Honorable Ministers, distinguished guests, ladies and gentleman, now I am taking off chapeau as a co-chair of the session and would like to share Japan's efforts to achieve sustainable UHC.

Universal Health Coverage (UHC) is defined by WHO as "access to key promotive, preventive, curative and rehabilitative health interventions for all at an affordable cost, thereby achieving equity in access." Japan has been thriving to sustain and improve UHC since 1961. I would like to share with you key lessons learnt from three core elements of UHC, namely, access to key health intervention, affordability and equity.

First of all, I would like to stress the importance of assuring access to basic public health services for all citizens. Japan's infant mortality has dropped from more than 70 per 1000 births in 1945 to 10 in 1975 and then to 2 in 2016, the world's lowest. This rapid decrease can mainly be attributed to a series of public health interventions for prevention and health promotion including safe water and sanitation, nutrition, vaccination, as well as school health programs, at the community level. However, as an aging society, eminent challenge we are facing is to further encourage self-reliance of the elderly through prevention of degenerative conditions including frailty, decline in locomotive function, and sarcopenia.

To facilitate evidence-based interventions for preventing diseases, mitigating worsening conditions, and promoting recovery, we will establish a nation-wide comprehensive and personalized data platform, integrating, for the first time, health-related data including health check-ups, medical and long-term care.

Second lesson is to adequately secure affordability of health care. Japan introduced national health care insurance scheme that covers the whole population in 1961. This ensured affordable access to fundamental health care and saved many Japanese from impoverishment by having a severe disease. In the case of elderly health care in Japan, we once introduced free user fee policy in 1973. At this point, the proportion of people aged more than 65 years old was about 8%. However, due to ever growing demand

induced by low user fee, as well as growing proportion of the elderly, it soon became evident that the low user fee policy was not financially sustainable. And yet, it took us some 30 years to reintroduce a meaningful proportional co-payment after a prolonged and fierce political debate over an increase of out-of-pocket payment for the elderly. Therefore, out-of-pocket payment for health care should always be on a declining trend rather than the opposite based on our lessons learned in a harsh way.

Last but not least, I would like to share the lessons regarding equity in access to health care. Our health care delivery system has been characterized by "free access" system, where patients can access any specialists without referral from gate-keeping practitioners. However, as doctors can practice clinics anywhere they wish under any specialty they claim, doctors tend to prefer urban settings over rural areas and less burdensome specialties over long-hour stressful shift. This could induce unfortunate mismatch against optimal availability of doctors based on patient's needs in terms of geography and specialty. To address such mal-distribution of doctors, one promising model is to cover remote areas, where doctors are scarce, by deploying doctors from urban areas on a rotational basis. This approach has been proved to be effective in my home prefecture of Ehime and could serve as a reference for other settings.

Finally, I would like to propose the launch of the "ASEAN-Japan UHC Initiative" to enhance basic data system, collaborative research and human resources development aiming to achieve sustainable UHC by 2030. Through this initiative, I am convinced that we, ASEAN and Japan, can together accelerate our mutual efforts and contribute jointly to the world for this noble cause.

Thank you.