

GLOBAL

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**THE SCHOLARLY JOURNAL FOR THE NEW HEALTH SECURITY PARADIGM
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GLOBAL HEALTH GOVERNANCE IS AN OPEN ACCESS, PEER-REVIEWED, ONLINE JOURNAL THAT PROVIDES A PLATFORM FOR ACADEMICS AND PRACTITIONERS TO EXPLORE GLOBAL HEALTH ISSUES AND THEIR IMPLICATIONS FOR GOVERNANCE AND SECURITY AT NATIONAL AND INTERNATIONAL LEVELS.

THE JOURNAL PROVIDES INTERDISCIPLINARY ANALYSES AND A VIGOROUS EXCHANGE OF PERSPECTIVES THAT ARE ESSENTIAL TO THE UNDERSTANDING OF THE NATURE OF GLOBAL HEALTH CHALLENGES AND THE STRATEGIES AIMED AT THEIR SOLUTION. THE JOURNAL IS PARTICULARLY INTERESTED IN ADDRESSING THE POLITICAL, ECONOMIC, SOCIAL, MILITARY AND STRATEGIC ASPECTS OF GLOBAL HEALTH ISSUES.

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Dear Global Health Community,

We are pleased to release a partial version of our Spring 2019 GHG Issue. This release is timed to coincide with the 2019 G20 Osaka summit taking place from June 28 to June 29, 2019.

Our full issue will be released in late July of 2019.

-Global Health Governance Editorial Team

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Japan's Health Diplomacy: Projecting Soft Power in the Era of Global Health

Hisashi Kato, Tim K. Mackey, Yee K. Heng

Few scholars have studied the use of “Global Health Diplomacy” by the Japanese Government, a unique form of diplomacy that relies on the use of “soft power” and “smart power” but also one that is undergoing changes based on current geopolitical developments in Japan and the Asia-pacific region. This article will provide a review of the literature based on a multilingual document review on Japanese global health diplomacy by examining how health diplomacy has been used by the Japanese government in furtherance of broader foreign policy and diplomatic goals in the international fora. This article will also discuss the limitations of Japan’s nascent health diplomacy strategy and possible challenges in the near-future; specifically, the possible revision of Article 9 of its Constitution.

INTRODUCTION

One of the most frequently made criticisms towards Japanese foreign aid policies is that Japan is a large funder of international development initiatives but doesn't provide direct support beyond finances and technical assistance. However, through the establishment of the Official Development Assistance (ODA) charter and judicial justifications on the usage of Self Defense Force (SDF) for non-coercive means such as Peace Keeping Operations (PKO) and ODA in 1992, Japan has undergone changes in its foreign assistance policies, which have further accelerated from the beginning of the second administration of Prime Minister Shinzo Abe since 2012.

In his inaugural address, Prime Minister Abe made the remark that Japanese diplomacy should be the “diplomacy that takes a panoramic perspective of the world map”¹ Moreover, in terms of legal justifications for making Japan capable of active commitments, the Abe administration has made historical changes from the past. In his keynote address in Shangri-La dialogue in 2014, Prime Minister Abe made the following remark specifically highlighting that Japan should be a “proactive contributor to peace”

“Imagine now that civilians or NGO workers there, powerless to defend themselves, came under sudden attack by armed elements. Under the approach that the Japanese government has taken to date, Japan’s Self-Defense Forces are unable to go rescue these civilians enduring the attack. Is this an appropriate response into the future? My government is thinking hard about it, and a close consultation is underway within the ruling coalition parties. It is precisely because Japan is a country that depends a great deal on the peace and stability of the international community that Japan wishes to work even more proactively for world peace, and wishes to raise the banner of “Proactive Contributor to Peace.”²

In response, in 2015, the Diet passed a law that allows the SDF to carry weapons to assist allies and/or to protect Japanese civilians during PKO operations. Hence, Japanese diplomacy is now in a phase of historical transition. Prime Minister Abe went further to claim that in terms of global health (a multidisciplinary field originating from international health that includes disciplines of public health, public policy, international relations, economics, and security), Japan has what it takes to make contributions for the well-being of others. In the article he published in the medical journal *the Lancet*, he made the following illustrative statement:

“Japan’s strategy on global health diplomacy corresponds to the changing strategic environment. The 21st century calls for major challenges of the international community, in addition to the leadership of 20th-century-style power politics. This dynamism is described as the age of smart power. Japan has capacity and determination to undertake this new form of leadership.”³

This statement by Prime Minister Abe highlights the need for and importance of academic research in the field of Japanese global health diplomacy (GHD). This article is the first scholarly paper regarding Japanese health diplomacy that examines multilingual source documents and literature while using Joseph Nye’s frameworks of soft and smart power. In this article, we analyze the current position of Japanese diplomacy and how foreign policy actions are being made, presented, and implemented with a specific focus on the sub-field of health diplomacy. This is accomplished by conducting a literature review and primary document policy analysis in both Japanese and English. We use the theoretical framework of “power” by Joseph Nye, to identify, describe and assess the characteristics of Japan’s use of “health diplomacy”.

TYPES OF DIPLOMATIC POWER AND THE RISE OF HEALTH DIPLOMACY

The evolution of Japanese diplomacy has undergone several dramatic shifts in the post-WWII period, where diplomatic policies were heavily focused on building good relationships with Asian counterparts. In the first phase, Japanese aid assistance began in the 1950s as a means to make reparations for war crimes and other damages committed during WWII. As a second phase, in the 1980s, due to the national economical upward trend, the so-called “Bubble”, Japan significantly increased its foreign aid contributions. For example, in the year 1980, the ODA budget of Japan was 351.6 billion yen, but in only 10 years in 1990, it jumped up to 817.5 billion yen.⁴ However, since most of the aid was provided in the form of loans (in Japanese Yen) tied to specific projects, it also created significant financial burden on recipient countries due to incurring higher debt load compared to foreign aid that came in the form of grants and aid from other countries.

Importantly, as Japanese diplomacy has evolved, how can it be theoretically conceptualized and what do changing tendencies of foreign aid mean for the identity of Japanese diplomacy? Some works by Joseph Nye help us to answer these questions. Joseph Nye, defined power as: “the ability to influence the behavior of others to get the outcomes one wants.”⁵ According to Nye, power can be categorized into a few groups; hard power, soft power and smart power. He defined hard power as, “the ability to use the carrots and sticks of economic and military might to make others follow your will,”⁶

indicating that hard power is determined by the use of military or economic incentives and disincentives - although the categorizations of economic incentives has been controversial. Conversely, he defined the term, soft power as, "the ability to get what you want through attraction rather than coercion or payments."⁷ In other words, soft power does not rely on military activities but attractiveness of other venues of foreign policy (such as cultural diplomacy and foreign aid), which enables the state's power capabilities.

While soft power and hard power differ significantly from each another, Nye also created the concept of, "Smart Power". He defines smart power as "the ability to combine hard and soft power resources into effective strategies"⁸ Here, Nye provides a framework to appropriately address global issues that are complex, multilateral and multi-stakeholder. Hence, winning hearts and minds of people with soft power and at the same time appropriately using hard power capabilities represents an optimal foreign policy strategy.

Nye often refers to Japan as one of the best examples of a country that has effectively used the concept of soft power.⁹ Both the uniqueness of Japanese culture can be a resource to attract others, but also the concept of pacifism and a pacifist-centric constitution enacted after WWII have been considered Japanese soft power assets. Additionally, in recent years, the Japanese government has tried to utilize this concept of soft and smart power as one of its core diplomatic strategies and to differentiate its approach from other states. From utilization of Japanese animation characters such as the robot cat Doraemon as an ambassador, to provision of large amounts of aid to disaster affected areas, Japanese diplomacy is ultimately aimed at achieving the full use of its soft and limited hard power capabilities.

GHD is also an important Japanese diplomatic strategy that is based on the concept of effectively utilizing soft and smart power. What makes Japanese GHD unique and worthy of study is the fact that few countries are similarly inhibited in their ability to use their military as a foreign policy tool (as this is specifically restricted per Japan's current post-war Constitution in Article 9). Tokyo instead has to pursue diplomatic goals primarily through peaceful means. Therefore, Japan is an interesting case study because of its constitutional limitations and its peculiarity in its approach to global diplomatic agendas.

However, in order to better understand the specific operation of Japanese health diplomacy, a definition of the concept of "health diplomacy" is first needed. The earliest mentioning of the term in the literature appears in 2008 by Adams and Novotny when they defined GHD as "an emerging field that addresses the dual goals of improving global health and bettering international relations, particularly in conflict areas and in resource-poor environments."¹⁰ Although there is a subsequent review article by Lee et.al.,¹¹ that attempts to further define the term 'global health diplomacy' by aggregating the definitions of others, in this piece we instead follow the definition formulated by Katz et.al.,¹² as arguably this article provides the most precise, holistic, and categorical definition available.

According to GHD categorizations by Katz et.al., there are three different types of GHD; core, multi-stakeholder, and informal GHD.¹³ Core GHD has two different aspects; "bilateral treaties and agreements", and "multilateral treaties and agreement." By core health diplomacy, Katz et.al., means the diplomacy which takes places either in the form of negotiation between two formal state parties or, in a forum populated by state actors who govern international institutions, such as World Health Assembly in the World

Health Organization.¹⁴ This form of diplomacy is only practiced by a small numbers of state representatives (i.e. it explicitly does not include non-state actors), and is considered to be the most formal operation of health diplomacy.

Multi-stakeholder GHD, is defined as the diplomacy with partnerships with other agencies not only governmental but also with multilaterals. Good examples of this include the Global Funds to Fight AIDS, Tuberculosis and Malaria, the GAVI Alliance, Stop TB Partnership, Roll Back Malaria, etc.¹⁵ These organizations include Public Private Partnerships (PPPs) and are becoming a popular governance mechanism in global health.¹⁶ The modern field of GHD tends to include a larger sphere of multi-national governance and rulemaking regimes, such as the G8 summit, and international meetings and conferences on global health, often organized by UN organs and agencies but also including non-state actors. Therefore, multi-stakeholder GHD can be understood as less formal than core GHD, but more official and high-level diplomacy compared to informal GHD.

Lastly, informal GHD is defined as the diplomacy which “encompasses interactions between public health actors working around the world and their counterparts in the field, including host country officials, representatives of multilateral and non-governmental organizations, private enterprises and the public.”¹⁷ Informal GHD does not necessitate a government agency or state representative to be an actor. This feature significantly differentiates informal GHD from core and multi-stakeholder GHD in terms of participation of different actors and shared governance. The potential benefit of informal GHD is that, by incorporating diverse perspectives from non-state and non-multilateral actors, the strategy and levels of cooperation for tackling global health problems can potentially be more inclusive. The Bill and Melinda Gates Foundation represents one such example of a private actor, in this case a private philanthropy, emerging as a driving force in global health through large amounts of funding and stakeholder engagement and that may compel channels of informal GHD to open. From the year 1994 to 2010, Gates Foundation has spent over \$14 billion for global health.¹⁸

Hence, it is important to note that GHD takes place not only in the conventional spheres of diplomacy such as state-to-state, and diplomats-to-diplomats negotiations, but in other diverse arenas.

METHODS

To further explore Japanese GHD, we conducted an interdisciplinary literature review and primary document policy analysis specific to the topic of Japanese GHD. For the first phase, we used JSTOR and PubMed to search academic literature on the subject of Japanese health diplomacy. Since this research is about health diplomacy in Japan, for the literature search, we used the keywords “health diplomacy” and “Japan” in the abstract search function for articles published in both English and Japanese language. Based on these search parameters, PubMed and JSTOR returned 3 and 7 results respectively which met the criteria for this study with searches conducted in July 2018 (see Table 1 for summary of extracted articles). An additional fourth article published in a special 2011 *Lancet* series on Japan and global health was not originally captured in our literature review, but was detected in other related web searches and was relevant to the study so was added to our results and is also discussed. In order to complement the limited information available in scholarly articles, in the second phase, we conducted

document extraction and analysis for the purposes of identifying more formal policy documents. In this phase, searches were conducted on the search engine Google and Google Scholar for materials related to the keywords “Japan” and “Health Diplomacy” (国際保健外交 Kokusai-Hoken-Gaikou) in both Japanese and English. This allowed us to access a broader base of information, including official Japanese government documents that are only published in Japanese. We also conducted similar keyword searches on official Japanese government websites including the Ministry of Foreign Affairs (MOFA), Ministry of Defense (MOD), Ministry of Health, Labor and Welfare (MHLW), Cabinet Office (CAO) and Parliamentary Office to obtain official policy and legislative documents.

JAPAN'S HEALTH DIPLOMACY

Literature Review – A Focus on the Soft Power of GHD

As previously mentioned, there were only a few articles that met our criteria as literature focused on Japanese health diplomacy. This is not particularly surprising, given that the same search using the non-jurisdictional focused term “health diplomacy” with no country name garnered only 156 and 139 results in PubMed and JSTOR respectively. The focus of articles published on the broader concept of health diplomacy were primarily on diseases or were country specific (i.e. not about Japan but another country) and were generally non-empirical in nature. Among the 10 articles extracted using the initial keyword search for “Japan” and “Health Diplomacy” and the additional article detected in the *Lancet* special series on Japan, we will discuss 4 of the articles most relevant to our purposes. This is because search results extracted from JSTOR were either; (1) focused on the discussion of other countries’ GHD activities and not Japan¹⁹; or (2) articles that mentioned Japan, but were unrelated to the topic of Japanese GHD.²⁰

The small number of relevant articles indicates that, although the concept of GHD is arguably incorporated into Japanese foreign policies (as will be discussed later), research on Japanese GHD has not been established. In fact, the current literature on Japanese soft power is focused on other aspects such as “Cool Japan” or smart power policies associated with the operations of the SDF not specific to health.²¹ One possible explanation for the small number of articles is that health diplomacy is a relatively nascent field in political science and international relations, with arguably the first conceptualization of the topic in the literature occurring in 2008 by Adams and Novotny in an anthropology journal. Further, tangible policy implementation of GHD principles has only taken place in recent years –particularly starting from the Kan administration since 2010 to 2011.²² In fact, the 4 articles extracted for discussion in this study were published relatively recently in 2011, 2013, 2016 and 2018.

It is also important to note that the articles published on the subject of Japanese health diplomacy are not empirical, and in fact, in the case of the first article published in the medical journal *the Lancet*, not even written by an academic. This article was non-peer reviewed and was written by Prime Minister Abe in 2013.²³ However, despite not being an analytical piece, it provides significant insight regarding the objectives of Japanese GHD.

In the article, Abe first points out the contributions of Japan in global health and its role as an agenda setter. He argues that, “Japan has played a significant part, for example by leading discussions at the G8 Kyushu-Okinawa Summit in 2000 and by helping to

establish the Global Fund.” This effort of GHD can be categorized as multi-stakeholder diplomacy according to the definitions by Katz et.al. By collaborating with other states and institutions, Japan has helped to shape the framework of a global health regime that has prioritized combating particular infectious diseases using a public-private partnership model.²⁴

Other examples of multi-stakeholder diplomacy, explained in Abe’s article include Japan’s contributions in leading discussions supporting Universal Health Coverage (UHC) for the post-Millennium Development Goals (MDGs) framework, also known as the United Nations Sustainable Development Goals (SDGs). Abe argues that under the newly introduced Japanese diplomatic strategy called “Strategy on Global Health Diplomacy”, in order to fill gaps of inequities, Japan will contribute by helping to standardize UHC. Moreover, he argues that by utilizing the knowledge and successful experiences of Japan’s national health insurance system, Japan is in the position to assist developing countries to create well-functioning medical systems, social welfare, and redistribution schemes by standardizing healthcare delivery focused on UHC principles.

For the implementation of this strategy and its related global health programs, Prime Minister Abe also describes the creation of the Global Health Innovative Technology Fund (GHIT). The fund operates through initial government investments in private pharmaceutical companies for research and development (R&D) of medical technology and new medicines. It envisions encouraging these companies to develop medicines which they normally avoid, because the medicines developed in this program will be used in developing countries, situations where it is unlikely that they would be developed without government subsidy.²⁵

The second article on Japanese GHD was published in 2016 by Hinoshita, an article also written by a government official.²⁶ In this article Hinoshita expands on how the GHIT Fund is structured and details its applications for global health. Specifically, GHIT was founded to address the problem of Neglected Tropical Diseases (NTD), diseases common to some of the poorest and least developed countries.

Due to lack of commercial viability, pharmaceutical companies have difficulties justifying investment in drug discovery and product development for NTD drug candidates. Therefore, Japan has volunteered to actively commit to this problem as a part of its global health diplomacy through technology investment. GHIT functions as a PPPs; as of March 2015, MOFA, MHLW, Astellas Pharma, Eisai, Shionogi, Daiichi-Sankyo, Takeda, Chugai-pharma, and the Gates Foundation have joined this fund to develop medicines, vaccines, and diagnostic methods for NTDs. Along with investments from pharmaceutical companies and the Gates Foundation, a total of 10.5 billion yen have been used for R&D and a total of 7 billion yen have been disbursed to GHIT though the UNDP for the development of distribution pathways in the event new medicines are developed.²⁷

The third article was published in 2018 by a group of scholars and government officials documenting Japan’s contributions to GHD in the fora of G7 summits. Sakamoto et.al., describe in-detail how the Japanese government and its officials promoted UHC at G7 events and argue that strong leadership in agenda setting in this influential global forum has helped Japan raise awareness to UHC.²⁸ However, this article merely describes what Japan has done so far on global health in the context of the G7 and did not provide further analysis as to why Japan wants to promote its global health agenda or what is its ultimate goal from a diplomatic standpoint beyond simply promoting UHC.

A fourth and last article authored by Llano et al. in 2011 was published in a special

Lancet series dedicated to Japan and global health.²⁹ Authors briefly discussed the origins of Japanese GHD primarily in the context of ODA, including Japan's adoption of human security as a cornerstone of its foreign policy objectives in 1998 (which officially marked the entry of health as a foreign policy goal), coordination with UNICEF and the World Bank, and the establishment of the Japan International Cooperation Agency (JICA). Importantly, the authors conclude that though global health is driven by multistakeholder partnerships (including civil society and other non-state actors), Japan's stance on ODA and Development Assistance for Health (DAH) remains government-centric due primarily to lack of awareness, attention, and fragmentation of efforts from Japanese stakeholders.³⁰

Llano et al.'s article also includes an analysis of Japanese DAH based on data from the OECD and Institute for Health Metrics and Evaluation and found that Japan contributed the smallest share of DAH compared to other OECD countries (Japan's health ODA is only 2% of its total ODA share) and was the only country that experienced a sustained DAH decline since 2000.³¹ Hence, the article characterizes Japan as focused on core and multilateral forms of GHD that has primarily been concentrated on global health in Asia but is increasingly shifting towards improving health outcomes in Africa. Finally, authors close with a set of recommendations to reinvigorate Japan's leadership in global health including formation of a global health committee at the highest level of Japan's government, increasing Japan's health ODA, and tapping into the financial resources of non-government actors.³²

We also note that there were additional articles that discussed Japan's foreign policy stance in the context of global health, but did not explicitly mention global health diplomacy and were not included in our literature review but merit some discussion. A 2007 article in *the Lancet* by Mashiko Kourumura, former Vice-President of the Liberal Democratic Party and Minister for Foreign Affairs, describes Japan's help in establishing the Global Fund, fighting infectious diseases, improving maternal child health outcomes, strengthening health systems, and commitment to the MDGs.³³ The 2011 *Lancet* special series on Japan and global health (which included the article by Llano et al.) focused on the post-war evolution of health care in Japan and its growing commitment to global health, with a particular focusing on UHC, health insurance and system design, quality of care, and healthy aging.³⁴ Many of these articles also discussed aspects of Japan's commitment to global health that could inform Japanese GHD strategy.

Collectively, the four articles specific to Japanese GHD indicate that Japan is making recent proactive commitments for the development of global health, but at least one (Llano et al.) includes some criticism of Japan's global health commitments and overall strategy. However, all articles were written or co-authored by government officials (including the Llano et al. article that had co-authors from both academia and the Japanese government). Hence, the limited existing published literature generally lacks non-government and analytical perspectives on Japanese GHD. Despite these limitations, certain insights can be explored, such as the types of health diplomacy and international stakeholders engaged. Applying the typology of GHD which we introduced in the definition section, this literature can be summarized into certain major global health themes (see Table 2).

It appears based on this table that Japanese GHD actions are taking place primarily in the sphere of state-centric or multilateral health diplomacy. In other words, if we were to apply Katz et.al, definitions of GHD, the majority of Japanese GHD actions would be

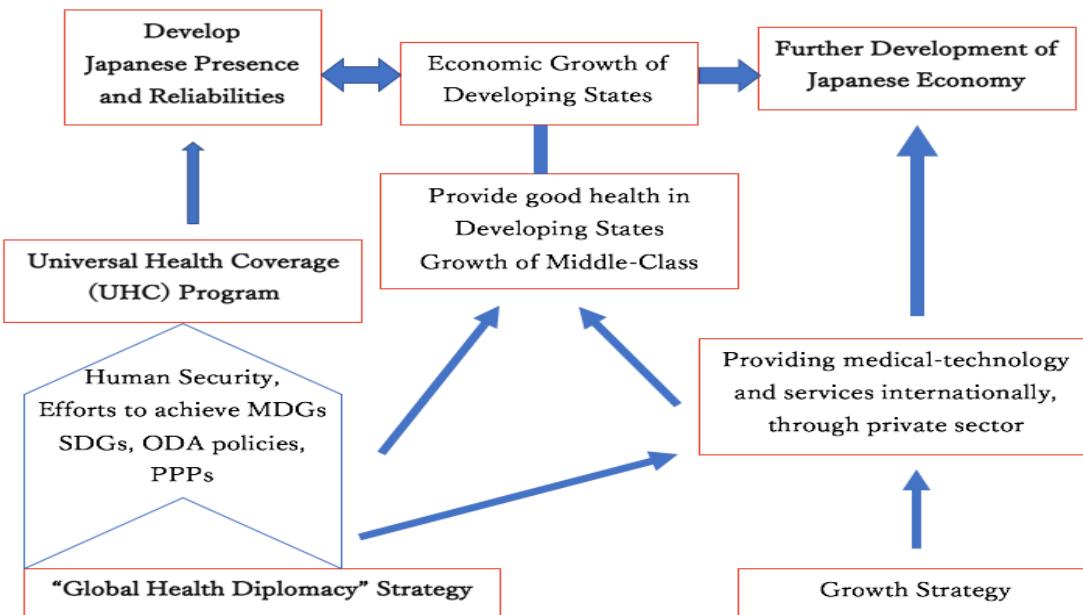
categorized as focused on multi-stakeholder diplomacy.

Overall, the literature on Japanese GHD provides a general description and singular viewpoint on its practice (Abe), focuses on global health diplomacy in the context of Japanese ODA and UHC (Llano et al.), and is limited to the description of a specific programs or forums of GHD -GHIT (Hinoshita) and fora of the G7 (Sakamoto et.al.) Hence, a complete picture of what Japan contributes to global health through diplomatic approaches remains relatively narrow and understudied. For this reason we found it necessary to extend our research beyond the literature to primary documents to better understand the practice of Japanese GHD.

Document Review – The Importance of ODA, Soft Power, and UHC

During our review of primary documents from government, nongovernment, and other sources, we reviewed information that provided a more specific view of the practice of health diplomacy by the Japanese government. Figure 1 is a translated chart by the Ministry of Foreign Affairs used to explain the positioning of GHD as a diplomatic strategy³⁵. This figure is very informative because it makes clear that the ultimate goal of Japan's "Global Health Diplomacy Strategy" is driven and reinforced by various internationally accepted concepts and practices such as human security, MDGs and SDGs, as well as economic growth and development. In the "Basic Design for Peace and Health"³⁶ written based on the renewed 2015 "Development Cooperation Charter"³⁷, it is stated that Japan will make "efforts to address health issues by fully mobilizing Japan's experience and expertise"³⁸

Figure 1: Overview of Japanese GHD Strategy (translated)



According to Sasaki and Llano et al., ODAs are positioned as a critical element of Japanese diplomacy. Sasaki argues that while the primary goal of ODA is to contribute to

the development of the recipient, it can also benefit the national interests of Japan.³⁹ Likewise, Figure 1 indicates that ultimate goal of Japan's GHD strategy is to promote the presence and reliability of Japan in international society, and to further develop and advance the Japanese economy. In other words, Japan is making contributions to global health through various methods including ODAs, PPPs, and financial contributions to international organization as a function of its own national interests.

To be clear, this does not mean that Japan is simply making global health contributions solely for national benefit. Rather, Japan is strategically using global health as a tool to promote its soft power capabilities, together with its economic might and resources. In terms of soft power, recipients' perception matters more than sender's intention. As long as a recipient is convinced that Japanese global health contributions are favorable, ODA can be viewed as a success for Japan. This is also reinforced by Llano et al.'s observation that Japan is responsive to specific requests from recipient countries versus general and unspecified funding. However, it may be too early to assess the effects of how GHD has contributed to the development of soft power because perceptions from other countries is not something that changes quickly or is easily measurable, though, as a soft power strategy, it appears it is having effects.

Singh argues, in the pre-1990s era ASEAN countries were skeptical of Japan taking an active role in Asia because of fear from its actions during WWII. However, by seeing Japan playing a vital role in countries such as Cambodia, while also providing needed financial and technical assistance through ODA programs, they began to have a more favorable attitude towards Japan.⁴⁰ Singh's piece unfortunately does not have any data to back up this claim, but survey data shows evidence of Japan being perceived positively from ASEAN countries through its activities in ODAs. According to data from Ipsos Marketing, 84% of ASEAN countries responders answered to the question "Japan's cooperation on development of Southeast Asian countries (e.g. ODA) is helpful" as either very or somewhat helpful.⁴¹

At the same time, surveys have also engaged on the question of Japan's approach on pacifism: 81% of ASEAN responders either value a lot or little regarding viewing Japan as a peace-loving nation.⁴² Also, in a different survey, the marketing consulting firm Ipsos asked the question to ASEAN countries responders of whether they think Japan is a warlike countries or not, with only an average of 4% answering affirmatively that Japan is warlike.⁴³ These surveys show that Japan's active engagement with ASEAN through ODAs and financial assistance has altered the perspectives of ASEAN countries from negative perceptions of the past to a view of a more trustworthy counterpart that helps the development of ASEAN members.

Additionally, published literature on Japan's GHD efforts mentioned UHC as a critical pillar. By further analyzing more recent government documents, we can update our understandings of the impact of UHC on Japan's global health stance and strategy. This starts with the 2016 Tokyo International Conference on African Development VI (TICAD VI) held in Nairobi, Kenya, Japan announced a new framework for implementing UHC called "UHC for Africa", with the World Bank, Global Fund, and African Development Bank (AfDB).⁴⁴ The "UHC for Africa" program was aimed not only at establishing robust health care coverage but also establishing good economic and state structures that are sustainable in the long-term. Additionally, although this program argues that UHC should be considered as a good investment target because of moral and

social reasons, it also argues a separate economic reasoning reflected in the following quote:

“However, UHC is also a good investment. Prevention of malnutrition and ill health is likely to have enormous benefits in terms of longer and more productive lives, higher earnings, and averted health care costs. Effectively meeting demand for family planning will accelerate the fertility transition, which in turn will result in higher rates of economic growth and more rapid poverty reduction.”⁴⁵

The dual health and economic benefits of UHC have been promoted by international organizations such as the WHO as a mechanism for poverty alleviation. For example, according to Thirumurthy et.al., the provisioning of Antiretroviral Treatment (ART) for HIV/AIDS in a region in Kenya helped AIDS patient to recover and as a result, patients could work longer hours, generate income growth and consequently this contributed to poverty reduction.⁴⁶ This example shows that promoting UHC can bring economic benefit to developing countries that can also benefit donors. In short, people in recipient countries can have their health maximized and poverty minimized and are likely to be thankful to the contributions of donors. By using the framework of Nye, favorable attitudes from others can be a source of power. Therefore, this Japanese program of promoting UHC can be understood as an example of GHD that is aimed for the growth of soft power.

More recently, in 2017, Japan pledged \$2.9 billion to countries pursuing UHC.⁴⁷ In December 2017, Japan co-hosted the UHC Forum 2017 with the World Bank, WHO, and UNICEF to discuss concrete methods of UHC implementation and issued the “Tokyo declaration on Universal Health Coverage”.⁴⁸ Another example of specific GHD commitments by Japan is the EMBRACE Program that focused on maternal child health (See Case Study below). It still too early to determine the effects of UHC on Japanese soft power capabilities, but the strong presence and leadership of Japan in international UHC initiatives and declarations is likely to have some tangible impact on global health and Japan’s position in the international development aid community.

Case Study of EMBRACE

In 2010, under the Kan administration, Japan announced “Japan’s Global Health Policy 2011-2015.” This agenda was implemented to engage on issues formally made part of the MDGs; specifically, child mortality, maternal health and combatting HIV/AIDS, TB, and malaria. The EMBRACE program stands for the abbreviation “Ensure Mothers and Babies Regular Access to Care” and was specifically developed to contribute to MDG targets 4 and 5. The EMBRACE program focused on providing antenatal care packages (including antenatal care visits, tetanus immunization, and Vitamin A supplementation) to local communities. Japan also announced work on establishing emergency care facilities and providing assistance to promote healthy post-natal care.

Today, EMBRACE is integrated as Japan’s broader UHC strategy. The EMBRACE program can be viewed as an attempt by the Kan administration to show that Japan was shifting from simply providing financial assistance to a more hands on approach and direct involvement in designing programs and interventions in global health specific to the MDGs and broader support of UHC.

Hence, information from Japan's own GHD strategy document and survey results indicate that global health is one of Japan's soft power tactics, particularly in the context of promoting UHC.

THE FUTURE OF JAPAN'S GHD?

Current approaches for Japanese global health programs that reflect its health diplomacy stance are based on soft power strategies. However, changes in the historical role of the SDF and potential changes to Japan's constitution may lead to a rise in the combination of both hard and soft power in future Japanese global health diplomacy approaches. We outline these developments below.

FUTURE ROLE OF SDF IN GHD

In Japan's non-global health agenda, there has already been cases in which the SDF were deployed with the aims of increasing soft and smart power presence. Heng analyzes the cases of Japanese smart power strategies via the deployment of SDF with a number of case studies.⁴⁹ In Iraq, the SDF undertook 3 levels of assistance programs. The first level was to provide food, water and medicines as emergency assistance. On the second level, the SDF worked to improve basic infrastructures, like repairing roads, creating facilities for healthy water, and improving sanitation. Finally, on the third level, Japan helped build power plants to develop critical infrastructure in post-war Iraq. Although the projects were driven by the SDF, arguably a hard power/military force, according to surveys, local Iraqis indicated favorable attitudes towards the Japanese SDF. The reason is because the SDF were deployed in an assistance capacity, rather than in a coercion or threat mode, and Japanese popular cultural representation, such as anime, were utilized in tandem with developmental assistance.⁵⁰

Other case studies also illustrate Japan's use of SDF to promote its diplomatic agendas. In March 2009, Japanese SDF vessels were deployed to Somalia for anti-piracy programs.⁵¹ More notably, Japan has been active in making commitments on disaster relief; 2013 Super Typhoon Haiyan's assistance in the Philippine⁵², earthquake assistances on 2008 in Sichuan, 2010 in Haiti, 2015 in Nepal, and other cases. Additionally, when Japan experienced its own natural disaster in the Tohoku earthquake and resulting tsunamis and nuclear disaster in 2011, the SDF was utilized for joint operations and assistance with the US military.⁵³

These case studies indicate that the Japanese government is attempting to use the SDF as a part of its smart power capabilities. However, currently the SDF has a limited scope of operation in the field of global health. Though Japan takes part in the US-led Pacific Partnership program which provides medical assistance to developing countries, compared to other countries such as the United States and China, Japan lacks the capacity to fully deploy the SDF in global health functions as a part of more systematic approaches to utilizing smart power tactics.

For example, the United States has specific hard power capabilities for providing health assistance, the USNS Mercy and USNS Comfort. These are Navy ships that function as fully equipped hospitals with 1000 beds and 1200 physicians, nurses, corpsman, technicians, and support staff.⁵⁴ Notable use of these "grey hull" maritime forms of health diplomacy include the USNS Mercy's deployment and provisioning of

assistance during the Haiyan Typhoon in 2013 and USNS Comfort's deployment during the Haiti earthquake. While the Japanese SDF could only provide basics such as water, food, and medicines, these ships functioned as fully equipped hospitals that could provide more complex health assistance, particularly in the context of countries that have undergone severe disruption to their public health systems and local hospital infrastructure.

At the end of WWII, Japan had a total of 30 hospital ships but since then, Japan no longer operates any. However, with the experiences of Tohoku Earthquake in 2011, the Japanese government has begun to reassess the necessity of hospital ships and therefore hosted a research and study group to discuss whether it should re-introduce them for disaster relief use.⁵⁵ According to estimates by the study group, the cost of building a new medical ship is 140 billion to 350 billion yen and annual operating cost was estimated between 9 to 25 billion yen. The cost is by far the biggest barrier of operating a medical humanitarian ship. However, as an alternative to making a new medical ship, a proposal was made to use preexisting private and or SDF ships and repurpose them into a medical humanitarian vessel in order to mitigate budgetary issues.⁵⁶

As of today, the Japanese government has not yet introduced a medical ship. However, if one is introduced, by taking advantages of smart power capabilities it will play, Japan may be able to utilize it as a possible instrument for global health diplomacy and further extend its approaches in exercising smart power as the US and China have done with their own medical ship humanitarian assets.

CONSTITUTIONAL REVISION: ARTICLE 9

Current debate in the domestic political agenda regarding Japan's re-militarization has the potential to have a lasting impact on its current and future GHD strategy. Specifically, Prime Minister Abe has advocated for amending Article 9 of Japan's current constitution (that came into effect in 1947), in which the country renounced war as a sovereign right and also agreed to not maintain a military force. In July 2014, the first step to expanding Japan's military and defense capabilities came through a reinterpretation of SDF powers allowing defense of allies in case of war, though stopped short of an actual amendment to the constitution. However, Prime Minister Abe continues to advocate for amending Article 9, including possible clarification of the SDF's legal status, purpose and character.⁵⁷ Though public support of an amendment process remains an uphill climb (a recent survey conducted by Kyodo News found that 54% of respondents oppose the amendment), if the Japanese constitution Article 9 is revised, it could represent a significant hindrance to perceptions about Japanese soft and smart power capabilities, including Japanese GHD.⁵⁸ We explain this rationale below.

First, revising Article 9, as is currently subject to intense domestic political debate in Japan, to allow the SDF to actively engage in kinetic operations overseas could inflict fear of re-militarization among international stakeholders, which could also undermine decades of international aid flows to recipient countries in the form of development assistance for health or other forms of ODA. This could effectively erode Japan's image as a state committed to soft power approaches to foreign policy challenges. This may especially be the case for neighboring Asian countries, who were heavily affected by the atrocities committed by imperial Japan during the WWII and who may fear the re-emergence of a military aggressive Japan.

Heng points out that, even though China is trying to promote soft power, because its political institutions are autocratic, this limits the capabilities of its soft power.⁵⁹ The same logic could also be applied to Japan. If Japan re-militarizes with a constitutional revision or further “reinterpretation” of Article 9, other countries could perceive that Japan is giving up its long-standing position as a peace-loving democratic nation and returning to the aggressive and autocratic state of the past. Since perceptions by others are one of the most important elements in the soft and smart power, if Japan is no-longer considered attractive due to perceptions about perceived re-militarization, Japanese soft and smart power could be diminished.

Second, if Article 9 undergoes changes, Tokyo will likely shift national spending from foreign assistance budgets to increase its military capabilities. Japan may lose certain incentives to make contributions to global health because they do not need to rely on soft power but instead seek to shift to hard power capabilities, which will increase the country’s security presence and influence in the region.

At the very least, by engaging in constitutional reform, perceptions towards Japan from other countries will change. The short and long-term impact of these changes on hard fought efforts to establish a persona of soft and smart power and its effect on Japan’s GHD strategy will be difficult to assess.

CONCLUSION

In this article, we analyzed how the Japanese government has attempted to achieve its soft and smart power goals by making contributions to the development of global health through diplomatic strategies.

As Prime Minister Abe argued in his article in *the Lancet*, Japanese experiences of rebuilding its national health insurance system provides lessons for broader global health goals of UHC that have produced formidable population health and development results post-war. In the year 1947, the average life expectancy of a Japanese woman was 53.96 years and for men it was 50.6 years.⁶⁰ However, based on data from 2016, that number has experienced a dramatic increase to 87.14 years and 80.98 years for women and men respectively, equating to Japanese life expectancy the highest in the world.⁶¹

In only about 70 years, Japan has succeeded in stabilizing the health of its nation dramatically. We argue that the value of Japan as a longevity country can also form the basis for greater soft power capability. This demographic trend is often framed as the “Aging society” and carries with it negative connotations. Though for countries who are currently struggling with low average life expectancy due to high disease burden, inadequate health coverage, or weak health institutions, the Japanese model and its translation to other countries could represent a viable form of health diplomacy coupled with capacity building.

Despite these opportunities of GHD translation to other countries, the current Japanese administration is standing at the cross roads of a historical policy change that could change the image and landscape of Japan’s position in the foreign policy hierarchy for decades to come. At the very minimum, the Abe administration should carefully consider how domestic policy changes may impact its strategic position on global health and health diplomacy as a critical instrument of Japan’s legacy of adept use of soft and smart power. Ideally that decision will be driven not only by national interests, but also

shared goals of advancing population health, economic growth that relates to good health outcomes, and security that can only exist with the rise of “healthy” nations.

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TABLES AND FIGURES

Table 1: Summary of 11 Articles Retrieved from PubMed, JSTOR and Lancet

Author Name and Year	Title of Article, Content Type, and Language	Included (Y/N)	Subject	Citation
Abe S. (2013)	Japan's strategy for global health diplomacy: why it matters (Comment-English)	Yes	Japan strategy on GHD	Abe S. Japan's strategy for global health diplomacy: why it matters. Lancet 2013;382(9896):915-6
Blouin, C, and Dubé, L. (2010)	Global health diplomacy for obesity prevention: Lessons from tobacco control (Article - English)	No	GHD specifically for obesity prevention	Blouin, C, and Dubé, L. 2010. "Global health diplomacy for obesity prevention: Lessons from tobacco control." <i>Journal of Public Health Policy</i> 31 (2): 244-255

Corbett, P, E. (1959)	International Organization (Book chapter-English)	No	How laws influence the relationship among different nations	Corbett, P E. 1959. "International Organization." In <i>Law in Diplomacy</i> , 187-250. Princeton University Press.
Dent, C. M. (2002)	Reconciling Multiple Economic Multilateralisms: The Case of Singapore (Article - English)	No	Analysis on Singapore's Foreign Economic Policy (FEP)	Dent, C M. 2002. "Reconciling Multiple Economic Multilateralisms: The Case of Singapore." <i>Contemporary Southeast Asia</i> 24 (1): 146-165.
Hinoshita E. (2016)	Industry, Academia and Government Partnership through the Global Health Innovative Technology Fund (GHIT) (Symposium – Japanese)	Yes	Global health funding	Hinoshita E. Industry, Academia and Government Partnership through the Global Health Innovative Technology Fund (GHIT). <i>Yakugaku Zasshi</i> 2016;136(2):237-42
Llano et al. (2011)*	Re-invigorating Japan's commitment to global health: challenges and opportunities (Series article – English)	Yes	Global health and foreign policy	Llano R, Kanamori S, Kunii O, Mori R, Takei T, Sakai H, Nakamura Y, Kurokawa K, Hai Y, Chen L, Takemi K and Shibuya K. 2011 " Re-invigorating Japan's commitment to global health: challenges and opportunities." <i>The Lancet</i> , 378, 1255-1264
Outterson, K. (2009)	Import Safety Rules and Generic Drug Markets. (Book chapter-English)	No	International framework to fight counterfeit medicines	Outterson, K. 2009. "Import Safety Rules and Generic Drug Markets." In <i>Import Safety: Regulatory Governance in the Global Economy</i> , 110-128. University of Pennsylvania Press.
Sakamoto et.al. (2018)	The G7 presidency and universal health coverage, Japan's contribution (Commentary [Lessons from the Field content type] - English)	Yes	GHD at G7 forum	Sakamoto H, Ezoe S, Hara K, Hinoshita E, Sekitani Y, Abe K, Inada H, Kato T, Komada K, Miyakawa M, Yamaya H, Yamamoto N, Abe S K and Shibuya K. 2018. "The G7 presidency and universal health coverage, Japan's

				contribution." <i>Bulletin of the World Health Organization</i> 96: 355-359.
Shen, S. (2004)	"SARS Diplomacy" of Beijing and Taipei: Competition Between the Chinese and Non-Chinese Orbits (Article - English)	No	GHD of SARS practiced by China	Shen, S. 2004. "The "SARS Diplomacy" of Beijing and Taipei: Competition Between the Chinese and Non-Chinese Orbits." <i>Asian Perspective</i> 28 (1): 45-65.
Shen, S. (2008)	Borrowing the Hong Kong Identity for Chinese Diplomacy: Implications of Margaret Chan's World Health Organization Election Campaign. (Article - English)	No	Chinese diplomatic practices at WHO	Shen, S. 2008. "Borrowing the Hong Kong Identity for Chinese Diplomacy: Implications of Margaret Chan's World Health Organization Election Campaign." <i>Pacific Affairs</i> 81 (3): 361-382.
Yanzhong, H. (2010)	Pursuing Health as Foreign Policy: The Case of China (Law Review article - English)	No	Global health and foreign policy of China	Yanzhong, H. 2010. "Pursuing Health as Foreign Policy: The Case of China." <i>International Journal of Global Legal Studies</i> 17 (1): 105-146

* article added in addition to the literature review

Table 2: Summary of Major GHD Themes in Literature

Global Health Issue	Types of GHD	Stakeholders
Agenda Setting	Core and Multi-Stakeholder	Japanese Government, G8 (7) states, UN Member states, MDGs, SDGs fora
Universal Health Coverage	Core and Multi-Stakeholder	Japanese Government, WHO, SGDs fora
Global Health Innovative Technology Fund (GHIT)	Informal	Japanese Government, Gates Foundation Pharmaceutical Companies,
Japanese ODA	Core and Multi-Stakeholder	Japanese Government, G8 states, WHO, World Bank, MDGs, Bilateral arrangements,

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- ⁴ MOFA. 2018. *ODA Budget*. 4 3. Accessed 8 2, 2018. <https://www.mofa.go.jp/mofaj/gaiko/oda/shiryo/yosan.html>.
- ⁵ Nye, J. 2004. "Soft Power The Means to Success in World Politics."
- ⁶ Nye, J. 2003. "Propaganda Isn't the Way: Soft Power." *International Herald Tribune*, January 10, 2003. Accessed 10 26, 2018. <https://www.belfercenter.org/publication/propaganda-isnt-way-soft-power>
- ⁷ Ibid., Nye 2004. P.X
- ⁸ Nye, J. 2011. "The Future of Power: Its Changing Nature and Use in the Twenty-First Century."
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- ¹¹ Lee, K, and Smith, R. 2011. "What is 'Global Health Diplomacy'? A Conceptual Review." *Global Health Governance* 5 (1).
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- ¹³ Ibid., p506
- ¹⁴ Ibid., pp506-507
- ¹⁵ Ibid., pp508-509
- ¹⁶ Clinton, C, and Sridhar, D. 2017. "Governing Global Health" Oxford University Press.
- ¹⁷ Ibid., p510
- ¹⁸ Ibid., pp510-511
- ¹⁹ Yanzhong, H. 2010. "Pursuing Health as Foreign Policy: The Case of China." *International Journal of Global Legal Studies* 17 (1): 105-146
- Shen, S. 2004. "The "SARS Diplomacy" of Beijing and Taipei: Competition Between the Chinese and Non-Chinese Orbits." *Asian Perspective* 28 (1): 45-65.
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- Corbett, P E. 1959. "International Organization." In *Law in Diplomacy*, 187-250. Princeton University Press.
- ²¹ Heng, Y K. 2014. "Beyond kawaii pop culture: Japan's normative soft power as a global trouble-shooter." *The Pacific Review* Vol. 27 (No. 2): 169-192.
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- ²⁷ Ibid., p241
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- ³¹ Ibid., p1258-1259
- ³² Ibid., p 2160-1263
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Why does global health matter to diplomacy? Global health as a security and economic challenge and as an opportunity for world leaders, with a special focus on the G7 Ise-Shima Summit

Koton Hara & Satoshi Ezoe

Why does global health matter to diplomacy as an agenda of world leaders while those leaders are facing other competing agendas? To respond to this question, the authors, who engaged in the preparatory and follow-up process of the global health agenda at the G7 Ise-Shima Summit, analyze the reasons why and how global health became a priority agenda of G7 Leaders, using the Ise-Shima Summit as a case. With regard to why, the authors discuss that global health became a center of global attention, being strongly linked with pressing security and economic challenges, as well as the attainment of sustainable development towards 2016, and that the G7 and its Presidency in 2016 had a comparative advantage to demonstrate a prescription on global health for the international community based on their rich expertise and experiences in the field. Then, with regard to how, the authors discuss the unique approach to global health taken at the G7 Ise-Shima Summit and the measures that successfully solidified the status of health as a priority agenda of world leaders, which led to upgrading global health to leaders' agendas at subsequent major international occasions.

INTRODUCTION

This article aims to answer the question why global health matters to diplomacy as an agenda of world leaders while those leaders are facing other competing agendas, such as downside risks to the global economy, terrorism and a record-high number of refugees.

In order to promote the recognition of health as an agenda of world leaders, it is also necessary to show how global health itself is now related to pressing challenges for diplomacy, and at the same time to what extent and in what ways health can be a viable tool to address those challenges in today's globalized world. Historically, the conventional purpose of diplomacy is to protect a territory from external threats and to ensure economic prosperity. However, as former UN Secretaries-General have pointed out, in the context of the continuous progress of global integration and interconnection, no country can solve all the challenges that it faces on its own. Now, the major functions of diplomacy in the 21st century include the promotion of development assistance to developing countries and the protection of human dignity, in addition to the realization of security and the creation of economic prosperity. Against the backdrop of this transition of diplomatic objectives, health has become more and more internationally highlighted as an important agenda of world leaders¹. This trend has been well reflected in the expansion of the G7 Summit agenda, which was originally established to address the oil crisis, then expanded to security issues in the first half of 1990s and then climate

change in the latter half of 1990s, and now includes wider global challenges, including global health, in the 21st century.

To respond to the question at the opening, the authors, who engaged in the preparatory process of the global health agenda at the G7 Ise-Shima Summit, firstly analyze the reasons why global health was elevated to be one of the G7 Leaders' priority agendas at the Ise-Shima Summit. We will look at the external situations by which global health had become the center of global attention, being strongly linked with pressing the security and economic challenges, as well as the attainment of sustainable development leading up to 2016, and the internal conditions where the G7 and its Presidency in 2016 had a comparative advantage to demonstrate a prescription for global health to the international community based on their rich expertise and experiences in the field.

Based on analysis on those reasons, the authors will also discuss the measures taken at G7 Ise-Shima Summit to actually make global health a priority agenda of world leaders. They will do so by consolidating the outcome of the health agenda at the G7 Ise-Shima Summit into a unique approach that solidified the status of health as a priority agenda of world leaders not only at the G7 but also at other major international occasions.

WHY DID THE G7 ISE-SHIMA SUMMIT MAKE HEALTH A PRIORITY AGENDA FOR LEADERS?

1.1. Increased sense of urgency in addressing global health from the security perspective

Firstly, we will look at the recent trend that public health emergencies are growing to become threats equivalent to conflicts and natural disasters, as well as the trend that those health emergencies are increasingly being triggered or exacerbated by conflicts and disasters.

Public health emergencies, especially pandemics, have negative impacts on the lives and livelihoods of human beings that are as severe as the impacts of wars and conflicts. In fact, not many threats claim human lives on a scale equivalent to pandemics. According to some estimates, while armed conflicts resulted in an average of 1 to 1.5 million deaths per year in the 20th century, the same scale of annual deaths are brought by AIDS or tuberculosis, which each claimed the lives of 1.5 million people in 2013². During the 1918 Spanish flu pandemic, as many as 100 million people died - up to 5 percent of the world's population. According to an estimate by the Bill & Melinda Gates Foundation, if a similar outbreak to the Spanish Flu were to happen today, the death toll could reach 360 million, despite the availability of vaccines as well as modern antiviral and antibacterial drugs³.

Most recently, the 2014 Ebola outbreak in several West African countries proved that infectious diseases know no borders and that an outbreak in one country threatens the security of other countries. The disease first emerged in Guinea and Sierra Leone, it then spread to several other African countries, as well as to the US and Europe. The total number of deaths from the outbreak amounted to about 11,300, with a likelihood of death at about 40 percent⁴. In September 2014, the UN Security Council adopted a resolution to position the Ebola outbreak in the affected countries as "a threat to the peace and security of the international community (UNSCR 2177)." From this perspective, preventing, preparing for and responding to pandemics should be regarded not only as a

health issue but also as indispensable actions for the security of every nation and the entire world⁵.

Moreover, health-related morbidity and deaths risks are further exacerbated by direct combat- or disaster-related effects⁶. Conflicts and disasters damage and disrupt health systems and infrastructures, reduce the capacity of and access to health services, and deteriorate the capacity to respond to severe infectious diseases, and thereby threaten individual and collective health. For example, post-conflict countries such as Angola and Congo are facing outbreaks of serious infectious diseases⁷; and polio, which had once been eradicated, is now re-emerging in Syria⁸. The most severely affected people under such circumstances tend to be the most vulnerable, including women, children and refugees. Under such situations, the Munich Security Conference took up health for the first time as one of its agendas at its side event entitled “Health Security Roundtable Munich: Healthcare under Attack.” The discussion at the event confirmed that strengthening health systems, particularly in fragile states, is necessary, highlighting the relationship between wars/conflicts and health status⁹.

1.2. Pressing needs to work collectively on global health from an economic perspective

We now review that both the persistence and expansion of communicable diseases and the emergence of non-communicable diseases (NCDs) are calling for collective global actions from an economic perspective.

With regard to health expenses, some 800 million people are spending out of pocket on health at least 10 percent of their household budget, and nearly 100 million people are being pushed into extreme poverty each year due to health care costs¹⁰. In addition, outbreaks of epidemic and pandemic disease can result in extreme negative economic impacts. For example, the World Bank has estimated that the three countries most severely affected by the 2014 Ebola outbreak in West Africa lost at least USD 2.2 billion in forgone economic growth in 2015 as a result of the epidemic (World Bank, 2016). Today, human/animal contact is increasing due to a growing population and expanded animal husbandry to feed more people. At the same time, person-to-person interaction is also expanding through vitalized trade and human mobility. These trends have enhanced the risk of outbreaks of communicable disease and their accompanied economic impacts¹¹. Moreover, undue fear of an infectious disease can spread even faster than the disease itself in the present world whose furthest corners are now closely connected by global media and social network services. Such spread of fear can alter public behaviors or policy decisions, and thereby paralyze an economy. Expected economic losses from potential pandemics could amount to around USD 60 billion per year¹².

In the context of such intentional and unintentional responses to a pandemic, it is not enough for a government to think only about its own country and its own people while attempting to safeguard its security and economy from the impacts of pandemics. This recognition is now widely shared not only by health experts but also by diplomats as matters relating to the free flow of goods and people¹³. For example, the SARS outbreak of 2003 enhanced a shared recognition that specific international rules are necessary to address such matters. This recognition eventually pushed health into the diplomatic sphere in 2005, leading to the inclusion of Article 2 of WHO’s International Health Regulations (IHR) that reads “to prevent, protect against, control and provide a public

health response to the international public health risks and avoid unnecessary interference with international traffic and trade”, adopted in 2005¹⁴. However, an improved framework of actions, building upon the lessons learned from the Ebola outbreak, is still necessary.

The economic impacts of Antimicrobial Resistance (AMR) have also gradually been recognized as an emerging economic threat. According to the Review on AMR that was commissioned by the UK Prime Minister in 2014 and whose final report was issued in 2016, even as existing antimicrobials are becoming less effective over time, the development of new antimicrobials is falling behind. If this state of affairs continues, it is anticipated that the challenges of AMR will claim a life every three seconds, resulting in the death of 10 million people in total, and bring an economic loss of 100 trillion USD by 2050.

Lastly but not least, with the increasing aging of the population, the composition of total disease burden will shift from acute to chronic and from communicable to non-communicable. Such a shift will require longer periods of daily care for chronically ill patients, which will result in the further expansion of public expenses in health care¹⁵. In fact, the increasing incidence of NCDs, mental illness and dementia all over the world has expanded the negative impact on the economic well-being individuals and nations, and it is expected to continue to increase. For example, NCDs and mental illness were major causes of morbidity and death in 2012, and 40 percent of the people who died from NCDs and mental illnesses were younger than 70 years old¹⁶. About 44.4 million people were affected by dementia in 2013 and this number is expected to increase by three fold to 135.5 million by 2050¹⁷.

1.3. More attention to positive security and economic impacts related to health

On the other hand, the promotion of health and the improvement of health outcomes yield many great positive security and economic impacts.

In order to respond to security issues such as terrorism and conflict, it is necessary not only to invest in enhancing national defense but also in addressing the root causes of those issues and ensuring ‘human security’, a concept that is promoted by Japan and now officially recognized at the UN, and consists of ‘freedom from fear’ and ‘freedom from want.’ Investing in health system strengthening towards attaining UHC is deemed to play a crucial role for ensuring security at the national, community and individual level, as it is the forefront of responding to infectious diseases NCDs¹⁸, and also reducing or covering the medical costs borne by individuals in doing so. Therefore, UHC is conducive to ensuring human security, by contributing to both ‘freedom of fear’ and ‘freedom of want.’ UHC can also enhance the resilience of a community through fostering its cohesiveness. The process of achieving UHC is linked to wider challenges of peace and democracy, such as restructuring entrenched governance, realizing rights while addressing marginalization and exclusion, and equitably redistributing opportunities. Therefore, it enables the people in a community to enjoy healthier lives with dignity in times of calm, and mitigates shocks to the community in times of emergency¹⁹.

Health is a driving force for promoting economic growth with significant returns on investment (ROIs). From the macro-economic perspective, a one dollar investment in health can yield up to ten dollars of economic growth²⁰. Another study shows that 24 percent of the full-income growth in low and middle income countries, comprising growth

in GDP and the value of the peoples' additional life years from 2000 to 2011, was a result of improved health²¹. Moreover, investment in prevention and preparedness are much cheaper than the cost of post hoc responses to epidemic outbreaks, which bring many negative economic impacts as mentioned above. For example, in the wake of the Ebola outbreak in West Africa, it is estimated that prior investment in health systems could have mitigated the impacts at only one third of the cost.²²

Also from the micro-economic perspective, good health is indispensable for reducing poverty and promoting personal well-being. For example, UHC can reduce the proportion of out-of-pocket expenses on health of total household expenses, enabling families to invest in more productive areas such as education.

1.4. Responsibility to implement health-related global goals under the new paradigm for sustainable future

In 2015, the UN General Assembly adopted 2030 Agenda for Sustainable Development which includes 17 so-called “Sustainable Development Goals” (SDGs), while attaching importance to universal implementation and global partnership as well as a people-centered approach, which corresponds to the concept of human security. Goal 3 of the SDGs is exclusively focused on health with its overarching commitment not only to realizing healthy lives both physically and mentally but also promoting well-being for all ages, as the afore-mentioned negative and positive health impacts. More specifically, the goal expanded its scope from infectious diseases and child and maternal health upheld in the previous Millennium Development Goals (MDGs) to include NCDs, taking into consideration demographic and epidemiological changes²³.

Along with this expansion in scope, concrete actions to be taken in order to achieve this goal cover not only specific efforts to respond infectious diseases but also strengthening health systems and promoting²⁴ UHC. UHC, Target 3.8 of the SDGs, is a particularly important element as exemplary of the SDGs' over-arching principle of “no one left behind.” Therefore, the implementation of the health-related SDGs, including UHC, is now one of the important agendas of world leaders. The Ise-Shima Summit was held amid the international expectation to steadily implement the health-related SGDs as the first G7 Summit held after the adoption of this 2030 Agenda.

1.5. Making most of the comparative advantage of the G7 and its 2016 Presidency in global health

The G7 has a comparative advantage in taking up the most pressing global agendas, while other international fora have difficulties in doing so due to their broader or more diverse membership; and in showing and expanding a prescription to address those agendas to the wider international community. To this end, a G7 Presidency itself needs to have a certain level of expertise and experiences conducive to leading the G7's interests and building a consensus on such a prescription.

Infectious diseases were discussed for the first time at the Kyushu-Okinawa Summit in 2000, and then health systems strengthening was highlighted in a comprehensive manner at the Hokkaido-Toyako Summit in 2008. Between and after those two Summits, global health had been a relatively regular part of the agenda. Therefore, the G7 had a

solid foundation on which to make global health priority agenda for world leaders. On the other hand, the UN General Assembly has been adopting resolutions on global health every year since 2008, but it has not been an agenda that world leaders directly discuss and intervene in, and the G20, the premier international forum for economic cooperation, had not taken up the health agenda until 2016.

Japan, holder of the G7 Presidency in 2016, also had experience taking up global health, including at the leaders' level, from the security and economic perspectives and UHC as the solution of those perspectives.

Japan stipulated its "National Security Strategy" in December 2013, which aims at contributing more to peace, stability and prosperity in the international community under the policy of proactive contribution to peace, based on the principles of international cooperation. The Strategy commits to strengthening cooperation toward global challenges based on universal values, such as freedom, democracy and human rights, as one of the strategic security approaches that Japan should take, and then sets concrete actions in response to development and humanitarian issues, including health, that could hinder peace and stability in the international community²⁵. Japan has also contributed to manifesting the health agenda as a part of its diplomatic policy in "Japan's Strategy on Global Health Diplomacy" announced in 2013²⁶, together with declarations of Japan's political resolve to do so as expressed by Prime Minister Abe in The Lancet in 2013 and 2015²⁷.

Therefore, Japan had an intention to contribute to health as security and diplomatic policy a little earlier than the Global Health Security Agenda (GHSA) led by the US since 2014, which pursues a multilateral and multi-sectoral approach to strengthening both the global capacity and nations' capacities to prevent, detect, and respond to human and animal infectious disease threats²⁸. Moreover, the Government of Japan developed its "Basic Design for Peace and Health" as a guideline for health challenges in September, 2015 as a part of its efforts for proactive contribution to peace.²⁹

Japan also achieved universal health coverage (UHC) as early as the 1960s through the adoption of its "Universal Health Insurance System", which has since served as the foundation of its economic growth, and has maintained it over the last 50 years. Japan also has cutting-edge medical technologies and rich experiences responding to natural disasters and an aging society.

2. HOW DID THE G7 ISE-SHIMA SUMMIT MAKE HEALTH A PRIORITY AGENDA FOR G7 LEADERS?

We have seen the external situations and internal conditions that helped global health become a leaders' priority agenda. Now, we would like to discuss how the G7 Ise-Shima Summit was able to place health in the unprecedented position of a priority agenda of the G7 Leaders?

With about 10% of the G7 Leaders' Declaration dedicated to health, it is clear that global health became a priority agenda at the G7 Ise-Shima Summit³¹. In summary, the health agenda at the Ise-Shima Summit consisted of the following three pillars: (i) reinforcing the Global Health Architecture to strengthen responses to public health emergencies, (ii) strengthening health systems with a view to attaining UHC and enhancing preparedness for emergencies, and (iii) addressing AMR, together with

innovation and R&D as a cross-cutting issue. A comprehensive package of actions to materialize the commitments in the Leaders' Declaration was also announced as the Annex "G7 Ise-Shima Vision for Global Health", which covered the aforementioned pillars³². As summarized in Table 1, the G7 Summits prior to the Ise-Shima Summit had constantly dealt with health, but not as comprehensively as the latter. The leaders also agreed on seven annexes on global health in the previous summits but focused rather on specific areas of global health such as infectious diseases at Saint Petersburg summit in 2006 and at Sea Island Summit in 2004, maternal and child health at Muskoka Summit in 2010 and AMR at Schloss Elmau Summit in 2015. While the Hokkaido-Toyako Summit welcomed a quite comprehensive document on global health, it comprised only the experts' recommendations to the leaders, not the leaders' commitments.

This seems to be because the Ise-Shima Summit took a unique approach, hereinafter referred to as the "Ise-Shima Approach to Global Health" that is presented in Chart 1 and consists of the following five elements that made the most of health features as diplomatic challenges and tools.

2.1. Offering a vision on how to take health forward from the economic and security perspectives

At the very beginning of the health section in the Leaders' Declaration, the G7 Leaders articulated that "health is the foundation of peace and prosperity" for an individual and a nation. While many other G7 Summits had consistently addressed health as a development issue, the Ise-Shima Summit gave a vision and future direction to health that would enable it to positively affect and contribute to security and the economy.

As a part of this effort, taking into consideration the positive and negative economic issues discussed in the previous sections, health-related commitments were included in the "Ise-Shima Economic Initiative," a policy package to improve the foundations for long-term economic growth, as well as to respond to current economic challenges such as downside risks and uncertainty. The Summit also shed light on active aging for the first time in order to turn the economic challenges brought on by aging into economic opportunities. Moreover, as the first Summit to be held after the adoption of the SDGs at the UN General Assembly in September, 2015, the Ise-Shima Summit was fully committed to implementing the health-related SDGs, and especially to attaining Goal 3.8 on UHC for the first time in the history of G7/G8 Summits, as a comprehensive framework that underpins all of those Goals³³.

2.2. Linking efforts in times of emergency to those in times of calm by the key phrase 'prevention and preparedness'

The Ise-Shima Summit linked efforts in times of emergency to those in times of calm by the key phrase 'prevention and preparedness,' where both of them had been dealt either separately or selectively in past G7 Summits, and positioned the various health-related efforts under both circumstances as not mutually exclusive but rather mutually reinforcing. More concretely, fostering health-related human resources, improving medical facilities, appliances and goods, and elaborating health fiscal systems with a view to attaining UHC were recognized as leading to preventing against and preparing for future health emergencies.

Historically, mid-to-long-term challenges such as strengthening health systems and thereby attaining UHC had been relegated to a position of lower priority during times of health emergencies. However, the concept of ‘prevention and preparedness’ brought about a consensus to continue working on those challenges under all circumstances whatsoever. This consensus was underlined by the roles and impacts of UHC in both security and the economy as mentioned above. Also from the perspective of preparedness, strengthening the implementation of WHO’s IHR, including through the GHSA, was reaffirmed as the follow-up of the Elmau Summit in 2015.

2.3. Making comprehensive and cross-cutting efforts

Furthermore, the Japanese Presidency proactively took a comprehensive and cross-cutting approach that is usually only possible under the initiative of Leaders, as Ministers only have their respective policy scopes.

Firstly, the G7, which takes pride in its sophisticated technology, discussed innovation as a cross-cutting issue, including such topics as innovation and R&D to address diseases that need attention but are not market-driven, such as neglected tropical diseases and AMR, acceleration of testing, manufacturing and distribution of medical products for public health emergencies, and innovation and R&D for active ageing.

Moreover, the G7 set forth multi-sectoral approaches, such as highlighting the health-humanitarian nexus in response to health emergencies, promoting a ‘One Health’ approach to AMR that covers agricultural and livestock industries, and improving nutrition for maternal and child health. It also committed to pursue multi-sectoral approaches to active ageing in order to reach the highest attainable level of well-being, from health care and long-term care to health promotion, welfare, employment, pension, housing, and urban/transportation planning, with due consideration to gender specific aspects. From a procedural perspective, as inputs to the Leaders’ discussions and/or follow-ups to their instructions, the greatest number of G7 ministerial meetings took up health issues in the history of G7/G8, starting from the Foreign Ministers’ Meeting to the STI, Agricultural and ICT Ministerial Meetings before the Summit, and then intensively at the Health Ministers Meeting after the Summit.

2.4. Offering new frameworks with necessary funding

The Ise-Shima Summit not only delivered a high-level political message but also offered new frameworks with necessary financial resources to realize that message. Firstly, the G7 requested and supported WHO reform especially the clarification of its chains of command and the establishment of an Emergency Response Programme and reflected upon WHO’s lack of capacity to adequately respond to the emergency of the Ebola outbreak. Moreover, as the Ebola outbreak also revealed the necessity of swift fundraising, the G7 backed the launch of the Pandemic Emergency Facility (PEF) of World Bank, an emergency funding mechanism complementary to the Contingency Fund for Emergencies (CEF) of WHO. WHO emergency reform and the creation of CEF were envisioned and initiated before the Ise-Shima Summit but the G7’s strong commitment with financial contributions expedited and strengthened the processes. As for the PEF, the idea was initiated by the World Bank leadership but the actual launch was ensured by the engagement of the G7 and its Presidency. For example, Japan led the coordination

and dialogue between World Bank and WHO in crystallizing the technical details of epidemiological and actuarial conditions, and the design of the PEF in relation to the CEF so that they would have complementary roles. Japan also urged the parties so that the PEF could be launched in time for the Ise-Shima Summit given its urgency.

While humanitarian agencies such as OCHA have played a significant role in cases of natural disasters such as earthquakes, they lack the expertise to respond to unknown infectious diseases, and coordination with WHO, which has rich expertise, was not sufficient in the Ebola outbreak. Therefore, the G7 Leaders also requested the formalization of a Standard Operating Procedure (SOP) for Health Emergencies, to enhance health and humanitarian system-wide coordination among WHO and other relevant UN partners, under the UN Secretary-General. In the case of the SOP, Japan facilitated the multiagency dialogue among OCHA, WHO and World Bank that culminated in the launch of “Level 3 (L3) Activation Procedures for Infectious Disease Events” by the Inter-Agency Standing Committee in December 2016 (Inter-Agency Standing Committee, 2016). This is a result of the commitment and support from the G7 Presidency, including an informal stakeholder conference hosted by Japan in April 2016 which was attended by the UN Secretary General’s representative and the heads of OCHA and WHO, who agreed to the principle that WHO should continue to take a lead but under the inter-agency mechanism led by the Secretary General. This was followed by further elaborated commitment and support at the G7 Kobe Health Ministers’ Meeting and its outcome³⁴.

As for UHC, in advance of assuming the G7 Presidency, Prime Minister Abe had already emphasized the need to bring together expertise and resources from donor countries, the international organizations including WHO, the Global Fund and World Bank, and the private sector to establish and promote an international alliance to support developing countries to achieve stronger health systems towards the ultimate goal of achieving UHC, at the event entitled “the Path towards Universal Health Coverage: Promotion of Equitable Global Health and Human Security in the post-2015 Development Era” held during the 70th UN General Assembly Meeting in 2015³⁵. Based on this call, Japan took initiative as the G7 Presidency in leading the International Health Partnership (IHP+) to enhance collaboration among donor agencies, has expanded its scope to include UHC, and officially launched “IHP+ for UHC2030” as an international framework to coordinate catalysts and leverage efforts of relevant stakeholders and various initiatives such as the new policy framework “UHC in Africa.”

To bring those frameworks into function, the government of Japan announced its decision to financially contribute up to USD 1.1 billion to health-related international agencies in advance of the Summit. For emergency responses, Prime Minister Abe announced a contribution of USD 50 million to WHO’s Health Emergencies Programme, of which Japan had already disbursed half as of the end of 2016. In addition, Japan has contributed approximately USD 10.8 million to the CEF, meaning that Japan had become its largest donor as of the end 2016, and Prime Minister Abe also announced a contribution of USD 50 million to the PEF earlier than any other country. With the G7’s financial commitments and their encouragement to the international community as stated in the Leaders’ Declaration, the 5th replenishment of the Global Fund successfully achieved a total pledge of USD 12.9 billion in September. At the “UHC Forum 2017” to be explained below, Prime Minister Abe announced that Japan would commit US\$ 2.9

billion for health, nutrition and water and sanitation in support of countries pursuing UHC.

2.5. Swiftly implementing with top-down instructions and expanding to other fora

It is also only leaders who can swiftly implement those commitments that encompass a wide-range of scopes beyond health, with strong leadership.

As for strengthening responses to public health emergencies, WHO reforms are now underway, with the newly established WHO Health Emergencies Programme, as well as concrete reform and supplementary budget plans that were approved at the World Health Assembly in May 2016, shortly after the Summit.

The emergency funding mechanisms, especially the PEF, are now fully operationalized. Moreover, the SOP for Health Emergencies was eventually agreed at the Inter-Agency Standing Committee (IASC) in December 2016 as a Level 3 activation procedure, and also welcomed in a UN General Assembly Resolution in December 2016. Progress was also made towards offering concrete assistance – including assistance with the development of national plans and completion of WHO Joint External Evaluations – to 76 countries and regions to build core capacities to implement the IHR. Moreover, consideration was given to including preparedness for, responses to and recovery from pandemics in policy commitments of the International Development Association (IDA) during its IDA18 replenishment meeting in December 2016.

Concerning the attainment of UHC with strong health systems and better preparedness, the IHP+ Steering Committee in June 2016 decided to adopt and launch “IHP+ for UHC2030” as a UHC platform. A new framework for “UHC in Africa” to serve as reference for achieving UHC and health system strengthening in African countries was launched in August, 2016 at the Sixth Tokyo International Conference on African Development (TICAD VI), proposing a set of actions in five areas in the UHC process; namely, financing, services, equity, preparedness and governance. In partnership with WHO, World Bank, UNICEF and the aforementioned new platform IHP+ for UHC2030, Japan co-hosted the “UHC Forum 2017” to stimulate global- and country-level progress towards UHC, which included the participation of the UN Secretary-General, the heads of WHO and UNICEF, the Prime Minister, Health Minister and Finance Minister of Japan and high level representatives of many other countries. Building on the “G7 Ise-Shima Vision for Global Health” and other major initiatives, the Forum highlighted the power of UHC as mentioned above and committed to strong inter-sectoral collaboration. Furthermore, a forum on promoting healthy and active ageing was held in Kobe, Japan, on the sidelines of the G7 Kobe Health Minister’s Meeting in September 2016 with a view toward sharing best practices and research to foster healthy longevity in societies.

The Ise-Shima Summit also paved a way forward for serious discussions on health at the G20 Summit, the premier international forum on economic cooperation, by sending the message that health-related issues have inextricable positive and negative impacts on the economy. The G20 Summit started to shed light on health at the Hangzhou Summit in September 2016, firstly with a focus on the strengthening of response to AMR, the economic impacts of which are particularly concerning, then the 71st UNGA in September did so by organizing the High-level Meeting on AMR in order to further accelerate political commitments. Then, the G20 Hamburg Summit in July 2017 placed particular importance on building a consensus among G20 members to work on and

promote cooperation for the three pillars of the health agenda at the Ise-Shima Summit, even with the change of leadership in many G7 countries. As Japan holds the G20 Presidency in 2019, the G20's actions on health are expected to be further materialized under its Presidency.

CONCLUSION

The G7 Ise-Shima Summit was held amid the international expectation for world leaders to address security and economic challenges that are more strongly linked with global health in the face of the Ebola outbreaks and the emergence of NCDs, and to swiftly implement the health-related global goals as the first G7 Summit held after the adoption of Agenda 2030 for Sustainable Development. The G7 Summit and its Presidency in 2016, Japan, had a comparative advantage to respond to such expectation, building on their expertise and experiences of delivering viable solutions with concrete actions to the international community. The G7 Leaders shed light on global health from the aspects of both security and the economy; highlighted the novel concept of "prevention and preparedness" which effectively linked efforts in times of emergency to those in times of calm; offered comprehensive and cross-cutting commitments backed by new frameworks and necessary funding; and swiftly translated those commitments into actions and expanded them to the international community. The "Ise-Shima Approach to Global Health" consolidated by the authors in this article and comprised of the above-mentioned five elements will continue to help global health remain as the Leaders' priority agenda in future international occasions.

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