

## **Hiroki Nakatani**

**Professor for Global Initiatives, Keio University**

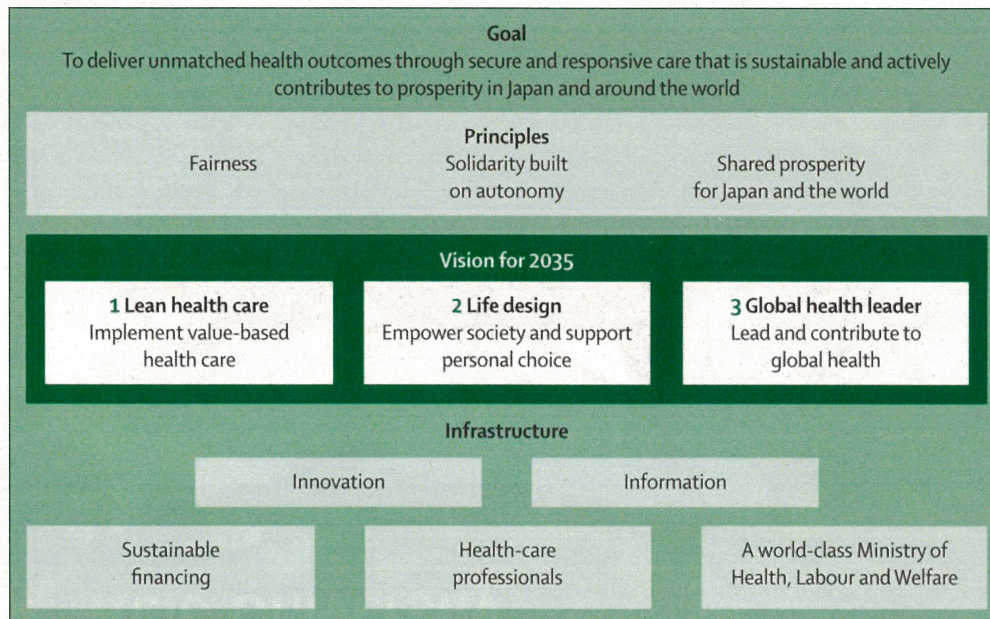


# Change is needed in our concept of “International Health”

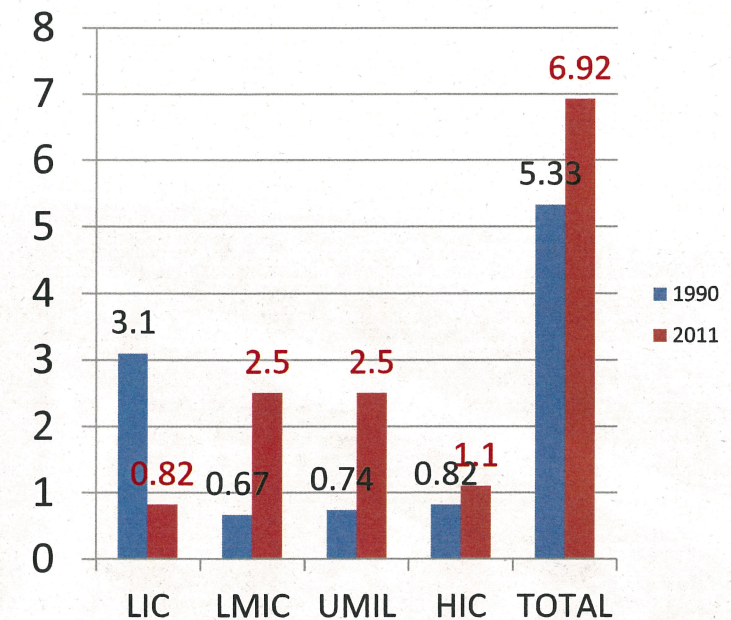
## Blue Era's International Health Assistance

Direct provision of preventive/curative services

## Red Era's Global Health ( Japan Vision 2035 )



Population by Wealth, 1990-2011

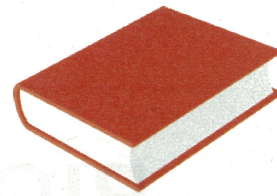


Original source: World Bank. World Development Indicators. Washington DC, World Bank 2013



# Present Global Health Paradigm 2000~2015

3.11  
+  
SARS

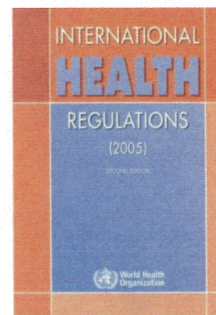


IOM Report; Review and more investment on Health Security

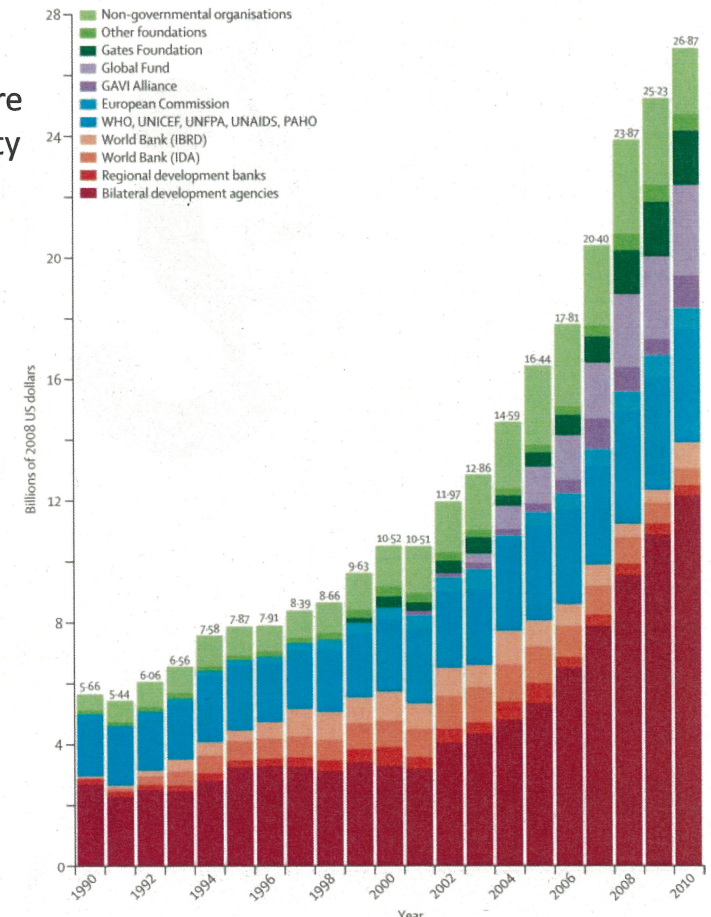


Financing Health  
MDGs  
( MCH and  
HTM )

Health Security



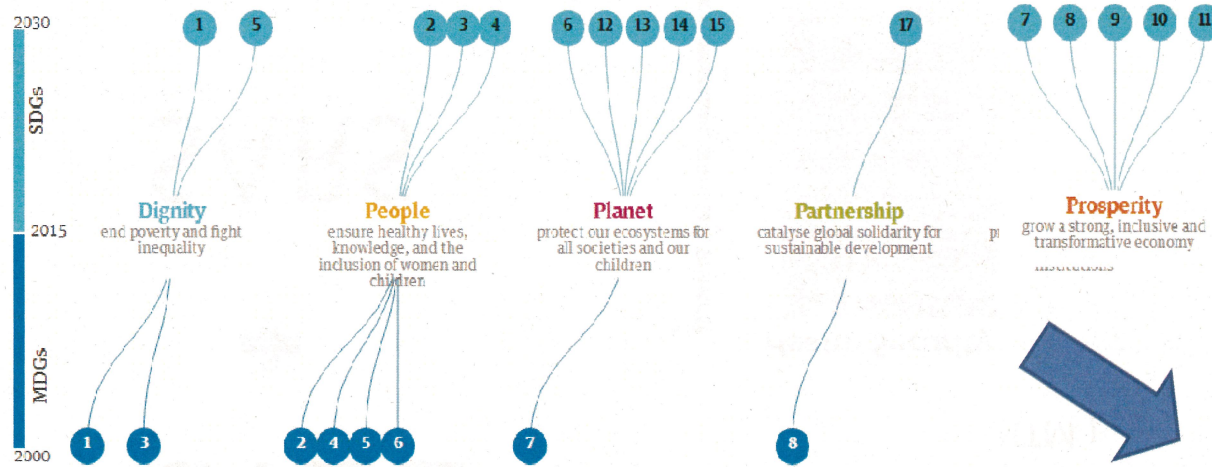
2005



Murray, C , Anderson, B et al; Assistance for health: trends and prospects, The Lancet, Volume 378, Issue 9785, Pages 8 - 10, 2 July 2011

# New Health Paradigm

From MDG  
To SDG



Source; <http://www.theguardian.com/global-development/ng-interactive/2015/jan/19/sustainable-development-goals-changing-world-17-steps-interactive>

## Ebola





# New Challenges, Approaches and Determinants

- Demographic Change
- Mortality/Morbidity Change
- Geo-political Change
- Globalization

→ Ageing and less children.

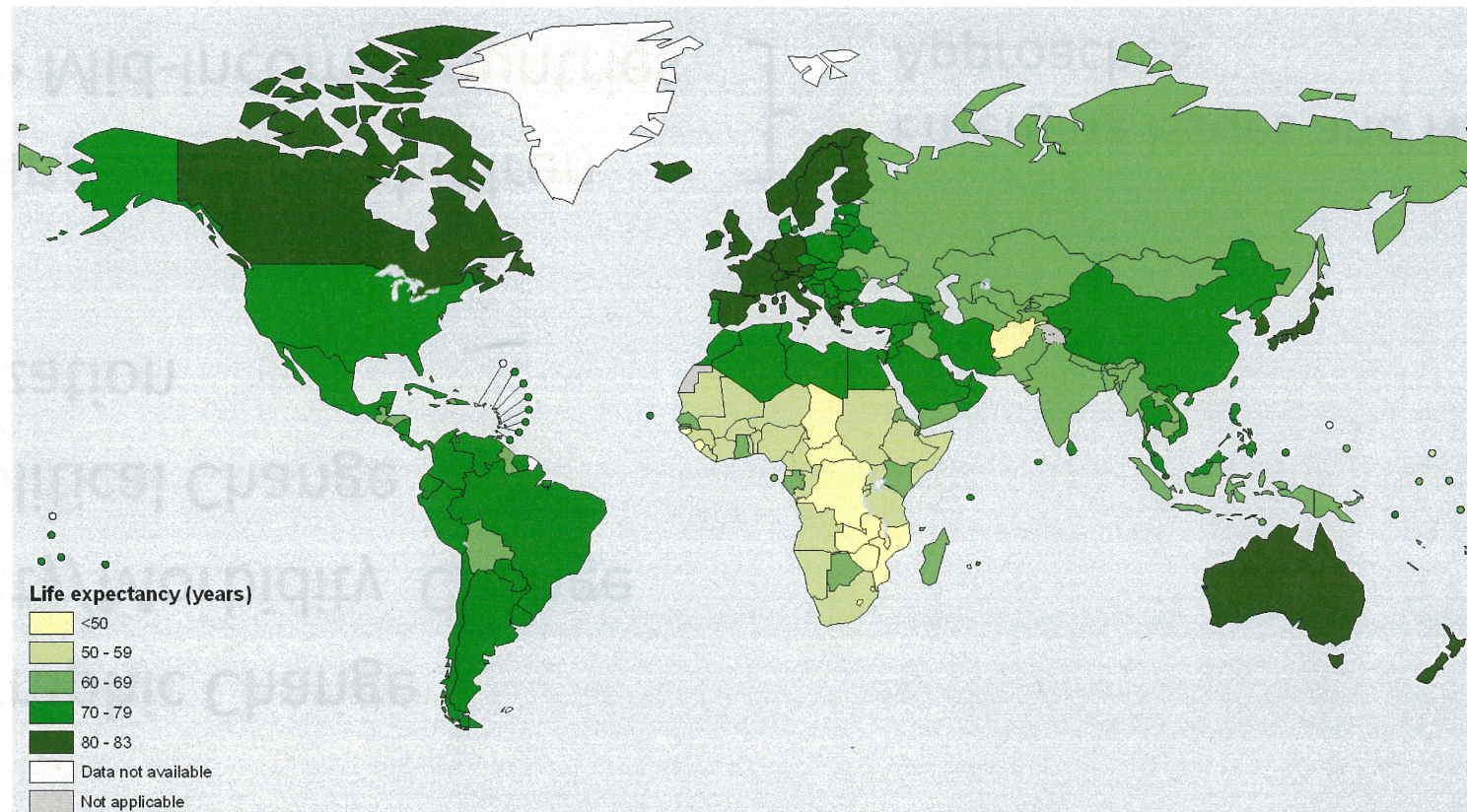
→ More Mid-income countries



Emerging Issues and New Approaches



# Life expectancy at birth Both sexes, 2009



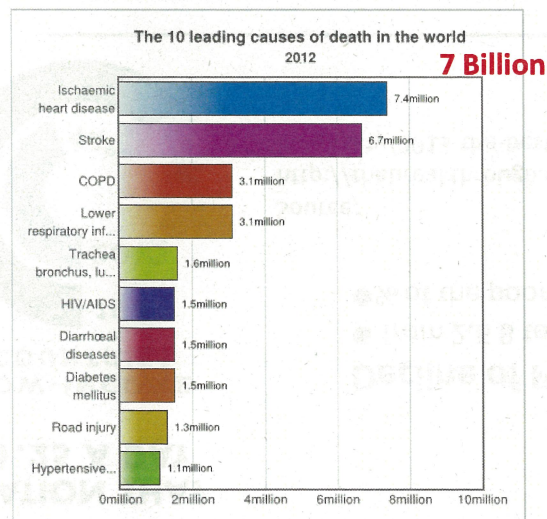
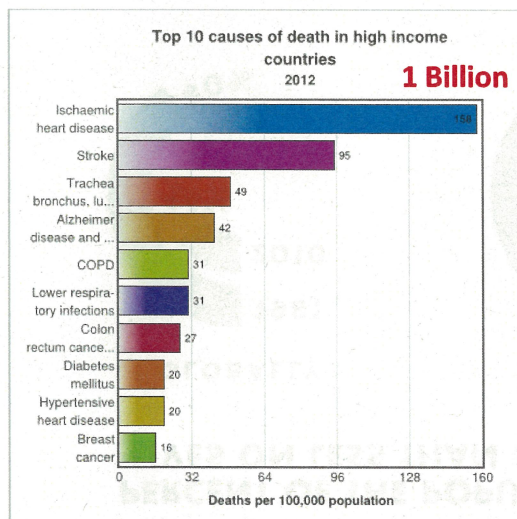
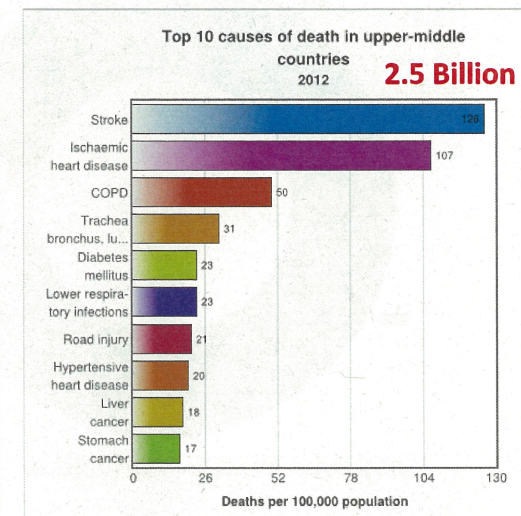
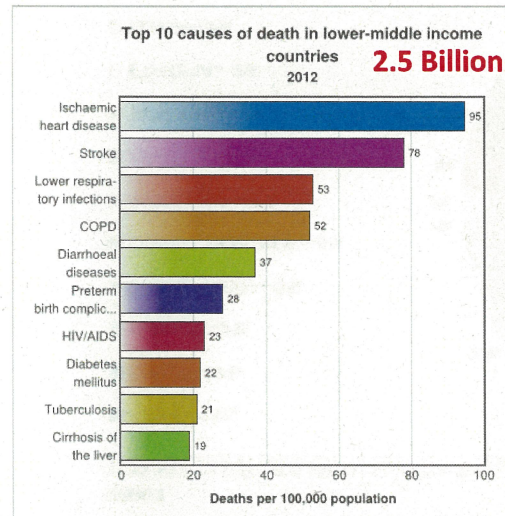
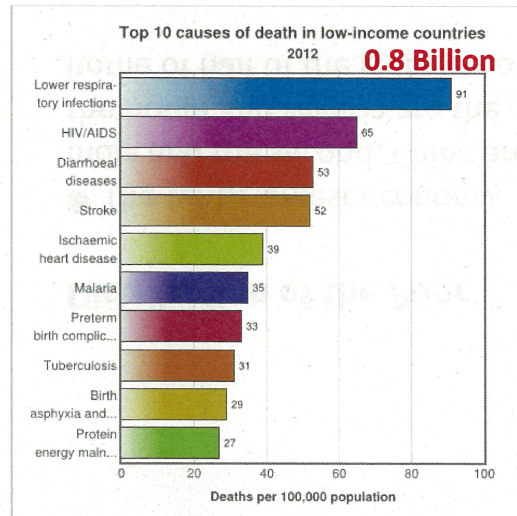
The boundaries and names shown and the designations used on this map do not imply the expression of any opinion whatsoever on the part of the World Health Organization concerning the legal status of any country, territory, city or area or of its authorities, or concerning the delimitation of its frontiers or boundaries. Dotted lines on maps represent approximate border lines for which there may not yet be full agreement.

Data Source: World Health Statistics 2011, WHO  
Map Production: Public Health Information  
and Geographic Information Systems (GIS)  
World Health Organization

 **World Health  
Organization**  
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## Top Ten Causes of Deaths by Income Category and Population

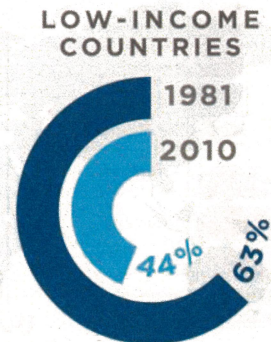
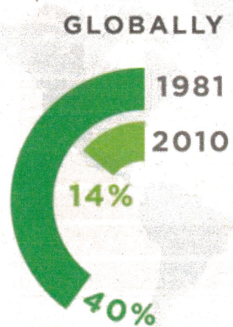


**Source**  
WHO Media Centre  
The top 10 causes of death, Fact sheet  
N°310, Updated May 2014  
<http://www.who.int/mediacentre/factsheets/fs310/en/>

**Source**  
World Bank. World Development Indicators. Washington DC, World Bank 2013



## PERCENT OF THE POPULATION THAT LIVES ON LESS THAN \$1.25 A DAY



## Decline of Population in Poverty

- from 2.6 B to 1 B from 1981 to 2010
- % of the poor declined from 60% to 44 %

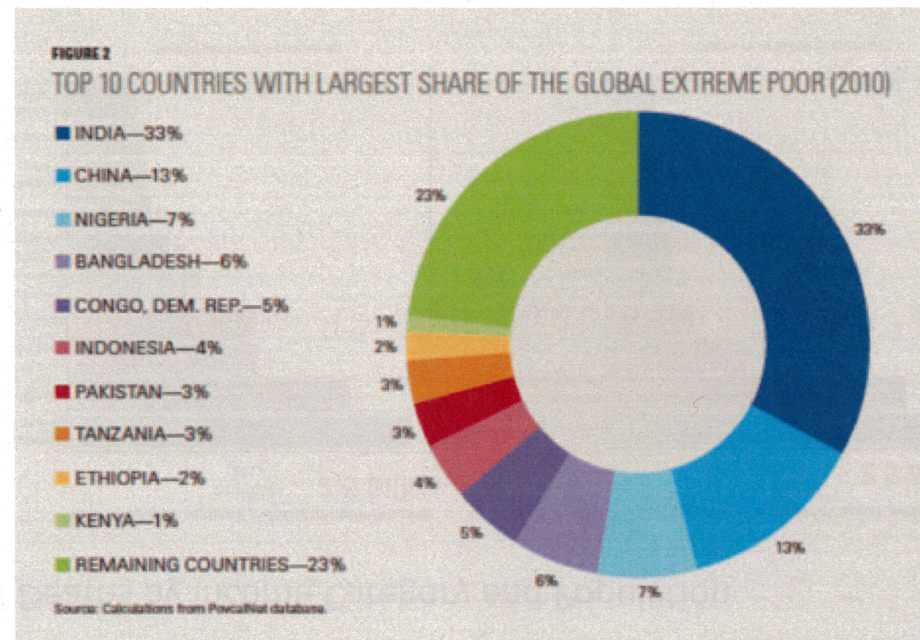
Source;

<http://thebreakthrough.org/index.php/programs/opportunity-and-inequality/2013-the-best-year-in-human-history>

## Distribution of the Poor

- The tenth largest economy, India and the second, China are the home and Nigeria are the home of half of the global poor.

Source; World Bank Group; Prosperity for All/Ending Extreme Poverty, Spring Meeting 2014

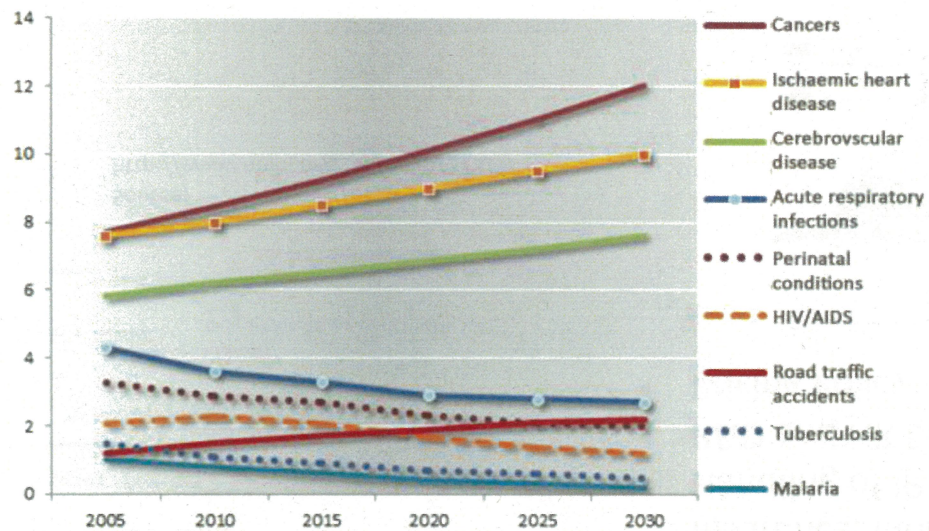




## Changes in Mortality and Morbidity

### Mortality, 2004–30

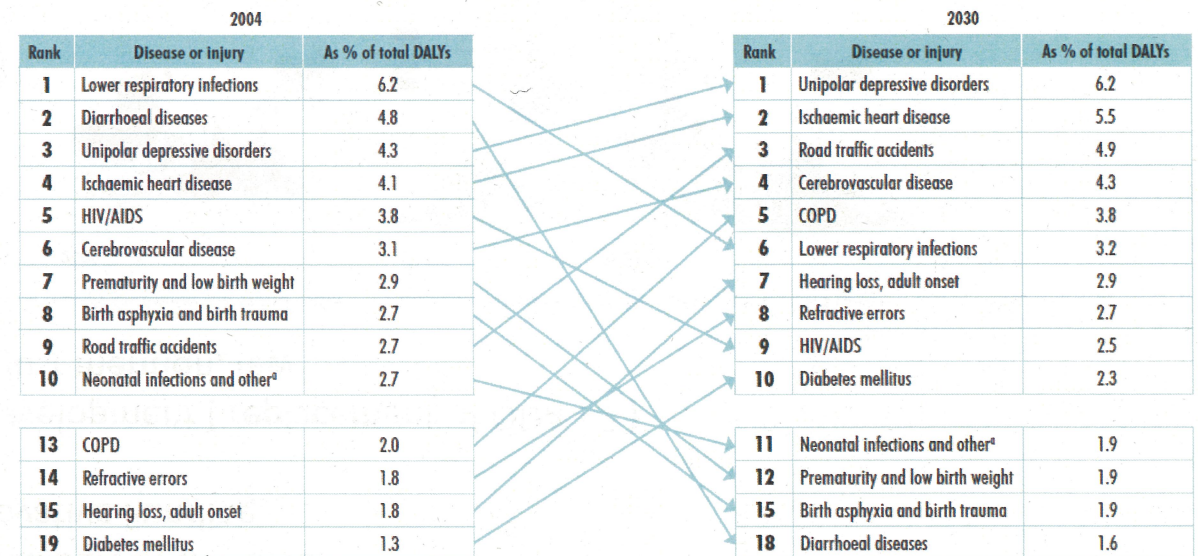
Million



[http://www.who.int/healthinfo/global\\_burden\\_disease/GBD\\_report\\_2004update\\_full.pdf?ua=1](http://www.who.int/healthinfo/global_burden_disease/GBD_report_2004update_full.pdf?ua=1)

### DALY, 2004-2030

Figure 1. Ten leading causes of burden of disease, world, 2004 and 2030



<sup>a</sup> This category also includes other non-infectious causes arising in the perinatal period apart from prematurity, low birth weight, birth trauma and asphyxia. These non-infectious causes are responsible for about 20% of DALYs shown in this category.

*The global burden of disease: 2004 update.* Geneva, World Health Organization, 2008.

# Required changes in approaches to Growing markets



The NEW ENGLAND  
JOURNAL of MEDICINE

HOME ARTICLES & MULTIMEDIA ISSUES SPECIALTIES & TOPICS FOR AUTHORS CME

## Table of Contents

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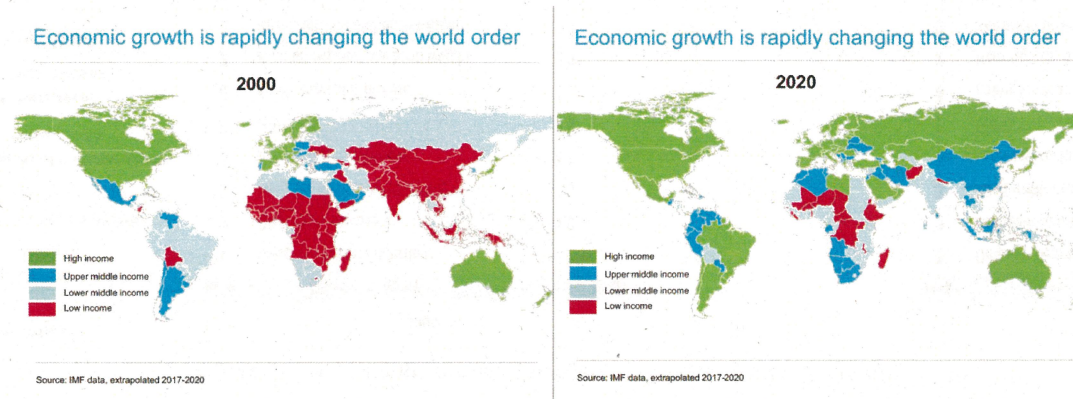
**PERSPECTIVE**  
The Trans-Pacific Partnership — Is It Bad for Your Health?  
A. Kárpáczynski  
Free Full Text Audio

2011-2013

Source;  
<http://www.nejm.org/toc/nejm/373/3/>

New Approaches are needed for the ODA gradulators.  
The followings will be encouraged by the SDG3 sub-item UHC.  
The ATM is essential part of the UHC.

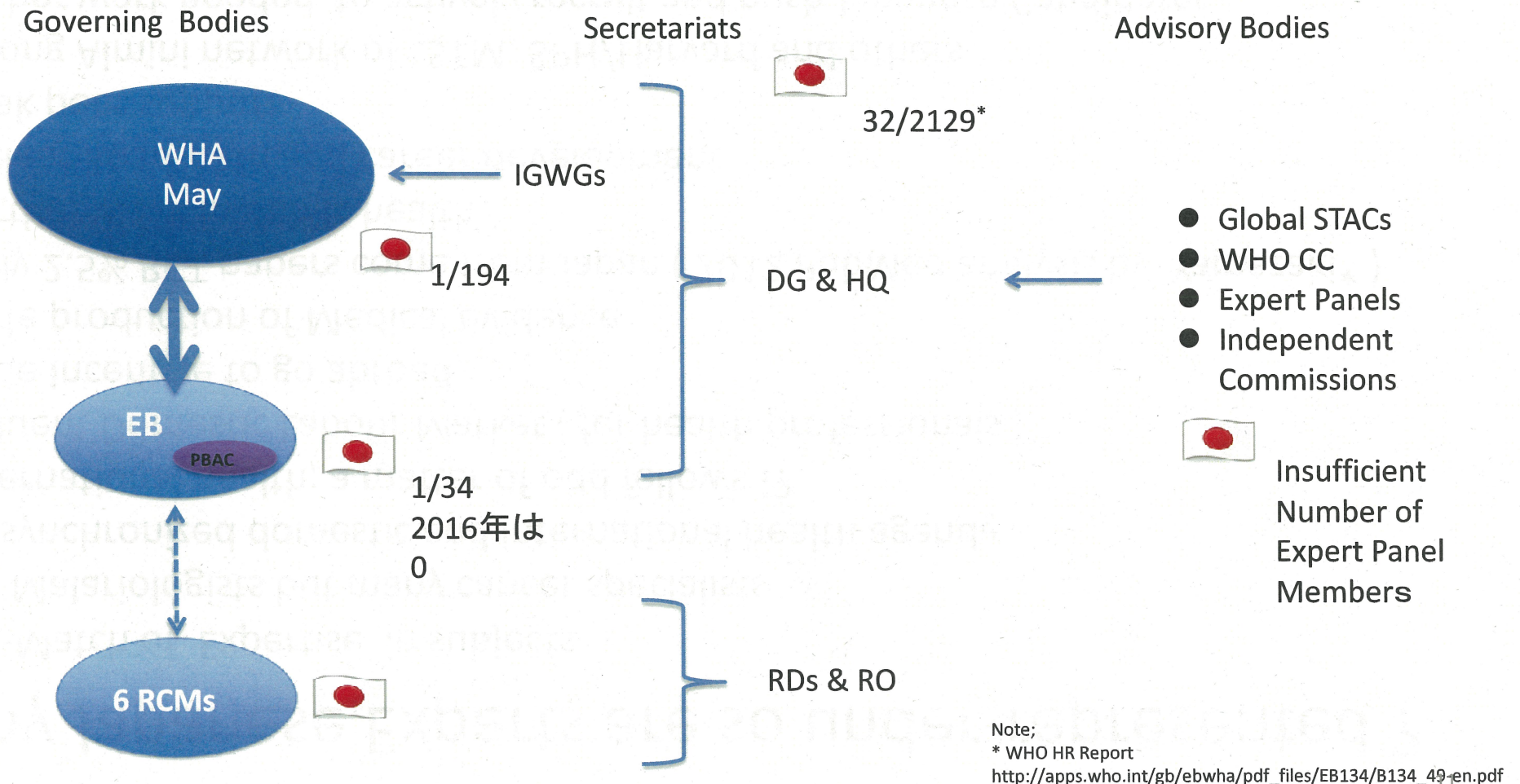
- Insurance, Innovative Funding
- Handling of IP
- R&D and HR Development ( replacement of ODA ! ? )
- Pricing Policy just mention, few



source;Ministry of Foreign Affairs of Netherlands  
[http://aighd.org/media/medialibrary/2013/03/2013.06.02\\_Symposium\\_HIV\\_Drug\\_Resistance\\_-\\_Steenbergen.pdf](http://aighd.org/media/medialibrary/2013/03/2013.06.02_Symposium_HIV_Drug_Resistance_-_Steenbergen.pdf)



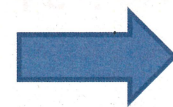
## WHO's Governance, Secretariats and Scientific Communities





# Why Japanese Experts are so under-represented ?

- Mis-Match of Expertise in subjects  
No Malariologists but many cancer specialists
- Unsynchronized domestic and international health agenda  
International health; a matter of odd fellows !?
- Affluent Domestic Labour Market ( for health professionals )  
Little Incentive to go abroad
- Little production of Medical evidence  
Only 2.5% RCT papers come from Japan ( 2012 PubMed analysis by Yamazaki\* )  
Further weak in public health
- Unclear Road-path and career development
- Weak peer support  
Strong Alumni network of LSTM, SPH/Harvard and others
- Further work needed to actively recruit and push Japanese Candidates
- Little entry from non-health sector



Risk of Over-diagnosis  
but Poor Treatment

\* 山崎茂明; 科学論文のミスコンダクト、丸善出版、2015年

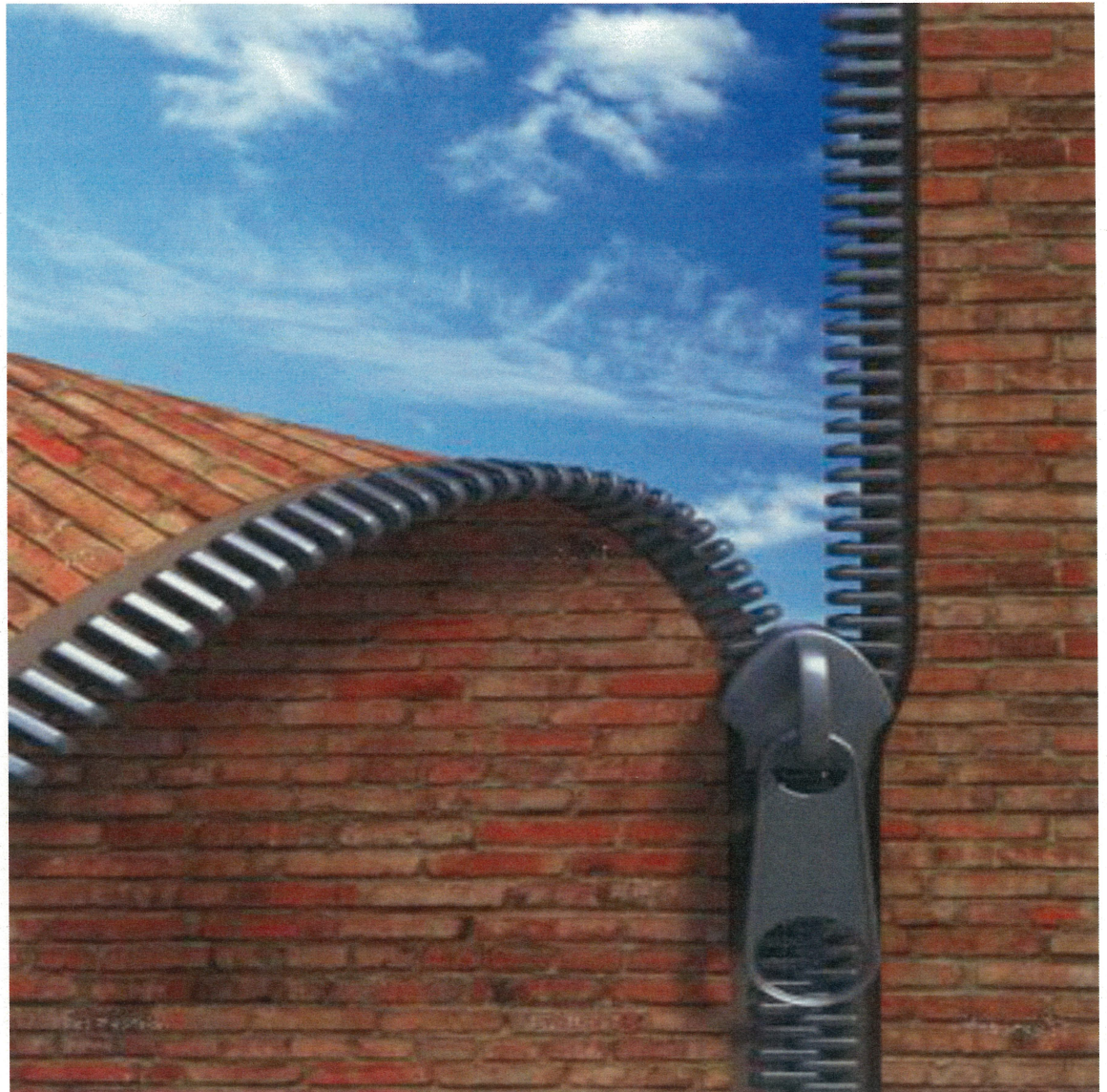


# To Open a New Era by Japanese Global health Experts ;

Need of Global Health Leaders from  
Japan

As;

- A Standard-setter
- An Architect of Global Governance
- A Senior Manager







## CONCEPT NOTE

### 国際保健に関する懇談会 WG

#### 国際保健政策人材チーム作業計画 Draft-Version 3

中谷比呂樹

2015/08/13

#### 1. 背景

保健医療 2035 における提言を遂行し、我が国がグローバルヘルスで影響力を維持・拡大するためには、内外の保健医療の実務と政策に精通した若手リーダーを養成することが急務である。そのリーダーは、国際的規範の設定に貢献し、国際的なガバナンスにも関与する。彼ら/彼女らは、海外との交流の中で育成されるものであり、その過程で、国の将来を担うリーダーとも接し切磋琢磨することにより双方にとって意義のある人材養成プログラムとなることを目指す。

#### 2. 目標とする成果

- 1 我が国の国際保健政策人材（グローバル・ヘルス・カデット；以下 GHC）養成の 5 年計画と実施計画を立てる
- 2 既存（Senior Cadet）および養成された GHC の活用方を提言する
- 3 海外における同種のプログラムへの支援方を提言する

#### 3. 作業計画

- 1 既存の各種提言のレビューと不実施の理由の探求
- 2 理念、前提条件の確認
- 3 既存の提言で盛り込まれていないことの同定、実施にあたってのボトルネック解消策の検討
- 4 養成された GHC の具体的活用の方策の検討
- 5 海外における同種のプログラムへの支援の方策の検討



#### 4. 検討課題 (例)

- 1 WHO 等でのような資質・能力が求められているのか
- 2 何故長年にわたりアンダーレップが解消されないのか
- 3 日本人の応募者の資質で一番不足しているのは何か
- 4 日本の雇用環境に問題があるのか
5. セカンドメント以外の日本人職員は何を政府に求めているのか
6. 大学からの人材交流の今後の展開 等

#### 5. メンバー (必要に応じて追加)

ワーキンググループの有識者、国際機関関係者、国立国際医療研究センター、厚生労働省等より構成 (調整中)

#### 6. 作業日程

- 9月上旬 キックオフ・ミーティング 3時間

全体構想の確認・役割分担

- その後、 約2週間毎に宿題報告と論議の形で詰める  
(5 課題 x 3 時間 計 10 週間程度)

○懇談会に適宜報告

- 11月末 ドラフトの検討

- 12月中旬 中間報告書のとりまとめ

- 必要に応じて、フォローアップ