Discussion Points

# Obesity Control as a Challenge for Society

## Promoting Understanding of Obesity and Finding Solutions Through Multi-Stakeholder Collaboration

HGPI Health and Global Policy Institute

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# CONTENTS

# Introduction

## Definitions and references for terminology used in this compilation of discussion points

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.

As lifestyle habits change and urbanization progresses, the number of people living with obesity in Japan continues to increase. Certain types of obesity (such as visceral obesity) are known risk factors for atherosclerotic diseases like myocardial infarction or cerebral infarction as well as obesity-related kidney disease, dyslipidemia, and type 2 diabetes. According to the FY2023 National Health and Nutrition Survey, the age-adjusted rate of obesity (defined as having a BMI≥25 $kg/m^2$) among adults age 20 years and older was 31.3% for men and 19.4% for women.※3 In addition, obesity-linked chronic diseases like hypertension, type 2 diabetes, and dyslipidemia continue to be among the most prevalent conditions in domestic patient surveys. Given these circumstances, it is urgent that Japan introduce measures to address obesity and the health harms caused by or related to obesity.




※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.

※3 MHLW. National Health and Nutrition Survey (FY2023). 2023.

The Japan Society for the Study of Obesity (JASSO) identifies "obesity disease" as a disease with a medical need for weight loss accompanied by health disorders caused by or related to obesity, or when there is potential for visceral obesity, which is a common cause of other health concerns.※4 In other words, obesity disease is not merely the state of being overweight; it is recognized as a disease that requires medical treatment in its own right. Obesity disease is a risk factor for other chronic diseases, but unlike obesity, it is also a serious health concern that can significantly impair the daily lives of affected parties. In addition to an indicator of obesity disease, high BMI is considered a preventable metabolic risk factor with the potential to contribute to an increase in non-communicable diseases (NCDs) or advanced cases of NCD.※5 In 2019, obesity, overweight, and other metabolic risk factors accounted for 18.15% of total disability-adjusted life years (DALYs) due to NCDs. This was an increase from 17.36% in 2013.※5 Furthermore, in addition to limitations on physical activity in everyday life or burdens caused by complicating conditions, people living with obesity disease may also encounter psychosocial problems like social isolation, discrimination, and prejudice.

At the same time, society does not fully understand the multifaceted nature of issues related to obesity and obesity disease, and these conditions are often still attributed to personal habits. Japan has yet to achieve widespread societal recognition that obesity disease is a disease that requires specialized medical intervention. This does not only apply to people living with obesity and citizens, but to health professionals, as well. This lack of recognition has delayed efforts to build systems to provide suitable support to people who require obesity prevention or obesity disease treatment. In addition, Japan does not treat obesity as an independent policy issue like cancer prevention or COVID-19 control, and has almost no policies specifically targeting obesity. Other issues that have been pointed out include the fact that among people living with obesity, members of vulnerable groups who face socioeconomic challenges lack access to necessary healthcare and support as well as opportunities to voice their issues to society. Establishing an integrated support system that goes beyond health promotion and includes a socioeconomic approach will be an essential step in addressing the structural challenges encountered by people living with obesity.

To contribute to resolving these issues, Health and Global Policy Institute (HGPI) launched the Obesity Control Promotion Project in FY2022. Through this project, we have been generating policy recommendations to advocate for integrated obesity control measures with meaningful involvement from people living with obesity, citizens, and communities. By advancing discussions with experts representing government, academia, industry, and civil society and gathering the voices of people living with obesity, this project has collected insights on proper diet and exercise habits over the life course, health checkups, and stigma countermeasures from the perspective of prevention; on early detection and initial treatment for obesity disease; and on establishing a multidisciplinary healthcare provision system and achieving health equity for people whose condition has advanced to severe obesity disease. The devoted efforts of these stakeholders have helped to gradually build recognition of obesity disease as a disease, and this has helped to catalyze cross-cutting collaboration among disciplines. Some local governments are now preparing to launch policies for obesity disease control, but the central Government has yet to implement any such policy.

In light of these circumstances, this survey was conducted to grasp the current status of existing policies related to obesity and obesity disease in Japan and to indicate a desirable direction for such policies in the future. Chapter 1 is titled "Past Developments in Obesity Control and Necessary Perspectives for Advancing Obesity Policies." It will review the history of obesity and NCD policies and describe perspectives on desirable future obesity policies. Chapter 2 lists issues that impact individuals living with obesity or obesity disease or issues that are associated with those conditions. It also shares concrete discussion points that should be examined for obesity and obesity disease prevention and the establishment of a healthcare provision system spanning the life course. This report was compiled independently by HGPI and is based on desk research in addition to interviews with people living with obesity, healthcare providers, experts in social epidemiology or public health, and policymakers.

※4 JASSO. Guidelines for the Management of Obesity Disease 2022. Life Science Publishing Co., Ltd. Tokyo. 2022.

※5 Nomura S, Sakamoto H, Ghaznavi C, Inoue M. Toward a third term of Health Japan 21 - implications from the rise in non-communicable disease burden and highly preventable risk factors. Lancet Reg Health West Pac. 2022 Apr;21:100377.

Chapter 1

# Past Developments in Obesity Control and Necessary Perspectives for Advancing Obesity Policies

## 1 The history of obesity control in Japan

The only mention of "obesity disease" in existing policies from the Government of Japan can be found in the fourth Medical Cost Optimization Plan, which lists obesity disease alongside other chronic diseases in a section describing an increase in hospitalization rates for lifestyle diseases. However, "obesity" is mentioned in a number of laws and regulations from the central Government and local governments from initiatives for better nutrition and health promotion to those for lifestyle disease control.

Historically, there are many empirical examples that emphasize the importance of diet and the health impacts of obesity and overeating. For example, in *Yōjōkun* ("The Book of Life-nourishing Principles," 1712), Edo era Confucian philosopher and physician Ekken Kaibara specifically mentions diet as a key element of healthy longevity, writing, "Eat and drink in moderation, without excess."※6 In other words, even classical medical texts warn of the negative health effects of excessive eating and drinking based on empirical knowledge. Obesity was not a widespread problem among the general public until recent years. Until 1951, tuberculosis was the leading cause of death in Japan, but the dramatic improvements in nutrition and rapid progress in medicine that occurred during Japan's economic growth after World War II led to it being overtaken by cerebrovascular disease. NCDs like stroke, cancer (malignant neoplasms), and heart disease have accounted for over half of all deaths since the 1960s.※7 As Japan's national disease profile has changed, domestic policies have shifted their focus from controlling infectious diseases by improving hygiene standards to disease prevention, health maintenance, and health promotion.

The term "adult disease" first appeared in the minutes of a meeting held by the Ministry of Health and Welfare (currently, the MHLW) in 1956.※8 "Adult diseases" were defined as "Diseases that primarily impact people in their 40s and with mortality rates that gradually increase with age, that account for a significant proportion of total mortality, and that frequently occur in working-age adults in their 40s to 60s." At the time, these were not viewed as preventable diseases, but early detection and early treatment were believed to be effective. This led to the introduction of health checkups as part of the Industrial Safety and Health Act in 1972. In 1978, the first "Measures for National Health Promotion" plan was implemented with a ten-year term. It strengthened secondary prevention which aims for early detection and treatment as part of "lifelong health promotion." Adult disease control was further strengthened when health checkups and health guidance for all ages were institutionalized with the 1982 enactment of the Elderly Health Act.

Subsequent advances in epidemiological research showed that in addition to genetic and environmental factors, lifestyle habits like diet, exercise, smoking, alcohol consumption, and stress also contribute to the onset of adult diseases. As a result, discussions began to focus on primary prevention centered on the improvement of lifestyle habits. In 1996, a report presented by the MHLW Public Health Council's Subcommittee on Adult and Intractable Diseases titled "Regarding the Basic Direction for Disease Control with a Focus on Lifestyle Habits (Opinion)" marked the transition from the concept of "adult diseases" to "lifestyle diseases." It has been pointed out that one factor behind this shift was recognition that relying on secondary prevention centered on early detection and treatment (which was the focus of the second "Measures for National Health Promotion" plan) was insufficient for curbing the increase in adult diseases.※9 That report expressed the intent to advance measures for prevention by building public awareness of the fact that lifestyle improvements can help prevent the onset and progression of diseases. This led to the introduction of goals related

※6 Kaibara, E. Yōjōkun, Nakamura Gakuen University revised ed. Kaibara Ekken Archive, Nakamura Gakuen University Junior College Library Media Center, Nakamura Gakuen University. https://www.nakamura-u.ac.jp/institute/media/library/kaibara/text03.html. Last retrieved on May 5, 2025.

※7 MHLW. "White Paper on the Labour Economy 2014. Basic Policy for Comprehensive Public Health Promotion (July 10, 2012.)."

※8 The Japan Society of Adult Diseases. "About Our Society – A Brief History." http://www.j-seijinbyou.gr.jp/history.html. Last retrieved on June 24, 2025.

※9 Tominaga, Y. "The Shift from 'Adult Diseases' to 'Lifestyle Diseases.'" Lifestyle Health 43.1 (1999): 1-2.

to lifestyle habit improvements in the "National Health Promotion Movement in the 21st Century," or Health Japan 21, which was launched in 2000 to serve as the third "Measures for National Health Promotion" plan. The legal basis for Health Japan 21 is provided by the Health Promotion Act enacted in 2003 as a revision of the Nutrition Improvement Act of 1952. According to Article 1 of the Health Promotion Act, its purpose is "advancing the people's improvement of their health" by promoting health and improving nutrition. Combined with secondary prevention provided through health checkups conducted in accordance with the Industrial Safety and Health Act and the Act on Assurance of Medical Care for Elderly People (formerly the Elderly Health Act), it is safe to say that primary prevention measures provided by the Health Promotion Act have advanced its purpose in a comprehensive manner.※10 Initiatives aiming at the prevention of lifestyle diseases have also been strengthened. After a revision in 2008, the Elderly Health Act became the Act on the Assurance of Medical Care for the Elderly, which introduced specific health checkups and specific health guidance focusing on metabolic syndrome among people ages 40 to 74. This system is currently being utilized for the prevention of metabolic syndrome.

A number of laws targeting specific diseases have been advanced in parallel with these policies for health promotion and prevention. For example, the Cancer Control Act (2006) and the Basic Act on Measures for Stroke, Heart Disease, and Other Cardiovascular Diseases (2020) mention obesity control for preventing the onset of each disease in their respective promotion plans in accordance with relevant laws. The mention of obesity control for specific diseases like cancer or CVDs highlights its importance as a primary prevention measure and encourages interventions for obesity in line with existing health promotion policies. As we can see, Japan has implemented multi-layered strategies for obesity control through both primary and secondary prevention.

## 2 Considering the ideal form of obesity control in terms of existing measures

### Obesity control as a disease control measure and obesity disease as a medical condition

Past measures for obesity control in Japan have advanced in the context of disease prevention. However, JASSO assigned clear definitions separating "obesity" and "obesity disease" in 2000, which established the concept of "obesity disease" as a medical condition.※11 Obesity disease is a condition in which excessive accumulation of adipose tissue results in various forms of health damage, that lowers quality of life,※12 and that requires medical treatment. Given these characteristics, it will be necessary to implement measures for obesity control separately from how existing policies for prevention or health have been advanced, as well as to hold discussions and introduce measures on healthcare provision systems and treatment methods for obesity disease.

On the other hand, efforts to advance discussions specifically on obesity disease control have had difficulty gaining traction. This may be because obesity disease itself is a risk factor for other health disorders, so obesity disease control has aspects related to prevention. Its characteristics may also be hindering efforts to advance such discussions. For example, the definition for the relative diagnosis of obesity disease includes obesity and eleven other potential comorbidities, so outside of cases of severe obesity disease, it may be going undiagnosed as an independent condition.

※10 Ihara, K. "Health Promotion of Senior Citizens: Japan's Past Developments in Health Promotion Administration in Public Health and Experts in a Super-Aging Society." Japanese Journal of Behavioral Medicine 19.2 (2013): 52-58.

※11 JASSO. "The Kobe Declaration 2018." https://www.jasso.or.jp/data/data/pdf/kobe2018_text.pdf. Last retrieved on June 24, 2025.

※12 Stephenson, J., Smith, C.M., Kearns, B. et al. The association between obesity and quality of life: a retrospective analysis of a large-scale population-based cohort study. BMC Public Health 21, 1990 (2021).

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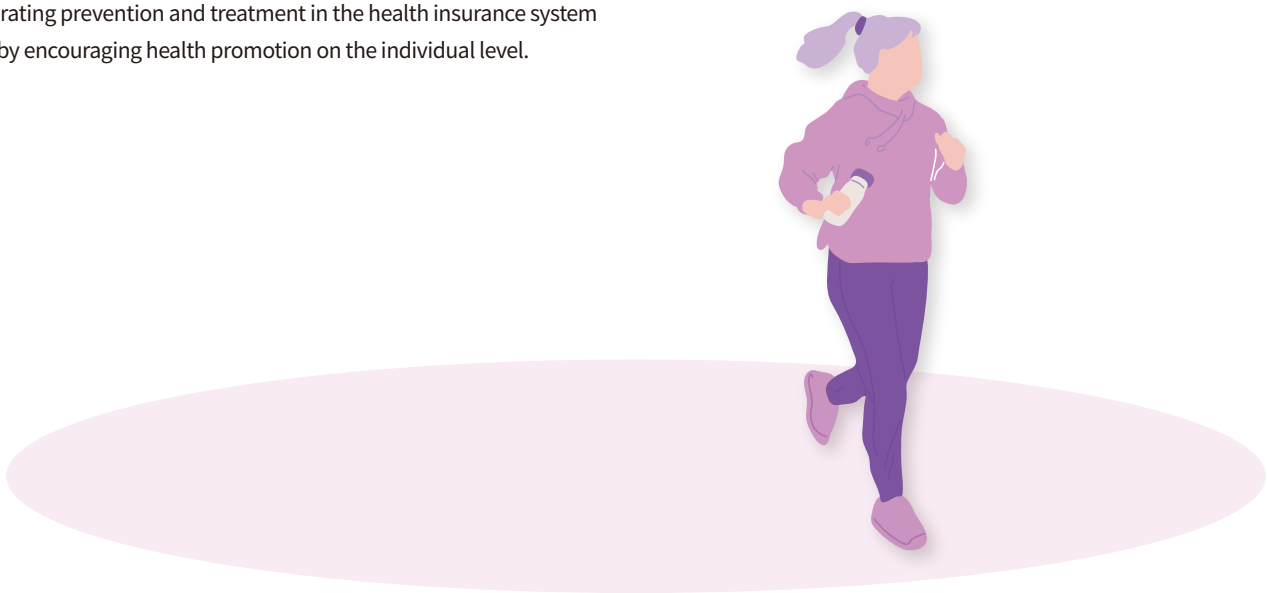
## The stigma caused by encouraging self-management in policies for health promotion and disease prevention

A number of provisions in existing laws and regulations on health promotion and disease prevention mention the promotion of self-management. For example, Article 2 of the Health Promotion Act (2003) states that “The people must endeavor to…improve their health.” Article 4 of the Long-Term Care Insurance Act (1997) obligates the public to make similar efforts, stating “A citizen must be aware of his or her physical and mental changes due to aging and shall always strive to maintain and enhance good health.” Behavioral changes to prevent the onset of lifestyle diseases are also encouraged as part of specific health guidance, which focus on supporting lifestyle improvement efforts from individuals. This can also be viewed as one way in which policies aim to curb healthcare costs and ensure social security system sustainability by clearly separating prevention and treatment in the health insurance system and by encouraging health promotion on the individual level.

However, it has been pointed out that the concept of self-management in health promotion or the emphasis on personal responsibility for health in the Health Promotion Act and other such laws may be reinforcing society’s tendency to view health concerns as problems caused by the affected party.※13 In fact, the presence of prejudice and stigma toward people living with obesity or obesity disease has been reported in studies from both Japan and overseas, including experiences of negative attitudes and discriminatory treatment (obesity stigma).※14※15 Studies have found that there is also implicit bias among healthcare professionals.※16※17 Such forms of stigma are thought to hinder efforts to build recognition that obesity disease is a condition that requires medical treatment. They are also viewed as a factor that causes affected parties to hesitate to adopt healthy habits or visit healthcare institutions for medical examinations. The possibility that such stigma also hinders the overall advancement of obesity policies cannot be ruled out.



※13 Tamate, S. 2022. The Ethics of Public Health: How Much Should the State Intervene in Health? Chikumashobo Ltd.

※14 Arora M, Barquera S, Farpour Lambert NJ, Hassell T, Heymsfield SB, Oldfield B, Ryan D, Salas XR, Scinta W, Vicari M. Stigma and obesity: the crux of the matter. Lancet Public Health. 2019 Nov;4(11):e549-e550.

※15 Taira, T. and Nakazato, M. “Obesity Stigma – The Stigma from Living With Obesity or Obesity Disease.” Medical Practice, 38(7), 1007-1010, Bunkodo Co., Ltd., 2021.

※16 Schwartz, M.B., Chambliss, H.O., Brownell, K.D., Blair, S.N. and Billington, C. (2003), Weight Bias among Health Professionals Specializing in Obesity. Obesity Research, 11: 1033-1039.

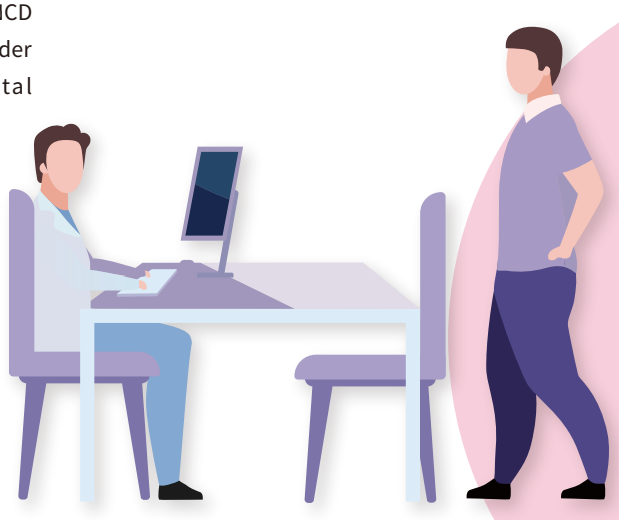
※17 Phelan, Sean M., et al. "Impact of weight bias and stigma on quality of care and outcomes for patients with obesity." Obesity reviews 16.4 (2015): 319-326.

## The perspective of Social Determinants of Health (SDH)

In addition to lifestyle habits such as diet, physical activity, alcohol consumption, and smoking, NCDs are caused by many factors that cannot be controlled through self-management alone. These include psychological, socioeconomic, and genetic factors. The perspective of Social Determinants of Health (SDH) is particularly important for obesity disease. Efforts to reflect the perspective of SDH in policy have been advancing. For example, the ultimate goals of the third term of Health Japan 21 are to extend healthy life expectancy and to reduce health disparity, and it sets a policy direction of promoting citizens' health through inclusion (or, ensuring that nobody is left behind in promoting health) and implementation (or, promoting more effective initiatives) (MHLW, 2023). In addition to improvements in individual behaviors and health status (as part of preventing the onset and progression of lifestyle diseases), it specifically aims to improve the social environment with emphasis on maintaining or improving social connections and mental health and establishing an environment in which people naturally become healthy. Goals for this vision include increasing the number of municipalities engaged in "promoting strategic incentives for the creation of healthy and sustainable food environments" or "creating comfortable urban spaces that encourage walking." As this example illustrates, recent policies have started incorporating the perspective of SDH, but in the context of widening socioeconomic disparities, it will be necessary for NCD control and policies for obesity disease in particular to consider expanding socioeconomic support and environmental improvements for all age groups.

## Data and evidence is insufficient for policy making

Advancing policies for obesity disease control requires comprehensive data on items spanning clinical settings to socioeconomic aspects, including the disease burden of obesity, socioeconomic impact, or the effectiveness of medical interventions. However, a sufficient amount of such real-world data has yet to be gathered or analyzed. The National Health and Nutrition Survey tracks obesity prevalence using BMI, but registries and epidemiological studies for grasping actual circumstances for obesity disease are limited. As a result, sufficient data has yet to be collected on basic items such as the domestic prevalence of obesity disease, incidence of complications, impact on healthcare costs, or treatment outcomes. Data on the cost-effectiveness of obesity disease treatments and long-term outcomes is also lacking. Additionally, studies on stigma toward people living with obesity or obesity disease (including stigma from healthcare professionals) or on the stigma experiences of those most affected have yet to be conducted in Japan, so evidence must be established in the future. This lack of evidence is an obstacle when attempting to position obesity disease as an important policy issue and is hindering efforts to develop evidence-based policies.



Chapter 2

# Discussion Points for the Consideration of Policies for Obesity and Obesity Disease (By Topic)

**In this chapter, we list background issues that manifest as obesity disease or individual issues that are related to it. We also share specific discussion points for the prevention of obesity and obesity disease throughout the life course as well as for the establishment of a healthcare provision system. This list is based on interviews with experts, and the main objective of this chapter is to show the diversity of issues related to obesity and obesity disease. After a discussion of the situation focusing on current issues, this chapter also shares desirable approaches for advancing future measures where necessary actions are apparent.**

## 1 Issues related to national statistics and data on obesity and obesity disease

### 1.1. The National Health and Nutrition Survey

The prevalence of obesity in Japan is often shared in terms of findings from the National Health and Nutrition Survey. However, only about half of eligible households participate in the National Health and Nutrition Survey, there are age disparities among participants, and participation rates among senior citizens and children are low.※3 Given these issues, the current design of this survey is inadequate for capturing the prevalence of obesity throughout Japan.

In addition, data on the dietary intake of the general population is needed to establish control groups in studies on caloric intake and other dietary items for people living with obesity or obesity disease. However, the National Health and Nutrition Survey is only conducted for one day and targets households. This makes it difficult to accurately grasp individual dietary intake, which can vary by day or by season.

### 1.2. Structuring disease data

Obesity disease can be diagnosed when a person has a BMI of 25 or more and one or more of eleven health disorders caused by obesity. However, in studies using real-world data, analysis is often performed using subjects with BMI of 25 or more and with prescriptions for some of the eleven health disorders, such those for hypoglycemia or hypertension. One reason for this may be that it is not common practice for physicians other than specialists or those serving at specialized medical facilities to register cases of obesity disease. The diagnostic criteria of obesity disease may also make it difficult to determine which cases satisfy requirements for disease registration and the submission of insurance claims. Another potential difficulty may be in identifying which of the eleven health disorders is present for those that are not immediately evident by the presence or absence of a prescription.

### 1.3. The desirable future direction for obesity and obesity disease-related statistics and data

Accurately calculating the prevalence of obesity disease will require reviewing how the National Health and Nutrition Survey and other national surveys are designed, how they are conducted, and how their findings are recorded. This includes the standard errors and confidence intervals needed to correctly understand the figures in those findings. In general, it is desirable that surveys on dietary intake span at least two days, or two or more non-consecutive days when possible, and are followed with a cross-seasonal survey as the next step.

An obesity disease database linked to electronic medical records has been developed through a collaborative effort among JASSO, specialized medical facilities, and related parties, and has been introduced at seven medical facilities specializing in obesity disease treatment.※18 Expectations are high for the accumulation of such databases to drive progress in research on treatments for obesity disease. However, the aforementioned database is limited to data from only a few medical facilities specializing in the treatment of obesity disease. It will also be necessary to grasp circumstances

※18 Nishikage S, Hirota Y, Nakagawa Y, Ishii M, Ohsugi M, Maeda E, Yoshimura K, Yamamoto A, Takayoshi T, Kato T, Yabe D, Matsuhisa M, Eguchi J, Wada J, Fujita Y, Kume S, Maegawa H, Miyake K, Shojima N, Yamauchi T, Yokote K, Ueki K, Miyo K, Ogawa W. Relation between obesity and health disorders as revealed by the J-ORBIT clinical information collection system directly linked to electronic medical records (J-ORBIT 1). J Diabetes Investig. 2025 Mar 27.

surrounding treatment at medical facilities that do not specialize in the treatment of obesity disease. In the future, it will also be important to conduct research utilizing data from the National Database of Health Insurance Claims and Specific Health Checkups of Japan (NDB) or from other private databases, as well as to accumulate a wide range of data including from Personal Health Records (PHRs) by promoting healthcare digital transformation (DX) and similar efforts. Furthermore, as overweight has been suggested to be associated with physical Health-Related Quality of Life (HRQOL),※19 expectations are also high for the accumulation of data or research on QOL that encompass the perspectives of people living with obesity disease.

# 2 Issues for each age group

## 2.1. Children

Childhood※20 obesity※21 is becoming more prevalent in many high, low-, and middle-income countries,※22 and it is known that people who experience childhood obesity are more likely to develop obesity as adults.※23 Childhood obesity is also rising in Japan, where the school health statistics from FY2024 showed that among children ages five to seventeen (as of April 1), the percentage of children who were overweight (with an obesity rate of 20% or higher on the Japanese obesity index for children)※24 was highest at age eleven for both boys and girls at approx. 11%. Among boys, this rate exceeded 10% for all ages from nine and older.※25

As with adults, it is believed that childhood obesity is impacted by complex background factors including genetic, social, economic, and environmental factors. Regarding genetic factors, women living with obesity are more likely to give birth to children with fetal macrosomia,※26 and such children are more likely to develop obesity in the future.※27 Furthermore, the Guide to Early Childhood Obesity states that because infancy is short in duration, genetic factors are known to be more influential than environmental factors in determining infant body size.※26 On the other hand, environmental factors include social or economic issues faced by children and their families (such as poverty, abuse, or social isolation) that often cannot be addressed by affected parties on their own. Childhood obesity is also associated with other diseases. For example, obesity is a known risk factor for repeated hospitalizations for childhood asthma.※28

### Childhood poverty and obesity

Findings show that childhood obesity is more common in households experiencing poverty or other social disadvantages. Another finding showed that children from lower income households before the 2008 global economic crisis had gained significantly more weight and had increased risk of overweight after the crisis.※29 The relative poverty rate for children in Japan is

※19 Takahashi Y, Sakai M, Tokuda Y, Takahashi O, Ohde S, Nakayama T, Fukuhara S, Fukui T, Shimbo T. The relation between self-reported body weight and health-related quality of life: a cross-sectional study in Japan. J Public Health (Oxf). 2011 Dec;33(4):518-26.

※20 Here, "childhood" refers to the period from age 1 to age 18. "Early childhood" refers to ages 1 to 6; "childhood" to ages 6 to 12; and "adolescence" to ages 12 to 18.

※21 In Japan, the term "overweight" in early childhood is defined as a degree of obesity (determined by dividing the difference between actual weight and standard weight for height by standard weight for height, then multiplying by 100) of +15% or more, and "obesity" during early childhood and adolescence refers to a value of +20% or more. "Childhood obesity disease" is a disease that effects people in early childhood to adolescence and is defined as, "A condition in which a person has or is likely to experience health problems caused by or related to obesity, and in which there is a medical need to lose weight." JASSO. Guidelines for the Management of Obesity Disease 2022. Life Science Publishing Co., Ltd. Tokyo. 2022.

※22 Ford ND, Patel SA, Narayan KM. Obesity in Low- and Middle-Income Countries: Burden, Drivers, and Emerging Challenges. Annu Rev Public Health. 2017 Mar 20;38:145-164.

※23 Simmonds M, Llewellyn A, Owen CG, Woolacott N. Predicting adult obesity from childhood obesity: a systematic review and meta-analysis. Obes Rev. 2016 Feb;17(2):95-107.

※24 Determined using the Japanese obesity index for children. This rate is depicted as a percentage and calculated by subtracting standard weight for height from actual weight, dividing the difference by standard weight for height, then multiplying by 100.

※25 School Health Survey - Summary of FY2024 Findings (Final figures). https://www.mext.go.jp/b_menu/toukei/chousa05/hoken/kekka/k_detail/2024.htm. Last retrieved on June 24, 2025.

※26 Japan Society of Obstetrics and Gynecology, Japan Association of Obstetricians and Gynecologists. Guideline for Gynecological Practice in Japan – Obstetrics, 2023 ed.

※27 Childhood Obesity Subcommittee, Committee on Nutrition, Japan Children's Medical and Health Council. 2019. Guide to Early Childhood Obesity.

※28 Okubo Y, Michihata N, Yoshida K, Morisaki N, Matsui H, Fushimi K, Yasunaga H. Impact of pediatric obesity on acute asthma exacerbation in Japan. Pediatr Allergy Immunol. 2017 Dec;28(8):763-767.

※29 Ueda P, Kondo N, Fujiwara T. The global economic crisis, household income and pre-adolescent overweight and underweight: a nationwide birth cohort study in Japan. Int J Obes (Lond). 2015 Sep;39(9):1414-20.

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15.4%.※30 In practical terms, this can be viewed as the equivalent of having to give up on higher education or being unable to participate in school trips or other such events. Experts say that children from lower income households have a hard time breaking out of such environments, and improving economic situations for their families means they must receive better educations, find jobs with better conditions, and break the cycle of poverty.

A number of efforts to support children experiencing socioeconomic issues like poverty, abuse, or isolation are being advanced by the government and private organizations. One example that is becoming more popular in Japan are Children's Cafeterias. Children's Cafeterias are mainly held by the private sector and provide children with food support, places to belong outside of the home, and opportunities to become familiar with adults in their communities who can be approached for help in times of need. They can also be counted on as places that allow children to encounter role models or career options outside of their families, experience diverse values or customs, and form connections in their communities. However, many Children's Cafeterias can only be held once or twice per month because they are operated by volunteers and lack sufficient funding or resources. In many cases, it is unrealistic to use them with the intent of providing daily dietary intake. In addition, a survey conducted in 2020 and 2021 found that about half of local governments do not provide information on Children's Cafeterias in public schools,※31 so there is room for improvement in terms of collaboration with schools. It will also be necessary to recognize that stigma may be preventing some of the children and families who truly need support from participating in Children's Cafeterias.

Food is a key issue in obesity and obesity disease control, and some experts have voiced the opinion that school lunches at elementary and middle schools are vital for children from households experiencing economic difficulties. A study on middle school students found that school lunch programs are one effective method for reducing obesity in that group.※32 A different study on Japanese middle school students compared nutrient intake on days with and without school lunch and found a significant difference of 60% or more for nutrients, with a higher percentage of children having insufficient intake for all nutrients on days without school lunch.※33 Recently, some municipalities have been introducing free school lunch programs, and it will be important to view school lunches as a method of approaching those who are unable to meet their nutrient intake needs as well as a method of reducing obesity in the population.

Cases of childhood obesity may be more common among families experiencing socioeconomic difficulties. Because obesity is, in part, one form in which such difficulties manifest, addressing childhood obesity requires first addressing the socioeconomic difficulties in question. While doing so, health support including support for obesity must also be advanced in parallel.

While Children's Cafeterias have been mentioned as one example of a support measure for social issues, such facilities require continuous fundraising to maintain operations. In addition to Children's Cafeterias that operate through donations from individuals or private companies, the number being operated with public funding or by corporations is on the rise. Expectations are high for various management methods to be utilized to create a sustainable system in the future. Young children and students should be told about Children's Cafeterias at schools, and Children's Cafeterias should be recognized and operated as places where any community member can form bonds with other community members rather than as places for children from families in need. In school lunch programs, tasks like menu preparation, ordering, and food preparation are performed despite the limited nature of funding. Steps should be taken to consider how to best allocate budgets for and operate meal programs in a stable and sustainable manner from the perspective of ensuring adequate dietary intake for children.

※30 Comprehensive Survey of Living Conditions, 2022 (Overview). https://www.mhlw.go.jp/toukei/saikin/hw/k-tyosa/k-tyosa22/index.html. Last retrieved on February 14, 2025.

※31 The FY2020 Health, Labour and Welfare Administration Promotion Research Subsidy (Special Health, Labour and Welfare Science Research Project) Study on Real-World Operations of and Issues in Children's Cafeterias During the COVID-19 Pandemic and Effectiveness Verification (20CA2076): A Nationwide Survey of Local Governments and Children's Cafeterias. https://mhlw-grants.niph.go.jp/system/files/report_pdf/202006072A-buntan1.pdf. Last retrieved on February 27, 2025.

※32 Miyawaki A, Lee JS, Kobayashi Y. Impact of the school lunch program on overweight and obesity among junior high school students: a nationwide study in Japan. J Public Health (Oxf). 2019 Jun 1;41(2):362-370.

※33 Asakura K, Sasaki S. School lunches in Japan: their contribution to healthier nutrient intake among elementary-school and junior high-school children. Public Health Nutr. 2017 Jun;20(9):1523-1533.

Regarding methods of addressing economic issues, there are various support programs available for low-income families. These include support provided under the Public Assistance Act, child-rearing support allowances provided under the Child Rearing Allowance Act, and assistance for school attendance provided under the Act on Aid of State for Encouragement of School Attendance of Children and Pupils in Difficult Conditions. However, there are also situations in which all families in need are unable to access support. For example, in some systems, support may be unavailable if a child does not meet criteria set by a local government or other body; relative poverty may be recognized as different from general poverty, so support may not reach children experiencing relative poverty; or systems may rely on families to submit applications in various types of systems before support can be provided. In the future, steps must be taken to examine systems that provide easier access to support for all, such as by utilizing the My Number system. Furthermore, the 2024 revision of the Act on the Promotion of Policy on Child Poverty included the promotion of surveys and research on child poverty to determine items to address. Moving forward, measures targeting obesity and other diseases related to child poverty should undergo evaluation based on data and be reflected in policy in more concrete terms.

### Nutrition and health education for children

Nutrition education provided from early childhood is regarded as an important aspect of obesity prevention, and expectations are also high for education provided consistently though the school years and adolescence. The Basic Act on Food and Nutrition Education enacted in 2005 provides seven basic principles that include nutrition education for children and that aim to achieve “healthy and cultured living” and “a thriving and prosperous society.” In addition, the Support System for Children and Child-rearing introduced in FY2015 made it possible for daycare centers and similar facilities to apply for a nutritional management premium by utilizing nutritionists or dietitians when providing meals; when consulting them on topics like menu planning; or by having them provide ongoing guidance on nutrition education or related topics. However, many nursery schools or kindergartens are not required to have nutritionists or dietitians on staff. In addition, the Diet and Nutrition Teacher System established in FY2005 places such diet and nutrition teachers at each school where they play important roles in nutrition education. However, there are regional variations in the number of diet and nutrition teachers, their duties, and circumstances surrounding their placements. Certain related parties have also voiced the opinion that the content of nutrition education in public schools differs by school according to approaches or attitudes toward nutrition education. Others have said that the periods that schools allocate for eating lunch are too short, particularly at public middle schools, and that this is making it difficult to utilize school lunch programs as part of the promotion of nutrition education.

Children’s education is not only important for diet, but it is also for health. The recent increase in young women with a BMI of 18.5 or below has become a serious problem that is damaging health. Both obesity and underweight can impact future generations, so it will also be important to educate people of all sexes on preconception care from before they reach the age for having children, including during early childhood and adolescence.

It has been twenty years since the enactment of the Basic Act on Food and Nutrition Education and the establishment of the Diet and Nutrition Teacher System, but there has yet to be sufficient evaluation of the changes experienced by young children and students by providing nutrition education as policy, or on the impact that law and system are having on items like obesity. Effective future measures may include designing data that holds up to evaluation; centralizing health data to encompass medical examination results for all generations, including the results of health checkups conducted in accordance with the Basic Act for Child and Maternal Health and Child Development; and, together with academia, establishing model municipalities where measures aimed at reducing overweight among children can be introduced and evaluated for effectiveness. We hope there is further scientific verification of the effectiveness of obesity control measures provided through education from early childhood and for findings to be reflected in policy.

Adachi City plans to implement a practical initiative in nutrition education that will ensure students possess basic cooking skills (e.g. being able to cook rice, make miso soup, or use a frying pan to

prepare fried eggs or other simple dishes) by the time they graduate middle school. Given topics such as working style reform or personnel shortages among teachers, however, discussions that take recent circumstances at schools into account will be necessary.

### Responding to risk of obesity or obesity disease in early childhood or among school-age children

Under the School Health and Safety Act, young children and students undergo regular health checkups every school year. However, not all people involved with young children and students are fully aware of obesity disease as a disease that requires treatment rather than as a condition, and it is likely that interventions are limited. While there are some examples of nutrition teachers providing personal guidance to address cases of obesity among young children and students,※34 for obesity disease, it is important that affected parties are guided to medical care at an early stage. This is because childhood obesity disease can cause accelerated bone maturation, causing affected children to attain their final height prematurely. Childhood obesity disease can also require medical intervention for conditions like glucose intolerance. However, there is significant regional variation in collaboration among schools and healthcare due to differences in systems or awareness among school physicians, school personnel, and local governments. In cases of obesity or obesity disease, it is also likely that the affected person and their family will experience psychological impacts, or that there will be stigma from those around them.

While there are some differences by region, Pediatric Lifestyle Disease Prevention Health Checkups are conducted for students in their fourth year of elementary school, first year of middle school, and first year of high school. In addition to health promotion, these checkups provide children with early detection and prevention of lifestyle diseases. This program was launched as “Pediatric Adult Disease Prevention Health Checkups” after an increase in childhood obesity from around the 1980s to the 2000s elevated awareness of obesity and related health damage, and the program was soon implemented nationwide.※35 Blood tests can detect conditions like lipid metabolism abnormalities, but blood sampling is invasive, making blood tests feel very burdensome for people in schools. Systems for accumulating data from test results are also insufficient, hindering efforts to confirm data over time. Another item of note is that while Pediatric Lifestyle Disease Prevention Health Checkups can be provided in each community through collaboration among schools, boards of education, and local medical associations, they are not included in the School Health and Safety Act. As a result, the decision to implement the program is left to local governments, resulting in disparities in implementation.

When school health checkups find young children or students with high BMIs that may signify obesity disease, schools should quickly collaborate with specialized medical facilities. The school health checkup manual states that underlying factors must be thoroughly examined when a young child or student has an obesity rate of 20% or more. It also states that it may be necessary to recommend examinations at healthcare institutions in cases where obesity could be considered a disease, such when the rate of growth for height is below normal on growth charts or when there is extreme obesity.※36 It also desirable that individual guidance is provided together with staff like the homeroom teacher, the school nurse, or the nutrition teacher for cases of primary obesity (in which obesity is not caused by a disease).※36 However, the decision of whether to refer young children or students who may have childhood obesity disease to a healthcare institution is often left to the school physician, and processes of recommendations for medical examination vary among prefectures and municipalities. In the future, it will be necessary for multi-stakeholders such as academia, government, and educational institutions to collaborate and engage in cross-cutting discussions to determine how to best respond to actual circumstances in schools.

※34 Ministry of Education, Culture, Sports, Science and Technology of Japan (MEXT) Commissioned Study on the Effectiveness of Placing Nutrition Teachers in Schools, FY2020 Report. https://www.mext.go.jp/content/20250507-mxt_kenshoku-000042373-2.pdf. Last retrieved on June 24, 2025.

※35 Inokuchi, M. “Medical checkups for lifestyle disease prevention for children.” Keio Health Research, 40 (1), 035-039, 2022. https://www.hcc.keio.ac.jp/ja/research/assets/files/40-2.pdf. Last retrieved on June 24, 2025.

※36 Japan Society of School Health with supervision from the School Health Education Division, Sports and Youth Bureau, MEXT. Manual for Health Checkups for Young Children and Students (FY2015 ed). https://www.gakkohoken.jp/book/ebook/ebook_H270030/index_h5.html#1. Last retrieved on June 24, 2025.

### Healthcare services for childhood obesity disease

In the treatment of obesity disease, one difference between children and adults is that for children, healthcare providers often find no other pathologies, such as abnormal liver function or glucose metabolism. This means that other than premiums for initial and follow-up consultations, there are often no insurance premiums for which healthcare providers can apply (i.e., for the treatment of comorbidities). Furthermore, it is rare for treatments like drug therapy to be used to treat childhood obesity disease, and treatment is often centered on providing guidance on lifestyle modification using information obtained during medical interviews. Despite the need to carefully gather information on daily life at home or school during medical interviews for childhood obesity disease, lifestyle guidance and other health services are not currently eligible for medical service fee reimbursement when "childhood obesity disease" is the only disease that is registered.

The treatment of childhood obesity disease is handled by physicians specializing in pediatric endocrinology or nutrition and who serve at university hospitals, core hospitals, or public hospitals. Personnel serving in such hospitals have reported that shortages among these physicians are making it difficult to see new patients with childhood obesity disease. To address this issue, the Japanese Society for Pediatric Endocrinology submitted an application to the Central Social Insurance Medical Council's Medical Technology Evaluation Subcommittee requesting the inclusion of a "Childhood Obesity Disease Guidance and Management Premium" during the FY2024 revision of the medical service fee schedule. The proposal would have granted reimbursement eligibility to visits lasting thirty minutes or more and in which specialists in pediatric medicine provide guidance on diet therapy, exercise therapy, behavioral therapy, or lifestyle improvements on an outpatient basis.※37 However, it was determined that the medical effectiveness of such guidance has not yet been demonstrated sufficiently for evaluation, so the requested premium was not included.※38

The nature of childhood obesity disease as a condition that affects children may make it difficult to conduct intervention studies or long-term outcome evaluations. While keeping this difficulty in mind, steps should be taken to examine the creation of a system that will enable young children and students with obesity disease to access ongoing treatment at local clinics after visiting specialized medical facilities, based on evidence accumulated through routine medical examinations. At the same time, it will also be important to broadly inform related parties about how to make effective use of existing frameworks, such as Outpatient Nutritional Guidance. After considering the establishment of new medical service fees related to childhood obesity disease based on thorough discussions and evidence, it will be necessary to create an environment in which all children living with childhood obesity can benefit from appropriate healthcare.

## 2.2. Working-age adults

Health checkups play a vital role in connecting health promotion and healthcare. While frameworks for health checkups and health guidance differ depending on age and type of insurance, after screenings are performed using the standard values set in each law governing health checkups, insurers provide beneficiaries with recommendations for medical examination or with health guidance aimed at improving lifestyle habits. Working-age adults are provided with disease screening and guidance through two frameworks, which are the aforementioned specific health checkups and specific health guidance performed in accordance with the Act on Assurance of Medical Care for Elderly People, and general health checkups and health guidance provided in accordance with the Industrial Safety and Health Act. A multicenter occupational cohort study involving approx. 100,000 people called the Japan Epidemiology Collaboration on Occupational Health Study (J-ECOH study) found that obesity among younger employees is increasing annually and the number of people who have already developed obesity when they enter the workforce is on the rise.※39

※37 Proposal for FY2024 Social Insurance Medical Service Fee Schedule. "1. Medical Technology Evaluation Proposal (Unlisted)." https://fa.kyorin.co.jp/naihoren/shinryohoshu2024/240101-299102.pdf. Last retrieved on June 24, 2025.

※38 MHLW. "Evaluation of Medical Technology for the FY2024 Revision of the Medical Service Fee Schedule (Draft)." https://www.mhlw.go.jp/content/12404000/001209024.pdf. Last retrieved on June 24, 2025.

※39 Hasegawa M, Akter S, Hu H, Kashino I, Kuwahara K, Okazaki H, Sasaki N, Ogasawara T, Eguchi M, Kochi T, Miyamoto T, Nakagawa T, Honda T, Yamamoto S, Murakami T, Shimizu M, Uehara A, Yamamoto M, Imai T, Nishihara A, Tomita K, Nagahama S, Hori A, Konishi M, Kabe I, Mizoue T, Kunugita N, Dohi S; Japan Epidemiology Collaboration on Occupational Health Study Group. Five-year cumulative incidence of overweight and obesity, and longitudinal change in body mass index in Japanese workers: The Japan Epidemiology Collaboration on Occupational Health Study. J Occup Health. 2020 Jan;62(1):e12095.

### Laws and systems for health promotion among working-age adults

Under the Industrial Safety and Health Act, small- and medium-sized enterprises (SMEs) with fewer than 50 employees are not required to appoint industrial physicians. Almost all (99.7%) of companies in Japan are SMEs,※40 so if people serving in primary industries such as agriculture and fisheries as well as sole proprietors are included, many working-age adults have no contact with occupational health specialists in the workplace. The current structure of these systems means differences in workplaces are creating disparities in access to occupational health services.

Furthermore, general health examinations for working-age adults are provided under the Industrial Safety and Health Act while cancer screening is conducted under the Health Promotion Act, creating a systemic issue in which different checkups are performed under different laws and by different entities. Regarding recommendations for medical examination, among employers with industrial physicians on staff, some have substantial systems in which employees can receive referrals from the industrial physician to encourage them to attend an examination. However, the Industrial Safety and Health Act does not obligate employers to provide recommendations for medical examination, so many entities without industrial physicians on staff do not provide these recommendations in a manner that reflects the personal health status of each employee.

The Industrial Safety and Health Act also provides for health promotion, with Article 69 stating, “An employer must endeavor to continuously and systematically take the necessary measures to provide its workers with health education and health counseling and to otherwise help maintain and improve its workers' health” (Paragraph 1) and, “A worker must endeavor to maintain and improve their health by making use of the measures taken by the employer as referred to in the preceding paragraph” (Paragraph 2). In other words, while these efforts are not mandatory, the Industrial Safety and Health Act obligates employers to endeavor to take measures to promote the health of workers and obligates workers to endeavor to lead healthy lives.

### Developing diet and exercise habits through occupational health

The obesity rate among younger working-age adults is on the rise.※39 While advancing initiatives for health and productivity management, it will be necessary for employers and occupational health professionals to further expand measures that support the creation of diet and exercise habits. Younger people have more muscle mass and other characteristics that make it easier for them to lose weight through exercise, so reinforcing interventions such as those that encourage them to develop exercise habits after entering the workforce is likely to be effective at helping them maintain weight or reverse obesity through their 30s. On the other hand, the effects of interventions for improving diet and exercise habits through lifestyle modifications among middle-age adults who are age 50 and older are often limited, but they may be highly cost-effective when considered in isolation from other treatments such as drug therapy. In the future, interventions which take into account the fact that drug therapy and non-drug therapy are different in effectiveness by age group should be considered for working-age adults.

## 2.3. Specific health checkups and specific health guidance

### The differences between metabolic syndrome and obesity disease

Specific health checkups and specific health guidance are provided to people age 40 years and older with the main goal of preventing lifestyle diseases among working-age adults. The main focus of this system is to control metabolic syndrome using abdominal circumference (of 85 cm or more for men and 90 cm or more for women) and BMI as screening indicators. To prevent lifestyle diseases, this system stratifies people by level of specific health guidance according to a number of additional risk factors (high blood pressure, lipid abnormalities, high blood sugar, and smoking) and provides them with health guidance in a stepwise manner, from the provision of information to hands-on guidance.

※40 The Small and Medium Enterprise Agency. “Presentation of statistics on the number of small and medium-sized enterprises and small businesses (as of June 2021).” https://www.chusho.meti.go.jp/koukai/chousa/chu_kigyocnt/2023/231213chukigyocnt.html. Last retrieved on June 24, 2025.

One item that must be kept in mind is that there are fundamental differences between the definitions and diagnostic criteria for metabolic syndrome, which is the main target of specific health checkups, and for obesity disease, which is diagnosed as a medical condition. When diagnosing metabolic syndrome, the main indicator is abdominal circumference and focus is placed on the accumulation of multiple risk factors related to metabolism. Obesity disease is diagnosed as a medical disease in which the excessive accumulation of body fat results in damage to health. As we can see, the targets for these conditions are not identical, and it is not the case that everyone who can be diagnosed with metabolic syndrome also has obesity disease. Conversely, some people living with obesity disease do not meet the criteria for metabolic syndrome.

While the concept of metabolic syndrome has been widely disseminated among the public through specific health checkups, it has been pointed out that this has paradoxically resulted in disregard toward its medical importance. The term "metabolic syndrome" coming into everyday use may have made it seem like less of a real health threat, and people may now lack awareness that it is a condition which requires a visit to a healthcare institution. This has been identified as one potential factor that is dampening the impact of efforts to provide appropriate medical collaboration and recommendations for medical examination for conditions ranging from metabolic syndrome to obesity disease. There have also been reports that people who are at high risk of developing obesity disease experience high psychological hurdles toward health checkups. Other issues that have been identified as potential barriers are that negative perceptions toward appearance may be prevailing over the sense of urgency to address obesity as a health risk, or that people may experience hesitancy to confront the condition directly due to insufficient knowledge and self-stigma.

### General issues in the specific health checkups and specific health guidance system

In FY2023, uptake for specific health checkups was 59.7%, but was low for specific health guidance, at 27.7%.※41 Even when people attend specific health guidance, by year three or four, the effects of health guidance are low, and some have expressed doubt that the specific health checkup system is effective at curbing healthcare costs.※42 Uptake for specific health guidance has not increased for a number of reasons. For example, in addition to a low degree of understanding of the program's purpose and content, some people do not even know how to apply for the program. Also, recognition of the program is even lower among dependents than insured people. Potential reasons that specific health guidance is not fully effective may be low commitment to the program or the limitations of self-directed efforts. In an effort to increase uptake for specific health guidance, there have recently been cases in which guidance was provided using basic results obtained on the day of the health checkup, but this is undesirable because such guidance does not reflect the full findings of the checkup as originally intended. In order for specific health guidance to be effective, it is important to use complete health checkup data when selecting people who require specific health guidance or recommendations for medical examination.

There are also issues related to the systems for screening and evaluation for specific health checkups. Screening criteria for determining eligibility for specific health guidance differ between men and women, but fewer women meet those criteria and have fewer opportunities to receive subsequent interventions. This may be causing gender disparity. Regarding evaluation methods, the evaluation method for specific health guidance changed from a process indicator (for example, how many times a participant was contacted and provided with guidance over a six-month period) to an outcome evaluation (a reduction of 2 kg body weight and 2 cm waist circumference) after the fourth Specific Health Checkup Implementation Plan came into effect. However, evidence that this outcome leads to CVD prevention is insufficient. There is also a systemic limitation in that people with severe obesity and a body weight of over 100 kg can achieve the aforementioned reduction target relatively easily. This creates a loophole in data collection and evaluation. In response, there is discussion that improvement in cardiovascular risk should be an outcome, but such a change has yet to be adopted. To prepare revisions for the fifth Specific Health Checkup Implementation Plan, high-quality evidence must be

※41 MHLW. "Data Related to Specific Health Checkups and Specific Health Guidance." https://www.mhlw.go.jp/stf/newpage_03092.html. Last retrieved on July 15, 2025.

※42 Fukuma S, Iizuka T, Ikenoue T, Tsugawa Y. Association of the National Health Guidance Intervention for Obesity and Cardiovascular Risks With Health Outcomes Among Japanese Men. JAMA Intern Med. 2020 Dec 1;180 (12):1630-1637.

generated to enhance the benefits and effectiveness of the program, and arrangements and decisions must be made with involvement from all stakeholders.

**The desirable future direction for specific health checkups and obesity disease control**

Despite the need for discussions on how effective specific health checkups and specific health guidance are at reducing healthcare costs, they carry a certain degree of significance in that they can be used to identify people at risk of obesity disease or to screen for people living with obesity disease. Considering how to promote measures for obesity disease based on the framework for specific health checkups may be one realistic strategy for helping people feel the effects of the services they receive through health initiatives or healthcare. At the same time, the existing specific health checkup system was not designed with screening for obesity disease and other diseases in mind, and there are discussions that anticipate changes in that system. Looking to build a wholly optimized health checkup system that cuts across diseases, it will be necessary to hold thorough discussions on the need for additional, evidence-based health checkup items and on which healthcare institutions will accept patients after screening.

Meanwhile, specific health guidance places heavy burdens on both providers and recipients, and there is room for further examination on the need for it to be provided yearly to eligible people starting at age 40. One potential method may be to provide specific health guidance every few years and to use health checkups provided under the Industrial Safety and Health Act to cover the years in between guidance. It will be necessary to consider efficient and effective methods not only for specific health guidance, but that can be applied to the entire health service framework, as well.

The Industrial Safety and Health Act obligates employers to conduct general health checkups, but actual behavioral change (e.g., improving lifestyle habits based on health checkups, health guidance examinations, or health checkup results; or attending examinations at healthcare institutions) is ultimately up to the individual. This is one systemic limitation, so the establishment of an environment that makes it possible to encourage behavioral change or to approach people who have yet to attend health checkups must be considered in the future. Moving forward, it will be necessary to examine, in a comprehensive manner, how to best structure effective policies that reach more citizens while controlling costs.

## 2.4. Senior citizens (sarcopenic obesity)

Sarcopenia is a form of progressive loss of skeletal muscle mass that occurs with aging and that causes reduced strength and physical function. Sarcopenic obesity is a combination of sarcopenia and obesity. Sarcopenic obesity is known to be associated with falls and fractures that impact activities of daily living (ADL) among senior citizens.4 Japan is experiencing an aging population, making it an important issue for the country. However, sarcopenic obesity is a relatively new concept and initiatives to address it in healthcare or from local governments are limited. Evidence for this condition should be created and measures focusing on obesity among senior citizens should be implemented throughout society.

# 3 Issues for the healthcare provision system for obesity disease

## 3.1. The current state of obesity disease diagnosis

Obesity leads to various health problems including diabetes, dyslipidemia, and hypertension. While treatment for these related conditions is provided proactively, obesity disease itself goes undiagnosed, and people living with obesity disease are often unable to receive appropriate treatment. According to the 2023 Patient Survey, only approx. 32,000 people have been diagnosed and reported as having obesity disease (E66).※43 However, the National Health and Nutrition Survey has reported that the

※43 Summary of Patient Survey 2023. https://www.mhlw.go.jp/toukei/saikin/hw/kanja/23/index.html. Last retrieved on June 24, 2025.

percentage of people living with obesity (defined as having a BMI of 25 or higher) among Japanese adults is approx. 30% for men and 20% for women.※3 As mentioned above, caution is necessary when considering the reliability of this data, but a simple calculation strongly suggests that far more people than 32,000 may be silently living with obesity disease, with their number potentially in the millions. Looking at numbers of cases of diseases closely related to obesity in the Patient Survey 2023, approx. 16 million people live with hypertension (I10-I15), 4.6 million people live with dyslipidemia (E78), and 3.6 million people live with type 2 diabetes (E11).※43 We can estimate that these figures include a certain number of people living with obesity disease but have yet to be diagnosed.

Low awareness toward the definition of obesity disease among healthcare professionals is one reason people living with obesity disease go undiagnosed despite fitting its criteria. The international definition of obesity is BMI≥30 and the definition of obesity in Japan is BMI≥25. In addition, in 2000, JASSO assigned a definition of "obesity disease" that is unique to Japan and that refers to a condition in which there are "complications or potential complications resulting from or related to the condition of obesity," such as hypertension, dyslipidemia, and type 2 diabetes. This is because despite lower rates of obesity, the prevalence of obesity-related diseases such as hypertension and dyslipidemia is higher among Asian people, including Japanese people, than among people from Western countries. However, this definition of obesity disease has yet to become widely recognized among healthcare professionals and is easily confused with similar concepts like "obesity" or "metabolic syndrome." In fact, a February 2025 survey conducted by a pharmaceutical company found that over 80% of responding physicians said obesity disease "requires treatment," so the presence of this gap in diagnoses can be considered as evidence of a lack of proper understanding.※44 It has also been pointed out that there is stigma rooted in the concept of personal responsibility toward obesity and obesity disease. Such stigma is not only present among citizens, but among healthcare providers, as well. We must not overlook the possibility that stigma in general clinics or outpatient facilities may be causing people to lose opportunities to receive interventions for obesity disease.

## 3.2. Awareness among healthcare professionals, people living with obesity disease, and other affected parties

Recent years have seen rapid advances in treatments for obesity disease, and in addition to diet therapy and exercise therapy, evidence has been established for the effectiveness of behavioral therapy, drug therapy, and surgical treatments.4 However, awareness of these treatments and of their eligibility for insurance coverage has yet to spread among healthcare professionals, people living with obesity disease, and other affected parties. One factor for delays in medical intervention may be that among people living with obesity disease, those whose conditions are relatively mild and do not meet the definition of severe obesity disease do not often experience immediate disruptions in their daily lives, like with other chronic diseases. This lack of awareness among healthcare professionals, people living with obesity disease, and other affected parties is hindering access to appropriate and timely treatments for obesity disease and is causing obesity disease to go overlooked in clinical settings. This results in the adoption of approaches based on treating the chronic diseases caused by obesity disease rather than fundamental solutions to the condition itself.

## 3.3. Diet therapy

Even when someone undergoes surgery or drug therapy, ongoing diet therapy and exercise therapy are fundamental for the treatment of obesity disease. Recognizing that other therapies are complementary to these therapies is a matter of vital importance. In particular, the basis of obesity disease treatment is diet therapy provided as part of nutritional guidance, but that guidance faces issues in reimbursement in the medical service fee schedule. Inpatient nutritional guidance for severe obesity disease (with an obesity rate of 70% or more, or a BMI of 35 or more) and outpatient nutritional guidance for severe obesity disease (with an obesity rate of 40% or more, or a BMI of 30 or more) are eligible for premiums when registered under the name "obesity disease." However, there are no diseases for which nutritional guidance is eligible for

※44 Eli Lilly Japan K.K., Mitsubishi Tanabe Pharma Corporation. "Findings of awareness survey of people living with obesity disease, physicians, and the general public." www.mt-pharma.co.jp/news/2025/MTPC250227.html. Last retrieved on June 24, 2025.

premiums when BMI is under 30 or when diseases like diabetes are present. For example, the premium for nutritional guidance can be difficult to obtain for a patient with a BMI of 29 and obstructive sleep apnea. There is also a limit on how many times the premium for nutritional guidance can be applied for, with a maximum of two times per month. While the initial consultation for nutritional guidance is expected to take about thirty minutes, in reality, it often takes longer if there are questions on topics like content of diet.

From the viewpoints of patients, there are many cases in which they have already received nutritional guidance in various forms, both inside and outside of healthcare institutions, and are still struggling to lose weight. Perseverance is a necessary element in any long-term diet therapy that requires self-management, but when people living with obesity disease cannot lose weight, the problem does not necessarily lie with them. In most cases, the underlying genetic and psychosocial factors for obesity disease limit the effects of self-management. Instead of unilateral nutritional guidance, obesity disease requires guidance in which people living with obesity disease are accompanied over the course of their daily lives and struggles from a multifaceted perspective, and which includes collaboration with other healthcare professionals while keeping SDH in mind. However, dietitians have generally not received sufficient education on how to respond to the needs of people living with obesity disease from this perspective.

## 3.4. Drug therapy

Among treatment options for obesity disease, drug therapy has seen revolutionary progress in recent years. The drugs indicated for obesity disease are called GLP-1 receptor agonists and GIP/GLP-1 reception agonists (hereafter referred to as “obesity drugs”). Drug therapy with obesity drugs has been shown to reduce weight and is eligible for insurance coverage. Obesity drugs can be an effective treatment option for people living with obesity disease, but the Optimal Clinical Use Guidelines currently restrict their use to certain medical facilities specializing in that condition. Restrictions set by the Optimal Clinical Use Guidelines are necessary to promote the safe use of obesity disease treatments with new mechanisms of action. However, people living with obesity and other affected parties who truly need obesity drugs may not be receiving them because the medical facilities that can prescribe them are limited.

There are also no lists of which specialized medical facilities meet the criteria set by the Optimal Clinical Use Guidelines, making it difficult for patients to select one or for their primary care physicians to make referrals. Current circumstances also create a dilemma surrounding specialized medical facilities. Given the limited number of specialized medical facilities or the limited capacity of such institutions, patients whose condition is stable may want to return to their local clinics to be treated through collaboration with their primary care physicians in a dual-primary care physician arrangement. However, as long as they continue to receive drug therapy, patients cannot be referred back to local clinics and must continue visiting specialized medical facilities for long periods of time.

## 3.5. Primary care physicians and clinics

Factors such as financial constraints facing the social security system have created difficult business circumstances for insured health institutions, regardless of whether they have care beds or not. In addition, the FY2024 revision of the medical service fee schedule introduced changes that, in practice, result in net negatives for clinics. On top of a tight business environment, clinics also face increasingly severe circumstances due to factors like aging among physicians in private practice, personnel shortages, and expanded workloads due to the launch of the Primary Care Physician Function Reporting System. Within that context, items related to obesity disease treatment and eligible for reimbursement are limited, especially at clinics, making it difficult to motivate clinics to participate in intervention. “Obesity disease” is not currently listed as a primary disease under Lifestyle Disease Management Premium (I) or (II), or the Specified Disease Treatment Management Premium. Because obesity disease is diagnosed for people with “Obesity (BMI $\geq$25) and one or more of the eleven related health concerns, or has visceral obesity,” in theory, there should be cases in which treatment is eligible for the Lifestyle Disease Management Premium by

handling the comorbid condition as the primary disease. However, insufficient recognition of the concept of "obesity disease" as a disease and its unclear positioning in the medical service fee schedule have created circumstances in which these premiums are not being fully utilized.

It has also been pointed out that general treatments that can be handled in clinics (such as weight loss guidance) are time-consuming as well as less effective and difficult to utilize for the proactive treatment of obesity disease. This means that interventions for obesity disease tend to be assigned low priority when time or human resources are limited.

On top of these challenges, both Lifestyle Disease Management Premium (I) and (II) now require treatment plans to be created and for copies of those plans to be attached to medical records, so healthcare professionals are now required to establish target values instead of administering drugs based on experience. The conventional focus of reference values for Lifestyle Disease Management has been on blood glucose, blood pressure, and lipids. Values related to the kidneys, which have deep links to obesity disease, have not been used as central indicators. Kidney disease shares many of the same risks as CVD, so this change may make it possible to raise awareness to provide patients with cross-disciplinary examinations.

## 3.6. Specialized medical facilities

As of January 30, 2025, 84 health institutions nationwide are certified by JASSO as hospitals specializing in the treatment of obesity disease. In addition to aforementioned challenges related to awareness of obesity disease among physicians or issues related to drug therapy, 16 of Japan's 47 prefectures have zero certified hospitals. This means a certain number of people living with obesity disease are unable to visit a hospital specializing in its treatment due to where they live, even if their primary care physician or attending physician from a different field is aware of the condition and has determined a referral to a specialized medical facility is necessary.

One treatment option for people living with severe obesity disease that has been shown to be effective for long-term weight loss is bariatric surgery (or, "weight loss and metabolic enhancement surgery"). Large-scale clinical trials have also found that bariatric surgery can lead to other health improvements, such as remission of type 2 diabetes or reduced cardiovascular events.※45 Surgical options for severe obesity disease in Japan include laparoscopic sleeve gastrectomy, which was granted insurance coverage in 2014; and sleeve gastrectomy (combined with bypass), which was granted coverage in 2025. However, as of April 22, 2025, there are only 31 integrated obesity treatment centers certified by the Japanese Society for the Treatment of Obesity (JASTO), and only around 900 bariatric surgeries are performed per year.※46

In addition to examinations in a number of departments including psychiatry, gynecology, and orthopedics, the treatment of severe obesity disease often requires multidisciplinary care (team treatment) that does not only involve physicians but also includes collaboration with professionals such as pharmacists, nurses, nutritionists, physical therapists, and clinical psychologists. While providing multidisciplinary care in this manner, based on the characteristics of the person living with obesity disease, treatment must also be advanced with a firm understanding of the many problems they may be experiencing, including underlying issues like dietary habits, living environment, psychological issues, or economic issues. Currently, some specialized medical facilities for obesity disease have obesity treatment coordinators and similar personnel who make various arrangements for the affected party. Their duties may include making appointments with healthcare professionals or other parties as well as providing consultations on topics like daily physical condition or lifestyle. In the U.S., it is common for medical facilities specializing in obesity treatment to have obesity treatment coordinators on staff, but Japan lacks a relevant certification for obesity treatment coordinators. Instead, this role is fulfilled by staff like dietitians, social workers, and integrated community care nurses. Furthermore, such staff can only be found at some specialized medical facilities, and each of those institutions employs such staff on its own.

※45 Sjöström, L., Peltonen, M., Jacobson, P., et al. (2012). Bariatric surgery and long-term cardiovascular events. JAMA, 307(1), 56-65.

※46 JASTO. "Urgent Survey, 2023." JASTO Insurance Committee. http://plaza.umin.ne.jp/~jsto/about/pdf/questionnairesurvey2023.pdf. Last retrieved on June 24, 2025.

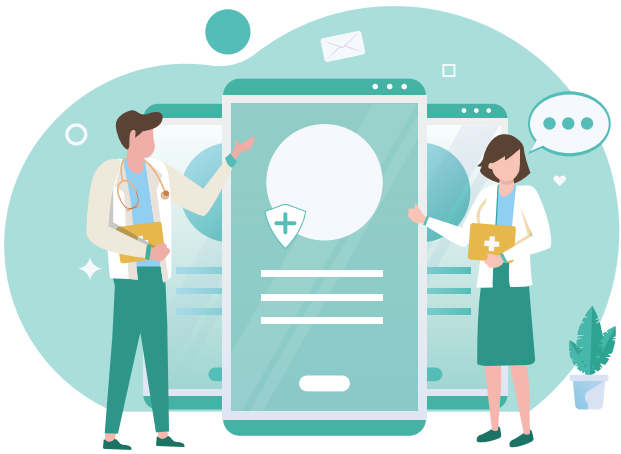
Because obesity disease is not only a medical issue but also a disease in which psychological and socioeconomic issues are expressed, a comprehensive approach involving multidisciplinary collaboration among obesity treatment coordinators and other professionals serving at specialized medical facilities is essential. Instead of relying on healthcare institutions to cover these expenses themselves, it will be necessary to generate evidence from clinical settings; to appropriately evaluate these services, including policy incentives; and to build a system that ensures that holistic, specialized, and multidisciplinary healthcare can be provided in each region. Furthermore, it is difficult for healthcare institutions to provide support related to lifestyle for people living with obesity disease, so collaboration with local governments is also desirable.

## 3.7. Issues related to the cosmetic use of obesity drugs or voluntary healthcare

A new drug for the treatment of obesity disease and with similar ingredients and actions to a drug that had previously received production and marketing approval for the treatment of type 2 diabetes was launched in Japan in February 2024. In Japan and overseas, it is drawing attention as a drug that will expand obesity treatment options.※47 However, one problem has emerged in the form of off-label use of obesity drugs for cosmetic weight loss, in which people acquire these drugs by requesting prescriptions through online or voluntary healthcare services or by simply purchasing them on their own, through online health services or online storefronts. The main problem with the off-label use of obesity drugs is the potential damage to the life or health of the people who acquire them for cosmetic weight loss. In general, it is not assumed that all uninsured treatments are inappropriate. Certain types of uninsured treatments (such as treatments provided for evaluation, or patient-selected treatments) are permitted when provided in combination with insured treatment, and even the off-label use of a drug may be eligible for insurance coverage if it is prescribed for its pharmacological effects. However, there are the four issues related to the off-label use of obesity drugs, described below.

First, the off-label use of obesity drugs for weight loss is not covered by the Adverse Drug Reaction Relief System. The Adverse Drug Reaction Relief System is defined as a “public system providing benefits (such as coverage of healthcare expenses or pensions) when the side effects that occur during the appropriate use of a drug (including those purchased at pharmacies, etc. in addition to those prescribed at hospitals or clinics) results in severe health damage requiring hospitalization.”※48 In other words, off-label use is not covered. This means that even when cosmetic treatment is provided with consent, there is no public compensation in the event of a severe adverse reaction. In addition, data is not gathered from such cosmetic treatments, nor is data from cosmetic treatments registered in the NDB or other public databases, so it is currently impossible to analyze their impact or to grasp circumstances surrounding such treatments.

Second, there have been cases in which people made emergency visits to insured medical facilities due to the side effects or health damage caused by the off-label use of obesity drugs for weight loss and received treatments covered by insurance. In fact, during hearings conducted for this report, there were examples of people who required emergency transport to insured medical facilities for conditions like acute pancreatitis. The number of healthcare institutions advertising cosmetic surgery has more than doubled over the past decade.※49 At the same time, consultations at the



※47 Two-year effects of semaglutide in adults with overweight or obesity: the STEP 5 trial. Nat Med. 2024.

※48 Pharmaceuticals and Medical Devices Agency (PMDA). “Outline of systems for the general public.” https://www.pmda.go.jp/kenkouhigai_camp/general01.html. Last retrieved on June 24, 2025.

※49 MHLW. “Summary of 2023 Medical Facilities Survey (Static and Dynamic) and Hospital Report.” https://www.mhlw.go.jp/toukei/saikin/hw/iryosd/23/dl/11gaikyo05.pdf. Last retrieved on June 24, 2025.

National Consumer Affairs Center also increased due to problems related to cosmetic medical services.※50 The existing system does not prohibit people from receiving insured treatments for side effects or health damage caused by voluntary treatments, but as cosmetic medical services continue to expand, such cases are likely to increase. In the future, managing limited social insurance funds in a manner that is acceptable to the public may require reviewing the definition of "combined treatment" (the combined use of insured and uninsured services) or the scope of health insurance coverage.

Third, despite the presence of serious issues described above, certain healthcare institutions are advertising the off-label use of obesity drugs online or through social networks in ways that do not comply with regulations on medical advertising described in related laws and regulations, using terms like, "GLP-1 diet." Research conducted for this report also found that in some cases, such advertising has led some people living with obesity disease and who would be eligible for insured treatment to mistakenly believe that drug therapy is only available as a voluntary treatment. This made them hesitant to seek drug therapy at a specialized medical facility due to concern about the cost. Additionally, the number of women living with underweight in Japan has been increasing in recent years and has become a challenge for society. Given the social climate that promotes lookism or obesity stigma through the broad use of social networks, advertisements for weight loss may lead to greater damage. In response, the Government has called on providers of such services to comply with "Guidelines on Advertisements for Medical Services, Dentistry, Hospitals, or Clinics (the Guidelines for Medical Advertising)" and has published a notification titled "Handling of Informed Consent for Cosmetic Medical Services and Other Voluntary Treatments."※51 The Government has also introduced a net patrol initiative to examine online medical advertising and is imposing administrative penalties such as fines or revocation of permission to operate when malicious medical advertising is discovered. Despite these efforts, such advertisements have yet to disappear.

Fourth, physicians have the right to prescribe GLP-1 agonists for weight loss at their discretion under the "Right to prescribe" granted by the Medical Practitioners' Act. In other words, a law that regulates physicians who prescribe obesity drugs for weight loss does not exist. It is also currently difficult for pharmaceutical companies to control the supply of these drugs and to avoid providing them to healthcare institutions that prescribe them for weight loss, and the capacity of the existing system to control distribution channels is limited. Addressing the serious health damage resulting from the off-label prescribing of obesity drugs in the future will require advancing cross-disciplinary discussions on and consideration of legal measures (like the Act on Securing Quality, Efficacy and Safety of Products Including Pharmaceuticals and Medical Devices) for the appropriate management of prescribing and distribution.

This concludes our list of issues related to the off-label use of obesity drugs, but as symbolized by the fact that the MHLW held its first study group on appropriate cosmetic medicinal practices in 2024, in addition to obesity drugs, it may be time to also consider the nature of voluntary medicine, including cosmetic medicine, within the context of the healthcare system as a whole. Moving forward, it will also be necessary to examine a framework that ensures citizens accurately understand the systems and risks of cosmetic medicine and that ensures problem-free voluntary treatments, including cosmetic medical treatments, based on appropriate informed consent.

※50 Public Relations Office, Minister's Secretariat, Cabinet Office. "Government of Japan Public Relations Office Online – Making Life of Tomorrow Easier, Explained. Consumers' Troubles with Cosmetic Medical Services: Points to Confirm Before Receiving Services." https://www.gov-online.go.jp/useful/article/201307/1.html. Last retrieved on June 24, 2025.

※51 MHLW. "Revision of 'Guidelines on Medical Advertising' and 'Handling of Informed Consent for Cosmetic Medical Services and Other Voluntary Treatments,' January 29, 2024." https://www.mhlw.go.jp/content/10800000/001198689.pdf. Last retrieved on July 10, 2025.

# Conclusion

Priorities in obesity policy vary by country, and in Japan, policies at both the central and local levels of government are currently inadequate. There are fewer people living with obesity in Japan than in Western countries, and the concept of “obesity disease” introduced in Japan is a relatively new one, so overall control measures have yet to catch up.

In general, health policy must determine targets of interventions based on evidence, appropriately allocate limited resources, and reduce disease burdens. On the other hand, evidence is not the only factor in the policymaking process; there are also other elements such as the scope of influence of each stakeholder, bargaining, and political power. All of these elements are insufficient in the promotion of obesity policy. This report has crystallized a number of discussion points in a comprehensive and multifaceted manner. To determine which of these discussion points to prioritize and address, it will be necessary to continue compiling scientific evidence based on data, to gather the voices of people living with obesity and other affected parties, and to deepen cross-disciplinary discussions. Action should be taken to integrate prevention, education, health promotion, health services, and healthcare and to advance obesity policy with a cross-cutting perspective.

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This summary of discussion points was compiled by Health and Global Policy Institute in its capacity as an independent health policy think-tank based on each discussion and interview for this initiative. This summary does not in any way represent the views of participating experts and other related parties or of the organizations to which they are affiliated.

## Afterword

For approximately three years, Health and Global Policy Institute has been examining the ideal state of obesity policy through collaboration with industry, government, academia, and civil society. Given our stated mission of “Achieving citizen-centered health policy,” a great motivation for these efforts has been the knowledge that the voices of people living with obesity are, more the most part, not reaching policy or the public in general, nor are they fully understood or known. Another major driving force for the continuation and advancement of this project has been our desire to amplify the voices of healthcare professionals who have been diligently accompanying people living with obesity and their families as they experience complex socioeconomic and psychological issues in addition to medical issues, and to convey those voices to policy. In the future, we will stay at this point of origin and aim to elevate QOL and extend healthy life expectancy for people living with obesity and their families and, with an overhead perspective that encompasses health policy as a whole, continue collaborating with stakeholders in Japan and overseas to contribute to progress in policies for obesity as well as to the creation of a support system that is seamless from prevention to treatment and that will correct health disparities throughout society.

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