about communication with the participants about the expectation i.e. inception report presentation and action plan presentation as it seemed that many of them did not fully understand what they were expected to present.

4. Should the JICA GLO-UHC Project create its own UHC Open House? Please share your opinions.

It depends on the aim of the course. The Tokyo open house was rich in the Japan's experience which would be very informative for someone particularly aims to develop a similar model. However, in case participants have less experience in health system or UHC concepts, it might be difficult for them to digest the information and take what can be applied to their country contexts. For example, some participants in this course found that Thailand's experience was more applicable to their countries taking into account the income level, culture, demographic profile, and socioeconomic status of the population even though both case studies have given good lessons learnt and knowledge to adapt. Therefore, if the course aims to create understanding of UHC, it might be beneficial to spend more time on fundamental concepts at the beginning of the course and, if possible, various case studies so that the participants can take the lessons effectively from each scenario and will not look for any particular model to adopt.

5. Other suggestions for the JICA GLO-UHC Project.

None.