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International Cooperation for Health in Japan

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日本における保健医療協力

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Although Japan as a top donor of official development aid contributes to health in developing countries, it's reputation is not as good as the Japanese Government estimates. The pupose of this research is to clearly set out Japan's policy making process for International cooperation for health, especially in the Nursing field and to point
out problems and tasks for the future.

The actual execution of Japan's international health projects is divided into two patterns. One is the pattern where materials or resources are the key points for aid. This category contains grant aid and contributions to international organizations. The other is the pattern where it is difficult to render assistance through using only resources but rather where transfering technology by experts is also important. This pattern involves technical assistance. In either case decisions are not based on firm guidelines, instead they are made in a haphazard way.

The most important reason why Japan's cooperation isinhibited from working well is Japan's own domestic system. In the case of nurses, who can play an important role in PHC projects, as is demonstrated by nurses from some North European countries, Japanese nurses are not given a chance to take an initiative in supporting the present aid system.The organization of talent so that it may be used effectively will determine the future of Japan's international cooperation for health.

Key Words (キーワード)
International cooperation (国際協力), International health (国際保健), Medical cooperation (医療協力), ODA(政府開発援助)

1 Introduction

In 1992, the total amount of Japan's ODA (Official Development Aid) was about 11.3 billion dollars. Japan, thus, became the top donor in the world. During the past ten years, when other developed countries' ODA was decreasing because of domestic economic problems, Japan alone had a steadily increasing ODA. None the less the reputation of Japan's ODA is not as good as the Japanese government evaluates.

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The purpose of this paper is to make clear the policy-making process of Japan's ODA by taking up a case of medical cooperation which aims to contribute toward to the promotion of health in the developing countries. This paper should point out some principal problems of Japan's present medical cooperation policy and its prospects for the future.

First, I shall explain the bold outline of Japanese medical cooperation, its forms, features and institutional framework. Second, I would like to explain the actual working of the policy-making system for Japanese medical cooperation.

2 The outline of Japanese medical cooperation

Japanese medical cooperation is divided into two categories; one is bilateral cooperation, the other is multilateral cooperation. The former provides aid for a specific developing country, while the latter dose not specify a certain country. In the second category there are contributions to world organizations such as WHO (World Health Organization), UNFPA (United Nation Fund for Population Activities), UNICEF (United Nations Children's Fund), etc. Bilateral cooperation is also divided into gratis and no gratis forms. The latter is called " Yen-Credit " or " Yen Loan". The gratis type of cooperation does not inquire the recipient country to pay back the money provided. Included in such aid is technical assistance, which transfer specific technology for health manpower training in developing countries, and grant aid which contributes to medical resources. In addition to other type of cooperation, disaster relief and aid by NGO (non-govern men organization) are included.

The substance of medical cooperation is also divided into two types; one directly promotes people's health in the developing countries, the other ameliorates health care delivery systems in those countries so that the health level of people is improved. In the former type, there is cooperation which mainly contributes to the cure of disease, for example building hospitals and improving the technology of diagnosis and treatment for diseases, and cooperation which contributes to the prevention of diseases, especially infectious diseases. Vaccination and hygienic education are contained in this type of cooperation. While in the latter type, there is training for physicians, nurses and other health providers, who are generally shortage in developing countries, as well as research for endemic diseases. Currently there are also cooperations which reforms health delivery systems, such as assessment of financial affairs relating to health matters.

The first feature of Japan's health cooperation is composed almost completely of gratis type aid and Yen loan aid is quite rare. Because medical cooperations are not evaluated using the standard "cost-benefit" analysis. In addition, developing countries generally can not afford to appropriate funds for health complex. Therefore gratis aid is regarded as suitable aid for medical cooperation.

The second feature is that most of the aid budget is used for building hospitals and purchasing medical instruments. This is especially so in connection with grant aid. Therefore Japan's medical cooperation is often criticized as no contributing generally to

people in the third world.

The third feature is that, like most other aid given by Japan, most health aid is for Asian countries, although, gradually, aid for the Least Developing Countries in Africa is increasing. This point is coincident with the principle of ODA charter that I mention to the next section.

The last feature of Japan's medical cooperation is that contributions for International organization are becoming the highest in the world. For instance, in case of the WHO, whose Director General is Japanese (H. Nakajima), Japan contributes positively to the programs of the WHO. However, Japan has neither sufficient manpower nor suitable specialists who work at the WHO. This is another point of criticism made by other developed countries.

As the largest part of Japan's ODA is made up of economic cooperation, the rate of cooperation for health is only 2–3% of the total amount of ODA. However, since ODA amounted to about 38 billion yen in 1990, Japan was the third largest donor of bilateral aid in the World (the first was USA, second was France). Japan's medical cooperation constituted more than 10% of all cooperation for health in the world.

3 Legal and institutional framework of policy-making in Japan's ODA

In Japan we do not have an ODA law. In order to acquire broader support for Japan's ODA, the government established the ODA charter in 1992. The charter explains that the basic philosophy of Japan's ODA supports for the self-help efforts towards economic takeoff and promotion of the sound economic development in developing countries. In accordance with the principles of the United Nations Charter, the principle of Japan's ODA takes into account each recipient country's requests, its socioeconomic conditions, and japan's bilateral relations with the recipient country. Furthermore, the ODA charter explains that Asia is a priority region and that priority issues are basic human needs, as well as global problems such as environment and population issues.

At the institutional level, the policy making process of Japan's ODA (i.e. aid projects, amount of aid money available and the form of aid), is controlled by a bureaucrat-ic politics, influenced by foreign and economic policy[1]. The first step in the process, is for the Foreign Ministry to receive requests for assistance from the government of recipient country. The Japanese government's policy is based on the principle of assistance-to-specific demand. Next, the Foreign Ministry prepares a list of aid requests and submits it to aid-related Ministries. In case of Yen loan aid, a majority of Japan's ODA, in addition to the Foreign Ministry, the Financial Ministry, the Ministry of International Trade and Industry, and the Economic Planning Agency discuss and assess requested aid projects and decide which ones to put into operation. In the case of gratis aid, which is the main type of medical cooperation by Japan, the central decision making Ministry is the Foreign Ministry, although other Ministries also join the policy making process. In the case of medical assistance the Health and Welfare Ministry and Education Ministry

are especially involved. Other Ministries are consulted by the Foreign Ministry to consider whether the requested project is suitable for development in the recipient country. Because these Ministries are not official members of ODA policy, their influence is insignificant. Third, the amount of aid money and the form and conditions of aid are decided by the four main ODA Ministries and Agency mentioned above, and the Foreign Ministry through diplomacy advises requesting countries. After the R/D (Record of Discussions) is concluded between two countries the aid project is carried out by practical organizations-OECD (Overseas Economic Cooperation Fund) for Yen loan projects and JICA (Japan International Cooperation Agency) for gratis aid.

In the case of health and medical assistance, after the project has been approved, JICA selects experts and sends them to the developing country for several weeks to investigate existing conditions on the field. Based on the experts' reports, the project is carried out by experts who have both the requested technology and the ability to transfer it. In the case of technical assistance projects it usually takes 5 years to transfer technology. During operation and at the end of the project, the project is evaluated by other experts inhealth affairs. It takes about 3–5 years to complete grant aid projects and after completion an evaluation team is also sent.

ODA budget is decided in a single-year budgeting framework. As ODA budgets are approved for each Department by the Diet, these Departments are entrusted to determine which projects and how much to fund. Therefore, the Diet can participate only to the extent of the total amount of ODA budget and allocation to each Ministry, but can not participate in the actual policy making process.

The above policy-making process is said to make Japan's ODA an incremental policy[2]. Because the priority of each Ministry is different, for instance the Foreign Ministry stresses the diplomatic factors, ODA policy is result of the interaction among routine work of different Ministries with different objectives.

Besides government or official agencies, however, there are several other actors who can effect medical and public health cooperation. These include medical experts, trading companies, medical consultants and politicians. Although there are no official reports of government which explain it, in practical terms, medical and public health cooperation has been done through the reciprocal relations or actions of these actors. The next section explains about this practical issue.

4 The actual process of the decision making for medical cooperation

The actual execution of Japan's international cooperative health projects, is divided into two patterns. One is the pattern where materials or resources are the key points for aid. This category contains grant aid and contributions to international organizations which are controlled by the Foreign Ministry or the Health and Welfare Ministry. The other is the pattern where it is difficult to render assistance through using only resources but instead where transferring technology by experts is also important. This pattern

involves technical assistance. There is a difference in the role played by various actors between these two patterns. Therefore, their influences to the policy-making process is also apart from the ODA institutional framework.

First I will explain the one pattern. In the case of grant aid, the central policy making actor is the Foreign Ministry although it meets with the Finance Ministry and other relevant Ministries. After a favorable decision, the grant aid project is executed by the Grant aid division of JICA. For this process, the policy-making of grant aid seems to be explained inside the institutional framework, however, there are other actors who can control the grant aid policy of the Foreign Ministry. These actors are important politicians and physicians whose suggestions can change the priority ranking of grant aid projects. For example, when Ministers visit developing countries they may promise to grant aid to the government. This is called "souvenir diplomacy" in Japan. In the case of grant aid, securing resources, especially budget, is important. This can be affected by personal intervention of politicians. Similarly, both influential physi-cians (who have connections with important physicians in recipient countries) and trading companies (who also have connection with bureaucrats of developing countries) can influence policy making. They know which projects can be adopt by the Japanese government. In fact, businessmen connected with Japanese trading companies may make requests for assistance instead of governments of developing countries[3].

The contributions to International organizations are decided on by the Foreign Ministry for UNFPA, UNICEF, etc, the Health and welfare Ministry for WHO, which exercise the budget for those organizations. For instance, the Health and Welfare Ministry has increased the amount of the optional budget for WHO, even though it has been criticized as following in the wake of WHO.

As the Foreign Ministry controls the grant aid and a large part of contribution to International organizations, jurisdiction disputes among Ministries do not occur (such disputes may occur in the case of Yen loan aid). Intervention by the Finance Ministry in the compilation of the budget may, however, affect the size of the actual budget although budgets can not be increased remarkably. Rather incremental increases are made because the total amount of budget is decided on using the result of the last year as a base. As bureaucrats in the Finance Ministry want to save money in the budget and those of the Trade and Industry Ministry want to protect Japanese companies, both prefer Yen loans to gratis aid. Responding to public opinion, both foreign and domestic, the Foreign Ministry seeks to make increase the budget for gratis aid and contributions to International organization. However, because of the control exercised by other Ministries, budget does not change dramatically from year to year.

Technical assistance is, as a general rule, first requested by the recipient government. After request, the Foreign Ministry of Japan asks the Health and Welfare Ministry, Education Ministry and other Ministries to introduce suitable experts for the project. After the team, consisting of experts, makes a few week field examination, the project is endorsed by the experts. However, practice is different from the above general rule. It

is the special knowledge or technology that is the key point for medical and public health cooperation. And the actor who has such knowledge is the medical profession. The Foreign Ministry does not have the technical know-how for cooperation, even though it can control the budget. The Foreign Ministry depends on JICA's judgment as to whether the requested project can conform to the recipient's environment. JICA also depends on the judgment of experts on the concrete level of project planning and practice. In the case of technical assistance, the relations of the Foreign Ministry, JICA and experts can not be always explained in a top-down pattern. Rather these players are controlled by each other. According to the explanation of JICA stuff,

> "..projects actuary done are only a small part of those requested. Even if a certain country has requested only one project, if the project is evaluated to be not suitable for the recipient country, it is rejected even though the Foreign Minis try wants to carry out. In fact, requests for high technical medical assistance from some African countries were rejected[4]".

In addition, there exists an another pattern called "Offer Form (or Menu Form)", which is the reverse of the request principle. Before the request, JICA suggests certain technical aid project to the Foreign Ministry. The Foreign Ministry, through the official dialogue, offers the project to the recipient country. The public health project in Thailand and Maternal health projects in Indonesia and Thailand have been carried out through this "Offer Form" pattern.

Although JICA seems to have a certain autonomy, JICA is in fact controlled by the Foreign Ministry in matters of the projects planning, especially budget. In fact, JICA does not have firm standards for selecting requested projects. It is forced to depend on opinion and judgment of experts. Indeed, sometimes JICA is controlled by experts, because the existence of an expert who can carry out requested project is an important deciding factor. According to the comment of the ex-chief of JICA, "we have many medical professionals who have high medical technology and excellent knowledge, but there are few who have that plus language ability and negotiation skill in the context of a different cultural society[5]". It seems that a key point in screening by JICA is whether a suitable expert is or is not available.

At the same time, the opinion of medical experts affects a project. Not only do they have an impact when they transfer their technology to the recipient country, but they also influence policy making, especially at the request stage. According to a medical expert, "A fairly large number of projects in Japan have been decided because of the relationship between a famous Japanese physician and the recipient one[6]". Moreover, when a recipient country requests several projects, the decision depends, in practice, on the judgment of medical experts[7]. In the case of technical assistance where the cooperation of an expert who has the technology is indispensable, this personal factor is strong enough to control medical aid policy even if the person has not a position of decision making but is only a medical expert.

As mentioned above, there is no single actor who can control international cooperation

for health in Japan. Though it is the central organization of decision making, the Foreign Ministry only present in outline of an idea about public health cooperation because health is only a part of the Foreign Ministry's ODA policy. In addition, as it does not have a good filter to select requested projects (especially in the case of technical assistance), it depends on JICA's screening. However, at the actually level, JICA makes its selections on a case by case method, but also does not have firm guidelines for medical and public health cooperation.

As famous physicians, trading businessmen, and politicians take part in the medical and public health projects even before recipient governments have made requests, it may generally be said that they know which type of projects can be accepted in Tokyo. Accordingly, projects which will likely be rejected by the Japanese government, for instance projects opposed to Japan's ODA principle, are never requested.

It seems that there are several reasons why medical cooperation is done in such a haphazard way. First, the ratio of medical cooperation to the whole ODA budget in Japan is small. Unlike economic cooperation, bureaucrats in the Foreign Ministry are not interested in medical cooperation and do not expect to accomplish diplomatic goals by carrying them out. So once budgeted for there is tendency for the Foreign Ministry not to intervene at the practical and technical level.

Second, the Health and Welfare and Education Ministries, which are the authorities concerned with medical, public health and education issues, do not have much influence on international cooperation for health. They never carry out their own projects. They emphasize officially their cooperation with the Foreign Ministry and JICA. But the actual condition where aid projects are carried out in the field of developing country, the interaction of these governmental actors can not be said to work well. They scarcely cooperate with each other on the aid field in the developing country[8].

Third, as medical experts, even an individual physician, have informations and technology of medicine, we can not neglect their influences upon international cooperation for health. Bureaucrats of the Foreign Ministry do not understand about medicine, and those of the Health and Welfare Ministry and Education Ministry are ignorant of foreign affairs, but there are physicians who are acquainted with both. In fact, the people who contribute most in developing international cooperation for health are such physicians. They occupy important posts for medical cooperation, such as bureaucrats in the Ministry of Health, chief of JICA, professors of universities, leaders of projects, so on. The power among physicians have more influence on medical cooperation than disputes among Ministries which has responsibility and power to act. It seems to me that clinical medicine and surgical technology are more predominant than primary medicine and public health in our society. Japanese government and private companies spend much money for development of new cancer treatment or other high technological medical treatments. Majority of medical students are interested in such remarkable field, they prefer to be a surgeon to a primary medicine or a specialist of public health. I suppose, the reason why clinical projects predominate over PHC in Japan's international cooperation for health, is

that, those domestic situation reflects on the Japanese medical aid policy.

5 Some problems of Japan's international cooperation for health

At present Japan's medical and public health cooperation, as well as other field of ODA, has many problems. I think, above all, the problems concerning policy-making and operational process are the most crucial and serious factors which have prevented Japan's ODA from getting a good reputation.

Being influenced easily by an individual intervention, it means that policy on international cooperation for health can be decided accidentally, without collecting and analyzing enough information. And, as most influential individuals in Japan do not have a communication network with ordinary people in developing countries, Japanese aid projects do not always coincide with what peoples of developing countries truly want.

In addition, the organizations connected with cooperation for health, namely, the Foreign Ministry, the Health and Welfare Ministry, Education Ministry, JICA do not have sufficient contact with each other[9]. Furthermore, evaluation of projects which have been completed is so superficial that the experience gained can not be used effectively in the future.

As a result, the policy of medical cooperation is accomplished without firm principle and formal decision-making process. The actual condition of Japan's medical assistance is far from ODA charter which is written to be accounted much of the basic human needs for general people in the developing countries. Therefore, Japan's cooperation for international health has, I'm sure, the following three characteristic problems.

First, Japan's medical cooperation tends toward building hospitals and providing high advanced medical equipment such as a CT scanner. Being different from in the case of technical cooperations such as upgrading health manpower, the strong intervention of above actors has a greater influence on decisions to provide medical equipment. Because in the case of technical cooperations, for example PHC project, unless we have experts who can stay at a recipient country for several years as well as transfer to their own technology, it can not be carried out even though a certain politician eager to enforce it. However, in the case of building hospital, if an important politician or physician succeeds in influencing to the decision-making process, it can be carried out. This is sobecause the decision can be made without complex technical and professional know-how. In addition, governments of developing countries, generally, prefer building modern hospitals which are under their authority and their own health rather than control over practicing PHC projects for the rural public. For the Japanese government, those modern hospitals can be a symbol of a big ODA donor.

Those hospitals and high advanced medical equipment are, however, not always used effectively in recipient countries. Modern hospitals need much running cost and many medical personnel, both of which are lacking in developing countries. Meanwhile, the situation in the rural areas where people can not afford to come to the hospital and pay

for treatment, is becoming worse than before. In a certain country there is a large gap in the health index of habitants of the big city and rural people[10]. And, because of the lack of budget and the low turn over rate of beds, the management of some hospitals is distressed[11]. Similarly, in the case of providing high advanced equipment, some equipment, not fitting tropical environment, is easily broken. Because of poor maintenance systems, once they are broken, they can be never used again[12].

A second problem is that Japan's health assistance does not use talents effectively. It is true that the number of JICA staff and medical consultants as well as medical experts is smaller than in the USA or other big donors. Generally Japanese physicians are not interested in health condition of developing countries, and do not want to go and stay there, even though they do want to go to USA or some European countries. So it is said that a shortage of talents causes Japan's health cooperation not to work well. But I think that the more serious problem is not a shortage of talents but the management of available talents.

In the case of nurses and other nursing related health providers, they have no chance to take an initiative in supporting international cooperation in Japan. It is said that nurses can play an important role in PHC projects such as health education programs and health examination programs in rural districts of developing countries. In fact, some North European countries, whose health cooperation is concentrated in PHC projects and never use ODA to build a hospital, use nurses as major talents for health cooperation. On the other hand, in Japan, they are excluded both from the policy making process and from the suggestion of programs by experts[13]. However we have many experts in the nursing field who are willing to work for developing countries and are not used effectively today. According to the reports of the International Nursing Foundation of Japan (INFJ), 70% of nurses do not hesitate to participate in a developing country in the event of a disaster. 80% of young people in service with Japan Overseas cooperation Volunteers (JOCV) in the medical field consist of nurses, midwives and public health nurses[14]. Some ex-JOCV nurses who want to be sent abroad as medical experts, are seeking and waiting a chance to serve, but it is difficult for them because of low educational background[15] or domestic problem such as shortage of nurses.

In the present state of Japan's medical cooperation, nurses and others nursing related talents have never been considered as experts who could take an initiative in supporting developing countries. The Japanese government excuses its concentration on building hospitals by stressing a lack of PHC experts. But the problem is a government posture which never brings up nursing experts.

The last problem is that the policy of international health cooperation is patterned after domestic medical conditions. It is said that in Japan clinical medicine is superior to preventive medicine, and surgeons have a much more powerful voice than public health practitioners. This situation seems to be reflected in the policy on international health cooperation. Japan's medical cooperation is concentrated on building hospitals and secondary treatment by certain physicians. As a result, a field such as nursing cooperation

has no influential person involved in the making of policy and thus is handicapped at the start.

It is true that a physician is a leading person in the medical field and he is permitted to do every kind of medical business by law in Japan. But, in fact, the present medical field is specialized and consists of many medical experts such as physical therapists, nurses, pharmacists, so on, who have each roles in accordance with their specialty. In contrast, in Japan's medical cooperation the voice of those co-medical experts has been often neglected and Japan's policy has been made only by the opinions of famous physicians who have a limited perspective for international health.

6 Conclusion: Toward the development of Japan's cooperation for health

Some grounds of the criticism for Japan's medical cooperation are said to due to problems in recipient countries themselves, for example, low administration ability or disposition to dependency on aid. But the most important factor which prevents Japan's cooperation from working well, I believe, attributes to Japan's problem of domestic organizations which do not meet aid policy. Japan's medical cooperation has not been decided rationally, but rather has been decided in a haphazard way, and Japan has not used talents available who could be experts for public health assistance. If we can improve these points, Japan's medical cooperation can more fruitfully contribute to people in developing countries.

The health problems of developing countries is quite different from the case of Japan. In addition, the health condition of developing countries is changing. Health indexes like infant mortality and life expectancy are very different among countries. Even inside one country there is a gap in the health condition between urban and rural populations. Furthermore, the structure of diseases is becoming diverse. In some developing countries, chronic diseases, like cancer and diabetes, are increasing as are infectious diseases. To assist more effectively we should cooperate by adapting to the health condition of each country. In addition, we need to make use of several special fields of experts, such a PHC, who are the most necessary in developing countries. It is not too much to say that both the consolidation of a system so that medical aid policy be decided in rational way and the organization of talents so that they may be used effectively, should produce the good prospect of Japan's international cooperation for health.

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9) For instance, according to the interview with a bureaucrat of Health and Welfare Ministry at Tokyo on March 31th in 1992, the meeting of Ministries has produced no re markable activities since 1990, when the first reports was submitted.

10) In Bolivia, life expectancy of poeple in urban areas where the government spends 80% of the health budget and which has 71% of the doctors, is 7 years longer than rural one (Uehara Naruo, 1989, Issues in Hospital Projects in Developing countries: A Case study in Bolivia, *Takemi paper Series, Harvard School of Public Health*, 10).

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13) Different from the case of physicians, the organization for policy making and any meetings concerning with international cooperation for health do not have any nursing stuff. Moreover although some training and education program had been started recently, for instance Tokyo university graduate school of international health and Foundation for Advanced Studies on International Development (FASID) program, general nurse can not apply to those programs because of low academic career.

14) More than six hundreds of Nurses, Midwivies, and Public health nurses were dispatched as a JOCV member by 1990, while eleven physicians and twenty-four dentists were sent.

15) Generally, goverments of developing countries want an expert who has a high academic career as well as a superior technical skill, but more than 90% of Japanese nurses do not have any bachelor's degrees.