Discussion Points

Obesity Control as a Challenge for Society:

Perspectives from Local Governments and Employees' Insurance Providers for the Advancement of Policies for Obesity and Obesity Disease

HGPI Health and Global Policy Institute

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Obesity Control as a Challenge for Society

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Definitions and references for terminology used in this report

Terms used in this report are defined below.

Body Mass Index (BMI)

Body Mass Index (BMI) is calculated using the formula of weight in kilograms divided by height in meters squared (BMI =W [kg]/H [m]^2).

Metabolic syndrome※1

● A person is diagnosed with metabolic syndrome when they present an increase in visceral fat (intra-abdominal fat) evaluated using waist circumference and meet two or more of three criteria: high blood glucose, abnormal lipid metabolism, or high blood pressure.
● The person in question does not have to satisfy BMI criteria for obesity (BMI≥25).

Obesity (condition)

A state of excessive fat accumulation in adipose tissue with BMI ≥25. The World Health Organization (WHO) considers a BMI of 30 or above as obese, but standards used to determine obesity vary by country.

Obesity disease

A disease with a medical need for weight loss due to complications or potential complications resulting from or related to the condition of obesity.

Severe obesity (condition)

Individuals who meet the criteria for the condition of obesity and with BMI≥35. This excludes people with secondary obesity.※2

Severe obesity (disease)

This is a disease that is diagnosed when an individual is determined to have severe obesity with a BMI≥35, meets the criteria for obesity disease, and has obesity-related health concerns or visceral fat accumulation.

【Works referenced】

The Japan Society for the Study of Obesity (JASSO). Guidelines for the Management of Obesity Disease 2022. Life Science Publishing Co., Ltd. Tokyo. 2022.

※1 The criteria for metabolic syndrome in Japan were defined in 2005 through joint efforts from eight academic societies: the Japanese Society of Internal Medicine, the Japan Atherosclerosis Society, the Japan Diabetes Society, the Japanese Society of Hypertension, the Japan Society for the Study of Obesity, the Japanese Circulation Society, the Japanese Society of Nephrology, and the Japanese Society on Thrombosis and Hemostasis. Ministry of Health, Labour and Welfare (MHLW). “Lifestyle disease management based on an analysis of health checkup data and health insurance claims.” https://www.mhlw.go.jp/bunya/kenkou/seikatsu/pdf/ikk-j.pdf. Last retrieved on June 4, 2025.

※2 Secondary obesity is defined as obesity with a clear cause and includes endocrine obesity, drug-induced obesity, genetic obesity, and hypothalamic obesity.

Introduction

"Obesity disease" does not merely refer to the state of being overweight. Rather, it is a disease where medical intervention is deemed necessary due to the health problems caused by obesity, or the state where the affected party is at high risk of developing those problems. Obesity disease is closely associated with serious complications like type 2 diabetes, hypertension, dyslipidemia, myocardial infarction, cerebral infarction, and obesity-related kidney disease. In addition to elevating quality of life (QOL) for affected parties, preventing the onset and progression of such complications through appropriate medical interventions is also vital from the perspective of health financing. For Japan, one of the world's few super-aging societies, failing to address obesity disease among working-age adults carries the risk of even greater demand for healthcare and long-term care services in the future, making it urgent that we establish systems for providing early diagnosis and intervention throughout the life course. Based on the recognition that obesity disease is not a matter of self-management but a condition that is caused by a combination of genetic, environmental, and socioeconomic factors, it is urgent that we implement approaches that integrate medical care, prevention, and policy.

Since its launch in 2022, Health and Global Policy Institute (HGPI) Obesity Control Promotion Project has held advanced discussions with experts representing government, academia, industry, and civil society while promoting obesity policies centered on and reflecting the voices of people living with or affected by obesity. In addition to examining the best actions to take for early detection through general and specific health checkups, subsequent medical consultations at healthcare institutions, and the establishment of specialized and multidisciplinary healthcare provision systems and treatments, HGPI has also examined eliminating obesity stigma and the need for prevention measures centered on appropriate dietary intake and exercise habits over the life course. We have also engaged in public outreach and advocacy efforts targeting the legislature, the executive branch, and local governments.

Addressing obesity disease will require implementing obesity control measures aimed at prevention and health promotion in tandem with a medical approach. Measures for obesity control are currently advancing as part of various prevention and health promotion initiatives from the national Government, local governments, and workplaces (including employers and employee health insurance providers) that aim to combat non-communicable diseases (NCDs). However, efforts from local governments and employee health insurance providers focusing on obesity disease remain extremely limited. In addition to examining this current state of affairs and its underlying reasons, this discussion paper aims to identify the ideal future obesity disease measures from local governments and employee health insurance providers from the perspectives of what will be optimal for patients and others with lived experience of obesity disease. To that end, we held interviews with local governments, employee health insurance providers, researchers, and healthcare professionals on perspectives to take into account when implementing obesity disease measures and to identify the environment, stakeholder coordination, evaluation indicators, and other items that such measures will require. Interview participants included local governments and employee health insurance providers that have already introduced measures for obesity disease. Given the limited nature of resources, the measures compiled below emphasize practical perspectives based on the need to design measures and policies that minimize burdens for people serving in clinical settings.

Interview Participants and Objectives

While the national Government has yet to implement a comprehensive policy on obesity disease, certain local governments and employee health insurance providers have implemented their own measures for this condition. Our interviews were held with six local governments, eight employee health insurance providers, and six researchers. Interviewees included representatives of local governments and insurers that are already implementing obesity disease measures. We asked them about the backgrounds of such measures, which programs are being prioritized, and what forms those programs take. We also gathered opinions from local governments and insurers who are not implementing such measures to gauge how they perceive obesity disease. Based on these interviews, we identified perspectives, environments, collaborative frameworks, and other such items needed to advance future obesity disease policies and control measures.

Interview Content and Discussion Points

1 The Current State of Obesity Disease Control Among Local Governments and Employee Health Insurance Providers

1-1 Content of Obesity Disease Initiatives from Local Governments and Employee Health Insurance Providers

Four of the local governments and employee health insurance providers we interviewed have already introduced obesity disease measures. Using existing health checkup systems, all of their initiatives are centered on conducting screening to identify people with obesity disease and BMIs of 30 or higher and subsequently referring them to healthcare institutions for medical consultations. They were also in the process of examining or have already implemented awareness campaigns for citizens, health insurance subscribers, and primary care physicians. While obesity disease encompasses a broad range of symptoms, we found that their measures for obesity disease are placing the initial focus on people with severe conditions that require medical intervention.

The following examples are drawn from separate local governments and employee health insurance providers.

Local governments

One program targets individuals with a BMI of 35 or higher, who have blood glucose, blood lipids, or blood pressure exceeding standard values, and who are not currently undergoing treatment (i.e. they do not have primary care physicians). Participants are provided with information regarding obesity disease and its treatment during interviews conducted by public health nurses or registered dietitians as part of specific health guidance and, upon request, are referred to healthcare institutions that can provide obesity disease treatment. The program is designed to remain flexible for participants who do not request obesity disease treatment, such

as by providing support for continued specific health guidance or consultation recommendations to treat conditions other than obesity disease. When the program was launched in FY2025, around 20 people were identified as eligible participants out of approx. 13,000 people who received specific health checkups. While over 100 people had BMIs of 35 or more, many were already undergoing treatment for blood sugar, lipids, or blood pressure, allowing program operators to rapidly identify and focus on those who had yet to attend a medical consultation.

Another program is screening people whose specific health checkup or "human dock" examination results meet the definition of severe obesity disease so that they can be connected to healthcare. In FY2024, this program identified around 30 eligible individuals who were then provided with recommendations to seek medical examinations. As a result, six of them visited a core hospital with an outpatient obesity clinic. The program implements an approach tailored to severity. People with a BMI of 32 or higher who are candidates for surgical intervention are offered workshops on treatment options and encouraged to seek care at specialized medical institutions. Those with mild obesity are encouraged to establish care with a primary care physician. The program also includes an awareness campaign targeting physicians, and the local government has prepared reference materials with the definition of obesity disease and intervention methods that it is calling on local physicians to distribute to patients. Although raising awareness through physicians is limited because they can only reach people who visit healthcare institutions, this effort is being positioned as the first step in expanding an information campaign. The local government is also working to raise awareness of obesity disease among community members through efforts like setting up information booths at local events or hosting lectures and seminars.

In a program for younger people who attend health checkups for adults in their 20s and 30s (which includes people enrolled in social insurance and lack other opportunities to receive health checkups), those whose BMI is 30 or more and receive "requires medical attention" for at least one indicator of complications (blood pressure, lipids, liver function, electrocardiogram, etc.) are provided with health guidance as well as recommendations to seek consultations at medical facilities specializing in obesity disease.

Group classes are then provided to those who attend health checkups but still struggle with obesity despite appropriate management of other health conditions. In addition, the local government and a childcare research association are starting a joint effort to host public lectures and provide information on obesity prevention from early childhood to promote health for future generations.

One local government is implementing obesity disease control measures within the health guidance framework using systems like the National Health Insurance (NHI) Prefectural Category 2 Transfer (Special Grant) system or the Insurer Initiatives Support System. Specifically, they have independently stratified people eligible for specific health guidance in detail, with "severe obesity disease" designated as its own category.

Employee health insurance providers

An employee health insurance provider has established an outpatient obesity clinic at one of their affiliate hospitals as well as a process for guiding high-risk individuals to that clinic through referrals from occupational physicians. Because this initiative involves occupational physicians, rather than informing all subscribers about it, information about it is restricted to Medical Collaboration Roundtables, which are forums for occupational physicians and occupational health nurses from major companies with on-site clinics. This program has treated over 50 patients over the past two years, and the insurer is considering increasing the number of days that outpatient care is available. Treatment provided through a combination of nutritional counseling and medication has been highly effective for some participants and the insurer would like to share these success stories throughout workplaces.

1-2 Starting Points for Obesity Disease Initiatives

Concern toward the increase in people living with obesity or metabolic syndrome in data held by each insurer provided starting points for the introduction of control measures.

The number of people who met the criteria for metabolic syndrome stayed the same or increased after the COVID-19 pandemic, causing concern. This led to the implementation of obesity control measures through public-private partnership agreements.

In one region, a data analysis conducted for the 2024 revision of the Health Promotion Plan found that more children and adults were overweight than compared to the interim revision five years earlier in 2019, and that target indicators had not been met. Around the same time, an outpatient obesity clinic was established at a local core hospital, so obesity disease measures were introduced through a public-private partnership agreement.

Health checkups data for those in their 20s and 30s showed a significant rise in people with a BMI of 30 or more. Around that same time, it became possible for community members to access specialized obesity treatment (including surgery) with the establishment of an obesity and nutritional improvement center at a local core hospital. This led to the introduction of measures through a public-private partnership agreement.

For one local government, high rates of obesity and metabolic syndrome have been issues for many years. These issues are partially driven by a local climate that discourages exercise and a high concentration of eating and dining establishments, many of which are open late. This led to the introduction of obesity control measures.

1-3 Recognition of Obesity Disease Among Local Governments and Employee Health Insurance Providers Without Targeted Initiatives

The measures for obesity disease described above are extremely limited, and many local governments and employee health insurance providers have yet to implement similar initiatives. When asked, these parties cited reasons such as the lack of inclusion of obesity disease in the health checkup screening system or the difficulty of grasping the prevalence of obesity disease due to a lack of recognition. However, some were aware that specific health checkups and specific health guidance are contributing to obesity disease control.

The prevalence of obesity diseases remains unclear due to its exclusion from screenings in the health checkup system.

Programs for obesity disease have yet to be developed due to low recognition.

Obesity is thought to be caused by a wide range of factors including genetic factors; alcohol consumption, smoking, and other lifestyle habits; and shift work or other work-related factors. This makes it unclear whom to target with preventive measures.

As specific health checkups and specific health guidance ultimately contribute to obesity disease control, and because metabolic syndrome influences the onset and progression of obesity disease and diabetes, specific health checkups and specific health guidance must be further strengthened.

Because self-guided weight loss efforts often have limits for people living with obesity disease, it will be necessary to strengthen consultation recommendations to guide them to medical care.

When a person's condition meets the criteria to be classified as obesity disease, responsibility for care shifts to medical facilities, limiting the role of local governments in certain aspects. As local governments must operate with limited resources, they tend to assign higher priority to the area of prevention and postpone efforts for people with preexisting conditions.

1-4 Limitations in Assessing Circumstances Due to Insufficient Data

Japan was the first country to define "obesity disease" as a medical condition, and it has a wealth of medical and health checkup data, including data from programs like specific health checkups. Since obesity disease treatment outcomes can be evaluated in terms of improvements in health impairments, there are high expectations for the effective use of data to that end. However, a future challenge will be establishing a system to gather data on obesity disease treatments, including treatments provided through self-pay (non-insured) healthcare services. In addition, local governments and employee health insurance providers generally require data and evidence to demonstrate the necessity of a program when making the decision to implement it. There is a lack of evidence in every area for obesity disease, including the total number of people living with the condition or the impact of programs in terms of health outcomes, behavioral change, cost-effectiveness, and labor productivity. This makes it difficult for insurers to prioritize the introduction of obesity disease countermeasures.

Local governments

Local government programs that target conditions that affect many people or pose a significant burden on healthcare expenditures tend to be assigned higher priority. The lack of data for obesity disease makes it difficult to obtain support from healthcare professionals and other stakeholders, so its priority does not increase.

Employee health insurance providers

Employee health insurance providers tend to be thorough in evaluating cost-effectiveness and give close scrutiny to financial benefits and necessary financial burdens in their capacity as insurers. Evidence showing that current investments will yield future benefits is effective for elevating the priority of obesity disease measures among such insurers. For instance, this evidence may include estimates of future savings in healthcare spending derived from predictive models.

If guidelines or systems were established to identify which of the eleven conditions associated with obesity disease are most effective to address in terms of reducing healthcare spending or improving employee productivity or presenteeism, it would facilitate more proactive responses in workplaces.

Among employees with obesity disease, some have both obesity and diabetes, and their condition has advanced to the point that it results in work restrictions. This has led to the recognition of the need for countermeasures. However, it is difficult to encourage behavioral change among employees or determine the cost-effectiveness of measures at the stage without subjective symptoms, which makes it difficult for obesity disease programs to become a higher priority.

1-5 Non-Data Factors for Countermeasure Prioritization Among Local Governments and Employee Health Insurance Providers

In addition to data, national policy guidelines or budgetary incentives are factors for the promotion of obesity disease measures among local governments. For workplaces, health and productivity management is the key to progress. In addition to a lack of data, however, there is also little impetus to assign obesity disease measures a higher priority. This hinders efforts to implement them.

Local governments

Directives (provided through laws or notifications) or budgetary incentives from the national Government are essential for local governments to implement new initiatives. For example, when the Severe Diabetic Nephropathy Prevention Program was incorporated into evaluation indicators for the Insurer Initiatives Support System and granted a financial point-based incentive from the national Government, local governments nationwide were quick to implement it. Similarly, establishing a system that evaluates outputs and outcomes from local governments by incorporating them into indicators for the Insurer Initiatives Support System and allocating budgets based on points is likely to be effective in encouraging the nationwide expansion of obesity disease initiatives, as well.

Conversely, given the limited nature of manpower and budgets, introducing too many national guidelines could hinder the ability of local governments to implement them, even if they recognize the issue at hand. The national Government should exercise a certain degree of consideration.

Workplaces

Health and productivity management is a major administrative issue for companies, so collaboration and cooperation between employers and employee health insurance providers are likely to generate greater results. Even when guidelines or indicators from the national Government are not compulsory, the presentation of clear national guidelines is likely to heighten legitimacy for such initiatives and create an environment in which employers are less likely to face both internal and external criticism when promoting health and productivity management.

1-6 Existing Measures Related to Obesity Disease Without Explicit Labeling

For the reasons described in previous sections, many local governments and employee health insurance providers have not yet implemented measures for obesity disease and do not consider it a priority item. However, we found many existing initiatives that can be considered as partial measures for obesity disease or that directly or indirectly contribute to obesity disease control, even if they are not explicitly labeled as such. These include initiatives for testing, reinforcing consultation recommendations, or raising awareness. Among those measures, we also heard about the challenges involved in implementing measures for both obesity and obesity disease.

The following examples are drawn from separate local governments and employee health insurance providers.

Local governments

One local government is advancing a program for the prevention of advanced hypertension and diabetes for people who are eligible for specific health guidance as well as those who are not. While obesity and obesity disease were not designated as central themes in their awareness-raising activities, they are conducting health seminars on other themes, such as blood pressure. Before a local medical facility

specializing in obesity disease treatment was established, their efforts were limited to recommending people to seek treatment for underlying conditions at general healthcare institutions.

Among people eligible for specific health guidance, there are some people for whom it is preferable that they visit a healthcare facility that treats obesity disease than receive guidance. While consultation recommendations are provided as part of health guidance, the final decision on seeking treatment must ultimately be made by the individual.

Employee health insurance providers

Consultation recommendations are being provided to people with hypertension, diabetes, and dyslipidemia (which are commonly associated with obesity) but who are not undergoing treatment. There are also efforts to provide information on improving lifestyle habits using BMI.

Resources are being set aside specifically for cases in which health checkup results have "panic values," which are values that correspond to situations so dangerous they may be life-threatening. In this system, people are ordered to seek medical care and suspended from working until they submit a medical report to their employee health insurance provider. However, in general, obesity alone is not sufficient grounds for a person to be assigned a "panic value."

After formulating a Data Health Plan and conducting an analysis, one insurer found that male subscribers experience a rapid increase in body weight in their 20s and 30s. Fresh university graduates often gain weight rapidly after they first enter the workforce. There are a variety of causes of obesity among younger people. In some cases, people who exercised often and ate well during their student years become obese after entering the workforce because they exercise less while maintaining the same dietary habits. In other cases, they may adopt unbalanced, carbohydrate-heavy diets to save on food costs after moving out of their parents' homes, or they may cut back on sleep in favor of leisure activities, causing them to start skipping breakfast. Since younger age groups are more open to behavioral changes, one insurer is creating leaflets to promote healthy weight maintenance. In addition, health education booklets distributed to new employees joining mid-career include pages that prominently feature obesity prevention.

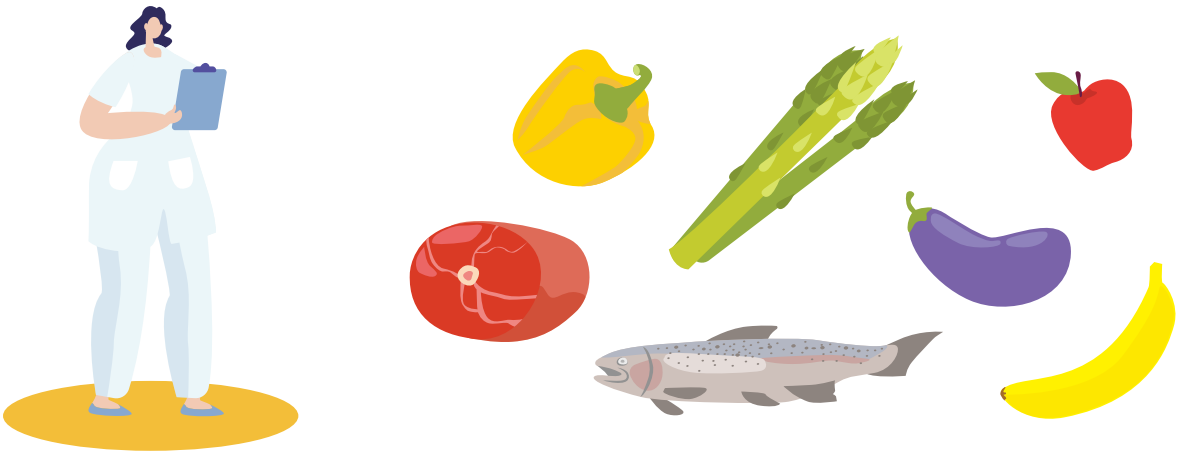
One insurer analyzed data on individuals eligible for specific health guidance and found, among other results, that obesity carries a high odds ratio as a risk factor for the onset of diabetes. However, the analysis did not stratify data by the degree of obesity. That insurer has also achieved significant improvements in a nudge-based program in which people with mild obesity are provided with notifications immediately before their next health checkup.

The pursuit of unnecessary weight loss and excessive thinness have become significant issues for women, requiring an approach opposite to the one used for obesity.

One insurer is conducting simple sleep apnea syndrome (SAS) exams for employees with obesity and who operate vehicles. These exams are necessary because SAS is linked to falling asleep at the wheel and mental health disorders, and they also have the potential to be utilized in obesity disease control.

SAS screening is being provided to those who request it. Among people with obesity, many are at high risk of SAS, so one insurer is raising awareness about the importance of weight control from the perspective of SAS prevention.

Given the need to transmit accurate information regarding severe obesity disease and concerns toward cases in which younger people are privately importing and making improper use of obesity medications, we believe that providing accurate knowledge will be vital.



2 Necessary Perspectives, Environments, and Collaboration Systems for Obesity Disease Control

Based on success factors, lessons learned, and future issues to address that were shared during our discussions with local governments and employee health insurance providers who are already implementing measures for obesity disease, the first portion of this chapter is titled, "Recommended Actions for Local Governments." It will focus on perspectives, environments, and collaboration systems that local governments require when implementing measures for obesity disease. The second portion of this chapter, titled "Expectations for Policies and Systems," is primarily intended for the national Government, prefectural governments, and academic societies. It focuses on challenges that local governments and employee health insurance providers cannot easily address on their own, and describes recommended policy and environmental measures to enable or facilitate their obesity disease measures.

2-1 Recommended Actions for Local Governments

2-1-1 Recommended Actions for Local Governments

Build Internal Systems

Obesity disease impacts people of all ages, from children to senior citizens, and addressing it requires an approach encompassing health promotion, prevention, and health checkups. This complex nature means obesity disease measures must span the jurisdiction of multiple departments at local governments. Although sharing data and building systems across departments is challenging, promoting cross-departmental collaboration will help streamline measures for obesity and other conditions. It will also be necessary to strengthen collaboration with public health nurses.

Obesity disease initiatives require efforts spanning health promotion, health checkups for infants and toddlers, specific health checkups, and budget allocation, so cross-departmental collaboration is essential. However, sharing specific health checkup results, medical claims data, information from the Basic Resident Registration Network, or other forms of personal information across departments requires clarifying the intended purpose of use as well as obtaining consent from the individual in question, both of which hinder cross-departmental collaboration. Furthermore, the public health nurses and dietitians who serve at local governments are scattered across different departments, making it difficult to provide support for entire families or introduce other integrated responses. Many diseases require measures that cut across sectors and age groups, not only obesity disease. In light of this fact, mechanisms for sharing information across departments within local governments must be systematically established with the premise that personal information is to be handled with appropriate care.

Guidance has been provided by municipal public health nurses since the introduction of the specific health guidance system, resulting in the creation of a robust infrastructure for support from public health nurses. Having this infrastructure in place has been effective when advancing new programs.

2-1-2 Recommended Actions for Local Governments

Establish Collaboration Systems With Physicians and Specialists from Local Medical Associations and Core Hospitals

We heard from a number of respondents that arranging systems for collaboration with local medical associations and core hospitals helped to facilitate smooth progress when implementing obesity disease measures. Collaboration with local physicians is effective in countermeasures for any health condition.

In one region, physicians from core hospitals and public health nurses that emphasize direct support for nearby community residents worked together to advance measures for kidney disease, diabetes, and other NCDs. There was also a system for collaboration among public health nurses from surrounding communities with a culture of fostering mutual capacity and exchanging information through well-established study groups and similar efforts. The presence of these collaborative arrangements led to smooth progress in the implementation of obesity disease measures.

In another example, influential healthcare professionals like physicians, presidents of medical associations, and executives at core hospitals have formed collaborative relationships in countermeasures for other NCDs. When the obesity disease program was introduced, physicians participated in planning and review meetings from the outset, allowing them to share their expertise in areas such as the establishment of criteria for identifying eligible program participants. These physicians had approachable personalities and well-established trusting relationships, which enabled participants to share information and consult with each other in detail. This allowed the medical association to send a request for cooperation to every primary care physician at once.

When there is a medical facility specializing in obesity disease in the region, conversations should be held on topics such as its patient capacity, how it can be involved in health checkups, and how to best provide eligible parties with consultation recommendations in advance, before implementing programs.

A local government made a prior agreement with the medical association that consultation recommendations for obesity disease would direct individuals to association-affiliated healthcare institutions. During that process, the medical association requested materials that explained the referral criteria for obesity disease in a manner that physicians would find easy to understand. Those materials were finalized before the program began.

One local government obtained permission from each healthcare institution when compiling a list of institutions capable of treating obesity disease. As the position of a local government makes it difficult for them to actively refer people to specific healthcare institutions, they are working to improve access by purposely mentioning nearby healthcare institutions with obesity clinics.

A team treatment approach in which healthcare institutions and local communities collaborate to maintain ongoing involvement is vital for preventing weight regain or dropout after the start of treatment.

2-1-3 Recommended Actions for Local Governments

Coordinate Among Prefectural Governments, Municipal Governments, and Boards of Education

Obesity disease control requires a life course approach in which it is important to provide diet and exercise education and intervention starting in infancy and early childhood. However, it is often difficult to coordinate policies and collaborate effectively because jurisdiction for such initiatives is divided among prefectural governments, municipal governments, and boards of education. Implementing effective measures will require prior clarification of the division of roles among public agencies, then determining how to tailor support methods to real-world circumstances.

School nutrition teachers teach in accordance with prefectural guidelines and lack opportunities to share information and align their recognition with dietitians in local governments. This siloed arrangement serves as an obstacle to collaboration. Addressing it will require establishing forums for coordination among prefectures, local governments, and schools, and developing a system that helps build shared awareness and that facilitates the smooth exchange of information.

Despite growing recognition of obesity prevention for preschool-aged children as a critical issue that requires efforts spanning entire cities, specific approaches for this issue have yet to be established. In real-world childcare settings, there is a significant psychological barrier to informing parents of a child's obesity, and it can be challenging to deliver interventions that reach the home environment (for example, to prevent grandparents from giving children too many snacks). Addressing these issues will require identifying practical support methods tailored to the realities of real-world childcare settings.

2-1-4 Recommended Actions for Local Governments and Employee Health Insurance Providers

Design Systems and Establish Support Tailored to the Needs of People Living With Obesity Disease or Serving in Care Settings

When local governments and employee health insurance providers advance measures for obesity disease, the needs and circumstances of people living with obesity disease become clearer and difficulties rooted in the stigma associated with obesity disease emerge. These parties must consider how to design systems that are more closely tailored to those most affected and establish forms of

support for those serving in real-world care settings.

Some people eligible for obesity disease programs have expressed concern toward the economic burden of undergoing continuous treatment. There are also people who live with mental disorders and experience weight gain due to medication side effects. So, in addition to those who are vigorously working in society, this group may also include people who have certain circumstances that must be kept in mind.

We found that women in their 30s and 40s tend to be diagnosed with obesity disease at a relatively high rate. According to our interviews, women may be more concerned about body image and more easily motivated to seek treatment.

There is a strong tendency for people to perceive obesity disease as a self-inflicted condition, and recognition of this condition as a disease has yet to become widespread. These factors make it difficult to connect people to care. Due to concern that the term "obesity" might be hurtful, public health nurses are also struggling with how to best approach conversations on this condition. We must raise awareness and establish support tools and training programs for public health nurses to eliminate stigma and to disseminate appropriate communication strategies.

2-2 Expectations for Policies and Systems

2-2-1 Expectations for Policies and Systems

Utilize Existing Policies and Systems

Given the limited nature of resources at local governments and employee health insurance providers as well as the cost of obesity disease control, it is desirable that obesity disease measures are added to existing measures such as specific health checkups, specific health guidance, or the Severe Diabetic Nephropathy Prevention Program.

Even if new needs emerge, it is difficult for those serving in care settings to handle increased workloads. Instead of establishing new systems when introducing measures for obesity disease, it is desirable that the existing system for specific health guidance is renovated to incorporate such measures. When renovating that system, it will be vital to design it in a way that accommodates those serving in care settings and that avoids increasing their burden.

One feasible option may be to add items to screen for obesity disease to the specific health guidance framework to identify people who do not meet existing criteria for health guidance but are obese, and then to provide them with disease awareness education as part of health guidance and referrals to healthcare institutions as needed.

Integrating obesity disease measures and the Severe Diabetic Nephropathy Prevention Program by expanding program eligibility to people with BMIs of 25 or higher is a realistic option for saving resources or keeping costs in check.

2-2-2 Expectations for Policies and Systems

Establish Data (Challenges for Local Governments and Employee Health Insurance Providers with Obesity Disease Initiatives)

Local governments and employee health insurance providers face a number of issues related to data collection and analysis for obesity disease. Addressing these issues will require designing systems for the establishment of analysis and indicator development capacity within local governments and employee health insurance providers as well as facilitating collaboration with external experts. However, issues related to data are common to all areas of health and medicine, and data is an area that relies heavily on national and prefectural policies, so there are limitations as to what individual local governments and employee health insurance providers can handle. Therefore, the following section will only list the data challenges related to obesity disease, while potential solutions will be described in Section 3-5, "Issues Related to Data Collection and Analysis."

Methods of analyzing data or compiling statistics on obesity disease have yet to be established, and the national Government has yet to define evaluation indicators. As a result, both local governments and employee health insurance providers are seeking methods to verify effectiveness of initiatives, as well as the analytical logic to assess the impact on reducing healthcare spending. It is also difficult for them to set reduction targets.

Even among people who meet the definition for obesity disease in clinical practice guidelines, few have records of obesity disease diagnosis in their medical claims data. This causes discrepancies between the data and actual circumstances. In other words, even if someone's records at a healthcare institution include conditions like diabetes or hypertension, it is very likely that those records do not include "obesity disease." This makes it difficult to accurately grasp the actual number of people living with obesity disease using medical claims data.

Obesity disease is not an item that is legally mandated for inclusion in health checkups, making it almost impossible to collect data aside from certain exceptions. Some insurers have digitized all health checkup results, allowing access to retroactive data. These insurers have constructed frameworks to perform automatic screening at data entry, which will allow new obesity disease screening items to be introduced simply by changing system settings.

2-2-3 Expectations for Policies and Systems

Standardize and Optimize Reference Values for Consultation Recommendations

The current health checkup system lacks a mechanism to screen people suspected of obesity disease or to offer them consultation recommendations. To ensure health insurers can reach everyone who may have obesity disease, it will be necessary to establish reference values for consultation recommendations that are set with the limitations of local healthcare resources and care provision systems in mind. When setting such reference values or criteria for collaboration among hospitals and clinics, it will be necessary to ensure they are standardized through arrangements with primary care physicians, academic societies specializing in areas related to obesity disease, and other related parties.

Using health checkups to identify people who meet the definition for obesity disease results in an extremely large number of people being flagged. It is unrealistic to recommend that all of them visit a healthcare institution for a medical examination. To prevent healthcare services from becoming overwhelmed, steps should be taken to stratify people with potential obesity disease by symptom and to prioritize treatment for those who require urgent medical intervention. In addition, to achieve standardization when setting reference values for consultation recommendations, coordination should involve medical associations and specialist academic societies in addition to specialists.

2-2-4 Expectations for Policies and Systems

Establish Healthcare Provision Systems

Systems for providing obesity disease treatment must be strengthened to ensure that people who are diagnosed with obesity disease by a primary care physician or after a health checkup can be smoothly connected to treatment from a specialist at the stage where specialized treatment is necessary. However, there are currently shortages and regional disparities among specialists and registered dietitians, and there are many cases in which patient referrals to appropriate facilities cannot be made. The more rural the area, the more severe these issues become. Addressing these issues will require utilizing online medical services and promoting the use of nutritional care stations. Also, because certified facility standards and eligibility criteria for insurance coverage set out in the optimal clinical use guidelines do not align with realities in real-world clinical settings, there are systemic obstacles that hinder early treatment for patients. It will be necessary to visualize the state of the care provision system and review systems so their designs are aligned with actual conditions in care settings.

Shortages and uneven regional distribution of healthcare resources

Severe personnel shortages mean that even cities designated by government order may have fewer than ten physicians specializing in obesity disease treatment. These shortages prevent the provision of comprehensive packages of referral options. For example, there are cases in which a primary care physician cannot treat obesity disease and is not always able to refer the patient to a university hospital with an obesity disease specialist on staff, or in which patients are turned away at reception at local healthcare institutions even if they have a referral from a university hospital.

Despite the fact that nutritional guidance is an essential part of obesity disease treatment, there are shortages of registered dieticians who can provide such guidance. Healthcare institutions without registered dietitians on staff should implement a number of measures to address this issue, such as adopting the latest technologies and apps to provide online nutritional and dietary guidance or to manage personal health information. Another measure may be to rely on external staff dispatched from nutritional care stations established by the Japan Dietetic Association and prefectural dietetic associations.

In the treatment of obesity disease, treatment outcomes are influenced by long-term post-surgical management (including nutritional counseling, lifestyle modifications, and weight regain prevention). Given this nature, rather than confining patients to specialized facilities, they must be smoothly transitioned to a collaborative, community-based framework. Establishing care delivery systems specializing in obesity disease in rural areas is impractical, so it will be necessary to foster generalists who can provide cross-disciplinary care spanning gastroenterology, endocrinology, and metabolism. It is also impossible to apply the specialist-centered model used in urban centers directly to rural areas. The severe disparity in medical resource distribution among regions is further demonstrated by the fact that some patients travel by air across prefectures to access treatment. While remote robotic surgery is attracting attention as one potential option for addressing the uneven distribution of physicians, population decline among rural areas is outpacing the physician shortage, so some are concerned toward a potential mismatch in expanded medical resources and actual demand.

There has been a gradual increase in obesity centers and clinics in recent years, but local governments and healthcare institutions do not fully grasp intake capacity at those centers and clinics. Academic societies and other organizations should take steps to clarify this situation. Local governments, workplaces, and obesity centers and clinics must also strengthen collaboration in the future.

"Obesity Disease Specialist" is a certification exclusive to the Japan Society for the Study of Obesity (JASSO) and is not recognized by the Japanese Medical Specialty Board. Consequently, there are limitations to increasing the number of Obesity Disease Specialists, particularly in rural areas where it is difficult to ensure patients who need obesity disease treatment can be referred to specialists. Obesity disease is generally treated by physicians certified as "Endocrinology, Metabolism, and Diabetes Specialists" by the Japanese Medical Specialty Board or at departments with such specialists, so this scope must be expanded. It will also be vital to broadly inform internists, general practitioners, and other primary care physicians about obesity disease treatment and to strengthen hospital collaboration with specialists.

Systemic issues for healthcare access

The Japanese Society for Treatment of Obesity (JSTO) certification system for bariatric surgery facilities may be misaligned with real-world conditions in rural areas. JSTO requires facilities to form patient support groups, but a shortage of doctors in rural areas makes taking on additional management responsibilities difficult. This is an obstacle when applying for the aforementioned certification. Furthermore, the fact that its requirements include "number of cases" and "the presence of a patient support group" leads to a structural problem in which it is more difficult for facilities that exercise greater care in selecting cases to obtain certification. In other words, the design of this system does not align with real-world conditions.

The Guidelines for Optimal Use specify the Japan Endocrine Society, the Japan Diabetes Society, and the Japanese Circulation Society, but do not include JASSO or JSTO, so we hope to see further strengthening of collaboration among related academic societies. Furthermore, due to one of the requirements for health insurance eligibility included in the aforementioned guidelines (namely, that patients must already be undergoing treatment for hypertension or dyslipidemia), there are cases in which patients are being prescribed blood pressure medications or other drugs that are not strictly necessary only to qualify for insurance coverage. This is a serious issue. There are also other conditions like "must undergo six months of dietary and exercise therapy" or "must receive nutritional counseling from a registered dietitian" that create systemic obstacles for timely access to treatment for patients who require early intervention

3 Overarching Issues Faced By Local Governments and Insurers

During the interviews we held on the topic of obesity disease control, we were also told about overarching issues faced by local governments and employee health insurance providers that must be addressed before they can advance measures for obesity disease. While the top priority for each local government and employee health insurance provider is to achieve the mission of promoting health for subscribers and to reduce social security expenditures, they are already operating at maximum capacity to meet the requirements of institutional regulations with limited human and financial resources. Participants described their inability to launch new programs for obesity disease and other conditions or to devote the necessary resources to programs they would like to prioritize, such as prevention programs and consultation recommendations. The following section shares necessary perspectives for addressing the issues faced by local governments and employee health insurance providers, as well as for strengthening the capacities of insurers.

3-1 Burdens Associated with Specific Health Checkups and Specific Health Guidance

Owing in part to related items like the Medical Insurance System for the Advanced Elderly or the Penalty and Incentive System in Medical Care Assistance for the Elderly Aged 75 and Over, specific health checkups and specific health guidance are the areas where local governments and employee health insurance providers devote the most resources. Insurers are also strengthening specific health checkups and specific health guidance in areas that lie beyond the scope of what these measures legally required to include through efforts like cross-referencing consultation recommendations and medical claims data, or expanding targeted age groups. Even when insurers want to devote more energy to programs for health promotion, prevention, and consultation recommendations outside of specific health checkups and specific health guidance, they are unable to allocate the necessary resources.

One employee health insurance provider is proactively expanding the scope of health guidance to provide it regardless of whether subscribers meet the criteria for metabolic syndrome. After expansion, it covers people who are under the age of 40 or who have yet to attend a follow-up examination despite having specific health checkup results that meet secondary health checkup criteria. A different employee health insurance provider is working to increase the rate at which people are connected to health guidance. Their efforts include establishing a system for immediately providing initial guidance to people who may be eligible for specific health guidance at group health checkup sites or at individual healthcare integrating such initiatives with collaborative health programs operated by employers and employee health insurance providers, some organizations have achieved a participation rate of 100% for health checkups and an implementation rate in the 60% range for specific health guidance.

Focusing solely on specific health guidance is not enough to curb the upward trend in BMI across all age groups. We must explore health promotion measures that go beyond health guidance, such as reinforcing awareness about diet and exercise habits through the use of apps.

Even when insurers would like to allocate more resources to strengthening post-checkup consultation recommendations, the specific health guidance system has a financial mechanism that increases the subsidy payment burden when implementation rates fall below a certain level. This leaves insurers with no choice but to prioritize the implementation rate itself, creating a dilemma in which they cannot devote sufficient resources to areas they truly want to focus on, such as strengthening post-checkup consultation recommendations.

3-2 Unrealized Priority Areas or Initiatives for Employee Health Insurance Providers

Employee health insurance providers recognize that improving health while people are still in the workforce will help reduce future healthcare expenditures. This is partially because contributions to the Medical Insurance System for the Advanced Elderly and the Medical Care Assistance for the Elderly Aged 75 and Over system account for about half of their expenditures, creating financial strain. They regard measures for prevention such as providing health checkups to subscribers or halting the progression of diseases as key priorities for their business, and they would like to focus efforts on these areas.

On the other hand, employee health insurance providers are unable to secure adequate resources for the further expansion of health promotion support. Expanding awareness-raising activities and other such initiatives remains a challenge.

While health and productivity management is important, too much emphasis is being placed on achieving results when planning collaborative health initiatives. It is desirable that more emphasis be placed on the process during that planning.

Since dispatched employees serve at their clients' organizations, their supervisors at staffing agencies do not always have full authority over them. This applies to both health and productivity management as well as labor management. In some cases, the supervisor at the staffing agency never even meets the dispatched employee in person. Defining the scope of a staffing agency's management responsibilities can be difficult, and this issue may extend to health and productivity management as well.

3-3 Insufficient Resources Among Local Governments and Employee Health Insurance Providers

Local governments and employee health insurance providers face a chronic lack of manpower, making it difficult for them to explore new initiatives. Within that context, they are endeavoring to overcome labor shortages by collaborating with external organizations and experts as well as leveraging the newest technologies. While it is becoming commonplace for insurers to outsource duties, they must exercise care when selecting and managing vendors to ensure that their objectives are met.

Many employee health insurance providers have limited human resources, and rely on small numbers of in-house staff for policy development and budget planning while outsourcing other tasks. The duties of optimizing healthcare expenditures and complying with Data Health Plans already put a strain on their staff, leaving them with insufficient time and energy to explore new initiatives. In such an environment, frontline staff often feel reluctant to take on new duties. While explaining a mission or the impact of a program to management is effective, it is vital to demonstrate in concrete terms how new initiatives will reduce workloads for frontline staff. When introducing new initiatives, proposals that can be integrated into existing projects without additional cost and that reduce workloads are more practical and resonate better with frontline staff.

When collaborating with vendors or external parties, it is important to have clearly-defined roles. Arrangements in which insurers lead the formulation of Data Health Plans while relying on feedback from expert advisors are effective for substantially improving plan quality and maintaining motivation.

Other effective methods of supplementing limited human resources include collaborating with Comprehensive Occupational Health Support Centers or other external support organizations to compensate for resource shortages, and promoting collaborative health initiatives together with employers.

Although many insurers outsource administrative tasks and the management of health checkup data, outsourcing work to multiple vendors can increase coordination overhead. To maximize efficiency, it is best to consolidate vendors wherever possible. An effective option is to prioritize services that offer one-stop, coherent services that include providing health checkup notifications, making appointments, digitizing checkup results, performing screenings, providing specific health guidance notifications, and conducting follow-up consultations and monitoring.

3-4 Issues Related to the Roles and Placement of Occupational Physicians and Occupational Health Nurses

While it is impractical for every employer to have an occupational physician and an occupational health nurse on staff, we should review how these professionals are placed and what their roles entail. Despite the need for collaboration among employers (including occupational health staff) and employee health insurance providers, there are differences in consultation recommendation criteria between these two parties, and areas where their roles duplicate or fail to align. As a result of these and other factors, the existing system is not always effective for all subscribers.

We must continuously review the roles of occupational physicians in terms of practical needs. For example, we should design a system offering occupational physicians more flexibility in the frequency and mode of mandatory monthly workplace inspections (including remote options) so they can devote more attention to high-priority tasks. There is also the challenge of personnel shortages across the entire field of occupational health. For example, because employers are not legally mandated to employ occupational health nurses, many workplaces lack them entirely. Other employers that do have occupational health nurses on staff require them to handle duties with limited manpower.

Regarding information coordination for people eligible for recommendations for secondary health checkups, discrepancies in consultation recommendation criteria sometimes result in cases where employers fail to provide them. For instance, an employee health insurance provider may use criteria from the Japan Society of Ningen Dock and Preventive Medical Care, while the employer uses consultation recommendation guidelines. However, there are effective systems in which occupational physicians carefully review health checkup results, identify people eligible for secondary examinations, and then provide them with consultation recommendations directly. Such systems are particularly effective in avoiding the aforementioned discrepancies in criteria.

3-5 Issues Related to Data Collection and Analysis

Efforts to collect data on obesity disease are hindered by the lack of an adequate collection system, but this issue reflects general challenges across data collection as a whole. Local governments face challenges in collaboration with workplaces, as well as in linking or integrating health checkup data with other medical or socioeconomic data. Meanwhile, employee health insurance providers face institutional restrictions on data sharing between insurers and employers.

Local governments

In principle, data from both local governments and employers is necessary to obtain a detailed understanding of health status for residents and to mount responses to the challenges shared by governments, such as approaching residents who miss health screenings or are indifferent about their health. However, local governments can only access data from people enrolled in NHI. For residents who were enrolled in social insurance, local governments cannot access historical health data linked to items such as health checkup results, treatment histories, and causes of death. This makes it difficult for local governments to identify and support high-risk individuals.

To address such issues, the national Government and prefectural governments should establish a framework in which they analyze the National Database of Health Insurance Claims and Specific Health Checkups of Japan (NDB) and share data on social insurance subscribers with local governments. They should also design systems that enable integrated data management across insurance providers and interventions targeting working-age adults. In fact, some prefectures are already conducting comprehensive analyses of healthcare data

held by insurers and establishing indicators. NDB Open Data does not include data at the municipality level, so municipal governments that require data must submit requests to the national Government. This process is extremely labor-intensive and places a heavy burden on municipalities. However, some prefectural governments are applying to the national Government to obtain data and are providing analysis support to municipalities with the intent of encouraging municipalities to focus on workplace data. Recognizing that a lack of resources among municipalities makes it difficult for them to compare health checkup data, one prefectural government is aggregating and analyzing municipal data as part of its Data Health Promotion Project. However, the prefecture has yet to begin linking that data with other data (such as medical claims data or income or other personal data), nor has it performed detailed analyses of health checkup data for each municipality.

Meanwhile, there are some municipal governments that are utilizing commercial tools to extract data from the Kokuho Database (KDB) and conducting long-term, regular monitoring of that data, then setting their own evaluation indicators tailored to local conditions. (Since prefectural governments cannot access the KDB, this example refers specifically to municipal governments.) In prefectures where KDB is held by prefectural National Health Insurance Federaion, there are also cases where the Federation hosts seminars or supports initiatives. These include training sessions on KDB operations or offering support in the formulation of Data Health Plans.

Above, we introduced good examples of data collection and analysis rooted in prefectural leadership or a clear division of roles among prefectures, municipalities, and National Health Insurance Federaion. With future progress in My Number integration, we have high expectations for the establishment of systems that allow for centralized collection and analysis of data from local governments or workplaces by the national and prefectural governments. In addition to reducing the burden of exchanging data among various bodies, this will also promote data standardization under the national Government, improve analysis accuracy, and create a foundation for cross-cutting policies that span diseases.

Furthermore, as local conditions, healthcare institutions, and resources differ among local governments, when necessary, the national Government and prefectural governments should collaborate with external experts to collect and analyze data that is collected while municipalities consider specific measures.

Employee health insurance providers

Employee health insurance providers generally collect health checkup data from institutions conducting health checkups, not employers. Data from health checkups for the prevention of lifestyle diseases is collected based on contracts, while data from general health checkups conducted under the Industrial Safety and Health Act is collected with the employer's consent. Because the latter creates major administrative workloads, mechanisms for the automatic and mandatory provision of data to insurers should be created.

Employers cannot possess medical data. While taking proper precautions to protect personal information, if both parties can access the data, they can conduct joint planning and review to determine what is best for the insured and to define the division of roles. Such collaboration is also likely to improve inconsistencies in data and evaluations.

3-6 Issues Related to National Indicators and Expectations for Improvement

Collecting the necessary data to determine and submit indicators places a significant burden on local governments and employee health insurance providers, and expectations are high for improvements from the national Government.

Local governments and employee health insurance providers are working to establish their own indicators, but such efforts create major burdens. The national Government should provide guidance on designing indicators, evaluation methods, and effectiveness to serve as reference.

The national Government should ensure that any evaluation indicators or program guidelines it provides are based on evidence. For example, the effects of specific health checkups and specific health guidance remain insufficiently validated, and some are skeptical of their effectiveness.

It is recommended that Data Health Plans use shared indicators, and the national Government has also provided a standard set of indicators. However, the national Government sometimes requires local governments to establish and submit evaluation indicators without fully considering their capacity to obtain data, and there are cases in which local governments cannot obtain relevant data without conducting new survey research among citizens. Local governments generally have no options for distributing surveys other than by mail, and even when they spend money on conducting a survey, the findings are not always worth the effort. If a survey seems likely to yield insufficient data, they have no choice but to use existing data for their calculations instead of conducting a new survey. The national Government should establish evaluation indicators based on existing data reported by local governments to the greatest extent possible.

3-7 The Need to Advance Programs from the Perspectives of the Insured

When advancing programs, local governments and employee health insurance providers recognize the difficulty of fully understanding the perspectives and needs of each insured person, and strongly believe in the importance of effective motivation strategies that result in appropriate behavioral change.

When the same subscriber is approached simultaneously by multiple related departments or through multiple programs, and measures for consultation recommendations or interventions from occupational physicians overlap, the person in question may experience message fatigue. Employers and insurers must establish a shared understanding, clarify their respective roles, and coordinate to eliminate these redundancies and inefficient practices.

Dispatch employees on fixed-term contracts do not receive wages for days taken off from work for health checkups or medical consultations, so there are some people who prioritize their economic circumstances over health. Some also worry that discovering a disease at a health checkup will cost them their ability to work or maintain their livelihood. Rather than simply engaging in messaging for health promotion, approaches and systems must be reviewed to address these socioeconomic challenges.

The goal is to diversify strategies for promoting specific health guidance programs to maintain continued interest among the people they target.

Some insurers have noted that people with high health literacy who work to manage their own health feel a sense of unfairness because more resources are currently being allocated to people in poor health. This is one reason why a mechanism should be created that provides advantages to people who proactively improve their health, making them feel accomplished. Systems should be designed to provide more than just financial benefits for insurers and allow individual subscribers to receive tangible incentives.

When designing systems, not only must they make it possible to minimize burden for frontline staff who are impacted by policy implementation, they must also fundamentally serve as mechanisms for ensuring appropriate healthcare is delivered to patients.

column

Current Measures in Liver Disease Control Related to Obesity Disease

Among obesity disease complications, Metabolic Dysfunction-Associated Steatotic Liver Disease (MASLD) has garnered attention in recent years. Owing in part to the fact that the national Government has presented Basic Guidelines for Hepatitis Control, many local governments and employee health insurance providers have introduced infectious hepatitis control measures. For non-infectious hepatitis, certain insurers have been strengthening consultation recommendations based on mandatory liver function tests that measure AST (GOT), ALT (GPT), and γ-GT (γ-GTP) taken during specific health checkups. However, as with obesity disease today, only a limited number of local governments and employee health insurance providers were actively advancing such initiatives. There have also been examples of awareness campaigns for hepatic steatosis prevention being conducted as part of lifestyle disease initiatives.

For hepatitis B and C, which are infectious diseases, one insurer performs screening during health checkups, followed by consultation recommendations and telephone follow-up. However, they have not introduced measures for non-infectious hepatitis, and they have not heard of many examples of such initiatives from other local governments or employee health insurance providers.

People whose liver function test results fall within the urgent reporting range are classified as high risk and given consultation recommendations with explicit deadlines. Many of these individuals also have related conditions such as obesity disease, excessive alcohol use, substance dependence, or mental health disorders. It will be important to broadly inform the public about risks associated with hepatic steatosis, such as the risk of progression to liver cancer, even for people who are not obese or who do not regularly consume alcohol.

A campaign started by the Japan Society of Hepatology in 2023 urges people to seek medical attention if their ALT levels (which are used to assess liver function with blood tests performed at routine health checkups) exceed 30. Yet, many healthcare institutions are unaware of the AST and ALT alert thresholds.

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Obesity Control as a Challenge for Society

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