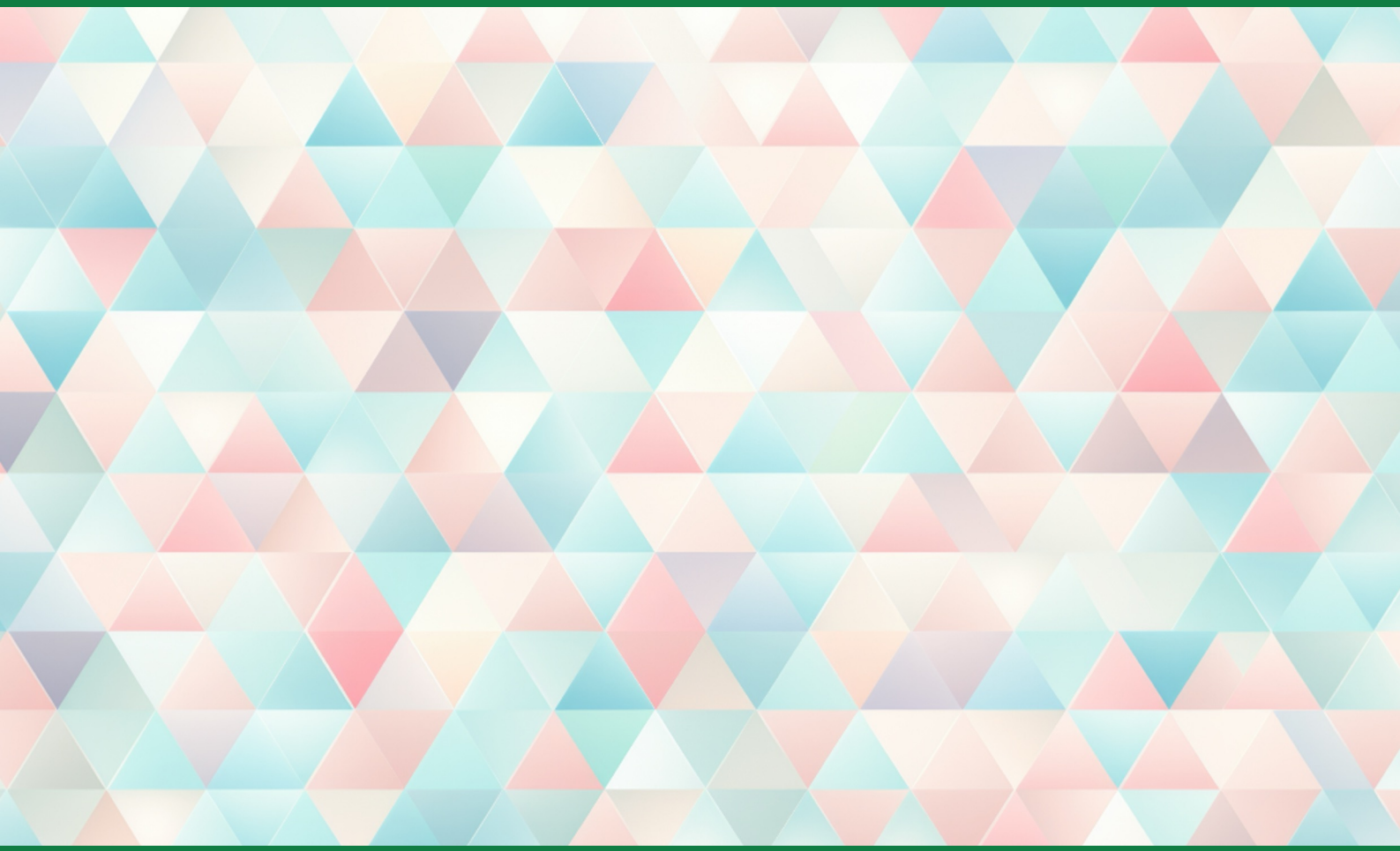
肥満症対策推進プロジェクト 公開シンポジウム（2024年12月4日）
「社会課題として考える肥満症対策～市民主体の政策実現に向けて～」報告書

日本医療政策機構（HGPI）

Obesity Control Promotion Project Public Symposium (December 4, 2024)
“Obesity Control as a Social Issue; Toward the Realization of Citizen-Centered Policies”
Event Report

Health and Global Policy Institute



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1. Introduction (Purpose and objectives of this report)

The number of people with obesity is increasing in advanced industrial countries and low- and middle-income countries, and the total number of people with obesity worldwide exceeded 2.5 billion in 2022. Consequently, the number of people living with chronic diseases caused by obesity is also on the rise, and Japan is no exception to this trend. In Japan, all insurers have been obligated to conduct specific health checkups and provide specific health guidance for obesity since 2008, and progress has been made in measures to prevent advanced chronic diseases. The final evaluation of the Second National Health Promotion Movement in the 21st Century (or "Health Japan 21 (Second Term)") found that life expectancy continues to increase, but criteria related to lifestyle habits have lacked improvement. For example, there has been no decrease in the number of people living with metabolic or pre-metabolic syndrome. Obesity is upstream of all of these underlying diseases, particularly obesity with visceral fat accumulation, and in addition to genetic and environmental factors, the temporal cascade of risk factors results in hypertension and abnormal glucose metabolism that eventually lead to arteriosclerosis, ischemic heart disease and cerebrovascular disease, and ultimately to severe outcomes like heart failure, stroke, and renal failure. As upstream interventions for obesity and obesity disease can help prevent or halt the progression of other diseases, in addition to reinforcing obesity prevention through lifestyle improvements, it will also be important to elevate society's understanding of obesity as a disease. To ensure people who need treatment are connected to the appropriate care, the preconception that obesity is only the result of personal responsibility and the stigma against obesity and obesity disease must be eliminated and measures for these conditions must be promoted throughout society through joint action among industry, government, academia, and civil society.

The Obesity Control Promotion Project at Health and Global Policy Institute (HGPI) was launched in 2022 to elevate interest toward obesity and obesity disease throughout society and to advance more effective, organic measures for these conditions. In FY2022, we gathered an advisory board of specialists representing various areas and hosted a public symposium to synthesize issues for future consideration. These findings were later compiled in policy recommendations. Based on those recommendations, in FY2023, we focused on the structure of the healthcare provision system and conducted interviews with people living with obesity and healthcare providers to create a patient journey based on the voices of those most affected. We also examined how to best structure each stage of the patient journey, from conducting health checkups to identifying people living with severe obesity and guiding them to care, as well as how to best structure the system for providing multidisciplinary treatment. We also delved into the need to prevent obesity through appropriate diet and exercise over the life course and compiled those discussions in policy recommendations. In addition, to raise awareness and identify issues related to obesity, we met with policymakers from local governments in the Hokkaido, Tohoku, and Kyushu regions to discuss obesity and other lifestyle diseases like cardiovascular disease (CVD), kidney disease, and diabetes.

In FY2024, the third year of this project, we hosted the public symposium described in this report with the aim of informing society of the issues surrounding obesity and obesity disease and necessary future measures identified over the course of our past activities. With our sights set on achieving obesity control measures that have collaboration and engagement from people living with obesity, citizens, and communities, we reflected on the latest knowledge to examine the ideal structure of systems for prevention, treatment, and healthcare provision together with experts from industry, government, academia, and civil society.

Event Overview
Date & Time: Wednesday, December 4, 2024; 13:30-18:00
JST Format: Hybrid (In-Person and Online (Zoom Webinar))
Venue: KUDAN-KAIKAN TERRACE CONFERENCE & BANQET

Program (Title omitted; in Japanese syllabary order.)

13:30-13:40 **Explanatory Introduction**
Asako Okawa (Associate, Health and Global Policy Institute)

13:45-14:05 **Keynote Lecture "Challenges of Obesity in Japan and the Measures Needed for the Future"**
Koutaro Yokote (President of Japan Society for the Study of Obesity/ President of Chiba University)

14:10-15:25 **Discussion 1**
"Roles and Collaboration of Stakeholders in Obesity and Obesity disease Management Across the Life Course"
Panelists:
Asuka Kato (Assistant Professor, Department of Health and Social Behavior, School of Public Health, The University of Tokyo)
Tsuguhiko Kato (Associate Professor, Division of Health Policy and Management, St.Luke's International University Graduate School of Public Health)
Ichiro Tatsuno (Director, Japanese Society for Treatment of Obesity/ President, Chiba Prefectural University of Health Sciences)
Seitaro Dohi (CEO, MOANA-Dohi Industrial Physician Office, Inc./ Professor of Industrial Hygiene, University of Occupational and Environmental Health/ Visiting Professor, Tokyo University of Technology)
Mihoko Yoshino (Executive Director-Medical, Diabetes Products, Japan Drug Development & Medical Affairs, Eli Lilly Japan K.K.)
Moderator: Eri Yoshimura (Senior Manager, Health and Global Policy Institute)

15:30-16:50 **Discussion 2**
"A Community-Based Obesity Care System from the Perspective of Those Affected"
Panelists:
Kazuo Kobayashi (Japan Physicians Association/ Director, Kobayashi Internal Medicine Clinic)
Atsuhito Saiki (Professor, Department of Internal Medicine, Graduate School of Medicine, Toho University)
Sayaka Tsuji (Registered Dietitian, Obesity Treatment Coordinator, Toho University Medical Center Sakura Hospital)
Izumi Hamada (Vice President, Market Access & External Affairs Division, Members of the Board, Novo Nordisk Pharma Ltd.)
Masaaki Yokota (Assistant Director-General, Health and Welfare Bureau, City of Chiba)
Moderator: Shotaro Tsukamoto (Senior Associate, Health and Global Policy Institute)

17:00 **Closing**

*Affiliations and titles are current as of time of participation.

2. Keynote Lecture "Challenges of Obesity in Japan and the Measures Needed for the Future"
Koutaro Yokote (President of Japan Society for the Study of Obesity/ President of Chiba University)

Obesity and obesity disease
The Japan Society for the Study of Obesity (JASSO) has published and updated diagnostic criteria and medical guidelines for obesity that can be used to screen for and provide appropriate care to people with a medical need for weight loss.

Obesity refers to a state of excessive fat accumulation in adipose tissue. A simple way to evaluate body fat is through Body Mass Index (BMI), which is calculated using the formula of weight in kilograms divided by height in meters squared (BMI =W[kg]/H[m]^2). The healthiest BMI is considered to be 22 to 25, as it is associated with the fewest diseases, while a BMI of 25 or higher is considered obese (in Europe and the United States, a BMI of 30 or higher is considered obese). While average BMI for type 2 diabetes is often around 30 in the West, a BMI of 23 to 24 is more common among Japanese and East Asian people with type 2 diabetes. Some individuals like athletes have BMIs of 25 or more without health problems.

Primary obesity is when an individual's BMI is 25 or higher and when secondary obesity (which includes endocrine obesity, genetic obesity, hypothalamic obesity, and drug-induced obesity) has been ruled out. "Obesity disease" is diagnosed when an individual is determined to have obesity with the presence of health disorders or visceral fat accumulation. "Severe obesity" refers to individuals with BMI≥35. Health disorders caused by or related to obesity and that are required to diagnose obesity disease include: glucose intolerance, dyslipidemia, hypertension, hyperuricemia or gout, coronary artery disease, cerebral infarction, nonalcoholic fatty liver disease (NAFLD), menstrual disorders or female infertility, obstructive sleep apnea, musculoskeletal disorders, and obesity-related kidney disease.

There are also obesity-related health disorders which are not included in diagnostic criteria for obesity disease, including colorectal or esophageal cancer (adenocarcinoma), gallstones, and bronchial asthma. Visceral fat is also a complicating factor for various metabolic diseases such as diabetes and CVD.

Current circumstances surrounding obesity treatment
Weight loss leads to significant improvements in health markers like blood pressure, lipids, blood sugar, and transaminases. This improvement is particularly noteworthy for losses of 3% or more, so the weight loss goal for people living with obesity set by JASSO is 3% or more of current body weight (and 5% to 10% for severe obesity). Weight loss is also likely to improve a number of health concerns and is considered effective from the perspective of medical economics. The foundation of obesity treatment is diet, exercise, and behavioral therapy, and it is important to support patients in their weight loss journey through team treatment involving professionals like registered dieticians, clinical psychologists, and nurses. However, maintaining lifestyle improvements is difficult, and a decrease in one's body weight triggers the biological mechanism of metabolic adaptation which attempts to restore weight and makes rebound more likely. In other words, weight loss is difficult to achieve solely through the willpower or devotion from the individual in question.

One method of treating obesity is laparoscopic sleeve gastrectomy (LSG), which reduces the size of the stomach and is mainly performed on people whose BMI is 35 or higher. This procedure was granted insurance coverage in 2014. Currently, 1,000 LSG operations are performed annually. Furthermore, in the past, there was no effective pharmacological treatment at the midpoint between lifestyle modification and surgery, but GLP-1 agonists became available for obesity in February 2024. A lipase inhibitor for reducing visceral fat is also now available over-the-counter.

The rise in obesity prevalence due to changes in the social environment
Humanity's struggle against hunger and famine reaches back to before recorded history, and we can imagine that the race for survival was won by those with access to the most food or whose bodies were best at storing nutrients. There may have also been eras when being plump was a symbol of status and beauty. However, times have changed; many foods have become cheap, and people can get around by driving cars and riding escalators rather than having to walk or pedal bicycles.

As these changes in the social environment have occurred, BMIs have increased around the world, and we are now in an era of an "obesity pandemic." Japan's most recent National Health and Nutrition Survey found that 30% of men and 20% of women have BMIs of 25 or more, while 5% of men have BMIs of 30 or more. In addition, 1.5% of men and 1% of women have BMIs of 35 or more, so this situation cannot go overlooked.

Issues to address

In taking steps to address obesity, it is also necessary to pay attention to issues associated with stigma. While genetic or physical predisposition or social factors can play important roles in the onset of obesity, public stigma increases the tendency that people will attribute obesity to personal lifestyle factors like eating habits. This exposes people living with obesity to the prejudiced view that they have poor self-control. There is also self-stigma, which is when people living with obesity perceive their condition as an issue of self-control rather than something that requires medical attention. Eliminating such forms of social and self-stigma will be an important step in elevating QOL for affected parties.

In Japan, it will also be necessary to pay attention to obesity among senior citizens. As an increasing number of people develop sarcopenic obesity, which can emerge when body fat increases while muscle mass decreases as people age, attention must also be given to helping prevent frailty and other health problems among senior citizens age 65 years and older. Data on sarcopenic obesity remains limited, so anticipation is high for future efforts to accumulate evidence.

There are also issues related to the appropriate use of obesity drugs. For example, some hospitals have reported patients being admitted to emergency departments with acute pancreatitis because they used GLP-1 agonists that were purchased online and used for weight loss despite not having regulatory approval for their effects, indications, or dosages. Such cases serve as a reminder that obesity drug treatments should only be provided to people who can benefit medically from weight loss with medically appropriate therapy and management, regardless of degree of obesity.

Over our long history, humans have developed a number of functions that increase our chances of survival in response to threats like starvation, infection, and injury. These include increased appetite, the accumulation of fat cells, the activation of immune or inflammatory responses, cell proliferation, and the formation of structures around cells in a process called extracellular matrix production. Modern living has resulted in rapid changes in our living environment, particularly in diet and exercise, and it is believed that these elaborate mechanisms which were once beneficial for our survival have failed to adapt and are now manifesting in the form of obesity and obesity disease, or comorbid conditions like atherosclerosis or diabetes. With an understanding of these facets of evolutionary biology and a basis in diet, exercise, and other lifestyle modifications, we must implement the necessary and appropriate pharmacotherapy and surgical treatments to elevate QOL.

Photographed by: Kazunori Izawa

3. Discussion 1
"Roles and Collaboration of Stakeholders in Obesity and Obesity disease Management Across the Life Course"

Purpose of this panel discussion
While obesity or obesity disease are impacted by a variety of complex factors like lifestyle, genetic predisposition, or socioeconomic and psychological issues, society does not fully understand or recognize the reality of this situation. Another major issue is stigma toward people living with obesity or obesity disease held by the general public and healthcare providers. In this panel discussion, we discussed the best methods of providing education, awareness-raising, and health programs for the prevention of obesity and obesity disease throughout the life course, from childhood to adulthood. We also examined the roles of stakeholders representing industry, government, academia, and civil society in each measure and how they can collaborate to establish a social environment that is conducive to measures for obesity and obesity disease.

Panelists:
Asuka Kato (Assistant Professor, Department of Health and Social Behavior, School of Public Health, The University of Tokyo)
Tsuguhiko Kato (Associate Professor, Division of Health Policy and Management, St.Luke's International University Graduate School of Public Health)
Ichiro Tatsuno (Director, Japanese Society for Treatment of Obesity/ President, Chiba Prefectural University of Health Sciences)
Seitaro Dohi (CEO, MOANA-Dohi Industrial Physician Office, Inc./ Professor of Industrial Hygiene, University of Occupational and Environmental Health/ Visiting Professor, Tokyo University of Technology)
Mihoko Yoshino (Executive Director-Medical, Diabetes Products, Japan Drug Development & Medical Affairs, Eli Lilly Japan K.K.)
Moderator: Eri Yoshimura (Senior Manager, Health and Global Policy Institute)

- **The characteristics of obesity issues in Japan from an epidemiological perspective**
  - Japan experienced a period of food insecurity after World War II and improving nutrition was the main concern. In school health, for example, this meant that emphasis was placed on addressing malnutrition among children through school lunch programs. The number of obese children quadrupled over the approx. 20 years of the Japanese economic miracle (from 1955 to 1973). While this number stabilized around 2000, it has started to increase again in recent years, and the Health Japan 21 (Second Term) target for childhood obesity has not been met. A similar increase can be found among adults in Japan, with the number of men living with obesity doubling since the 1980s. This trend has been accompanied by an increase in related health issues, such as an increase in type 2 diabetes.

  - One company is seeing an increase in obesity among people in their 20s and 30s. In the past, even among people who tended toward obesity before age 30, the number with obesity or lipid abnormalities decreased by the time they reached their 50s and 60s. Today, however, people are experiencing greater risks of obesity and other health concerns the more they age.

  - Comparing characteristics of people in Japan to those in Europe and America, Japanese people are less likely to store subcutaneous fat and more likely to store visceral fat. Visceral fat accumulation is associated with more health problems and is strongly associated with the risk of developing macrovascular disease. One characteristic of Asian people is that it is difficult to get a full picture of their health through appearance or BMI like people from Western countries.

Obesity, obesity disease, and society
- **The components and social impact of stigma**
  - American sociologist Erving Goffman defines stigma as when an individual is "disqualified from full social acceptance" due to characteristics, attributes, disabilities, or other features that distinguish them from "normals."

- People who are subject to stigma develop negative emotions known as “prejudice” that are generated from negative perceptions known as “stereotypes,” which ultimately leads to behaviors known as “discrimination.” This entire process is called “public stigma” (Corrigan PW, et al. World Psychiatry, 2009).

- Bruce G. Link and Jo C. Phelan identify the following five components of stigma.
  1. Distinguishing and labeling differences
  2. Associating human differences with negative attributes
  3. Separating “us” from “them”
  4. Status loss and discrimination
  5. Social and economic segregation

  Stigma is a combination of these factors that interact to create severe social or economic exclusion that includes deprivation from educational and employment opportunities. Therefore, stigma is a major social problem that transcends discrimination.

- Stereotypes of overweight and obesity include “generalizations that individuals with overweight or obesity are lazy, gluttonous, lacking in willpower and self-discipline, incompetent, unmotivated to improve their health, non-compliant with medical treatment, and are personally to blame for their higher body weight” (Rubino F, et al. Nature Medicine, 2020). Although this is a finding from research conducted in Europe and the U.S., similar findings have been reported in Japan in data on diabetes stereotypes. In the future, research on obesity and obesity disease-related stigma in Japan must be advanced and evidence must be accumulated. It will be particularly important to give careful consideration to the topic of stigma in the processes of advancing measures for obesity and obesity disease.

➢ **Stigma toward people living with obesity or obesity disease among healthcare professionals**

- Some healthcare professionals possess insufficient understanding toward the condition of obesity itself and hold the assumption that people living with obesity lack self-control or are lazy. Such preconceptions can be a factor that hinders treatment. We must also not allow ourselves to overlook the small stigmas that accumulate over the course of everyday communication in real-life clinical settings. To eliminate this prejudice and discrimination in the healthcare sector, building understanding of the pathophysiology of obesity and raising awareness will be essential.

➢ **Stigma toward employees living with obesity or obesity disease**

- The Industrial Safety and Health Act states that disease risk for individuals is a matter that employers should take into consideration to ensure that workplaces are safe. This means that it is prohibited by law to treat employees in an unfavorable manner because of diseases that are detected through health checkups or other means. In workplaces where occupational health systems have not been fully established, such as at SMEs or sole proprietorships, there are cases in which the safety net provided by this law is not fully functional. After building understanding and awareness of this law, employers and occupational health providers must respond to all forms of stigma and unfavorable treatment.

- Real-world working conditions for people living with obesity or obesity disease must be examined to determine if workplace environments allow them to continue working safely, if they are being treated unfairly, or if they are being discriminated against by employers. To link disease recognition to medical examination-seeking behavior, through whole-of-society efforts, it will be important to establish workplace environments where people can work with peace of mind even if they are diagnosed as overweight or obese.

➢ **Whole-of-society efforts in which obesity is not perceived as a matter of personal responsibility**

- It is undeniable that in some respects, the emphasis on prevention in the public health sphere has fostered the attitude that obesity is a matter of personal responsibility. In addition to diet, exercise, and other efforts undertaken by individuals, obesity and obesity disease control include various support measures for weight loss. This means it will be important for local governments and communities to engage in society-wide efforts to convey positive messages regarding health promotion and to provide targeted support measures.

- One major corporation's internal survey found significant regional disparities in obesity rates. They tended to be lower in areas relatively rich in nature where people still follow traditional diets and lifestyles, such as rural areas, and higher close to major urban areas. Findings like this suggest that obesity is not just a problem for individuals, but is something that is greatly impacted by environmental and social factors. As such, it will be essential for communities and businesses to work together to carry out comprehensive and continuous measures to transform organizational and social climates.

➢ **Promoting understanding of obesity and raising awareness of evidence-based treatments**

- It will be important to spread broad recognition that obesity and obesity disease are different. Steps must be taken to advance multi-regional clinical trials and efforts to accumulate real-world clinical evidence to communicate to more people that weight loss is effective in improving health disorders starting with diabetes and dyslipidemia.

- Awareness must be raised toward the fact that treatment options for obesity are not limited to diet, exercise, and cognitive-behavioral therapy, but also include internal therapies like surgery or new forms of pharmacotherapy. An important step in achieving this will be to continuously generate evidence on the therapeutic impact of weight loss like improvements to health disorders or reduced risk of macrovascular disease. Evidence demonstrating the socioeconomic benefits of obesity treatment (such as its potential to reduce the cost of healthcare or the burden of medical expenses) should also be presented.

➢ **Stigmas hindering prevention and interventions among working-age adults**

- Occupational health has been slow to define obesity as a disease or to implement systems for its intervention. However, to address future health risks, there is attention being paid to obesity prevention and changes in body weight, and interventions are being made after weight gain has been detected. In addition to the population approach, there is also a high-risk approach which stratifies obesity. However, messages to encourage better exercise and eating habits tend not to reach the people who need to implement such changes. When implementing the high-risk approach, it is difficult to determine how far such messages can go before they become bothersome to recipients. Targeting high-risk individuals with messaging may offend them and make them feel alienated, and can lead to the problems of labeling and stigma.

- Among people who witnessed their parents or grandparents with diabetes encounter unfair treatment due to stigma, some express concerns like "I am scared of being diagnosed with diabetes after a health checkup and being branded as a 'diabetic.'" It has been reported that this thinking leads to a tendency to avoid health checkups. Similar concerns toward obesity and obesity disease may be having an impact on health checkup-seeking behavior and access to support.

Obesity and obesity disease in children

➢ **The need for health education from early childhood**

- Over the course of providing obesity treatment, some healthcare providers have come to understand that about half of adults with severe obesity already had a tendency toward obesity during childhood, which has convinced those healthcare providers of the need for early education. The necessary knowledge on nutrition needed for a healthy life at an appropriate weight should be something that is acquired naturally over the course of communal living. While the original purpose of school lunch programs was to improve nutrition, discussions on their role in the era of overnutrition are ongoing. It is also essential that people develop physical exercise habits in childhood. Starting with measures against obesity and obesity disease, society must support healthy growth for children who will shoulder the future by providing education on maintaining a balanced diet and appropriate exercise habits and by determining how to best create systems to support health.

- The Ministry of Education, Culture, Sports, Science and Technology (MEXT) Annual Report of School Health Statistics Research shows that the number of children living with obesity is on the rise. However, sufficient analyses from the perspectives of public health and epidemiology that encompass background

factors like regional disparities have yet to be conducted. The National Institute of Population and Social Security Research has found that half of all births in recent years have been in metropolitan areas in Tokyo, Chiba, Kanagawa, Saitama, Osaka, and Fukuoka Prefectures, so it will be necessary to consider measures that reflect an understanding of the characteristics of and differences in child-rearing environments in each region while keeping the population distribution in mind.

- **Providing interventions for children living with obesity or obesity disease and their families through collaboration among diverse stakeholders**
  - Because some children may already develop obesity by the time they start elementary school, it will be necessary to consider methods of protecting the health of preschool-age children.
  - Because 95% of preschool children attend kindergartens, daycare centers, and certified childcare centers, approaches made through such facilities are likely to be effective. Nursery school and kindergarten teachers have a good grasp of home conditions for children and will be important points of contact for enabling early interventions.
  - Providing interventions that target specific households or individuals places heavy burdens on those receiving interventions and hurdles for reaching them are high. To overcome these challenges, networks or mechanisms that provide appropriate screening of children and households to determine who needs intervention and that naturally connect people to support should be established.
  - Nutritional management and health interventions for children provide effective paths for communicating the importance of health literacy to parents. Looking at obesity rates among members of the parents' generation, data from the 2019 National Health and Nutrition Survey shows that for men, 29.4% those ages 30 to 39 and 39.7% of those ages 40 to 49 live with obesity. It is well-known that the health of parents has a significant impact on children. Because approaches based on occupational health are effective in improving obesity among fathers, there should be more organic collaboration between the fields of pediatrics and occupational health in the future.
  - In addressing obesity and obesity disease among children, a population approach in which interventions are provided to an entire group regardless of degree of obesity risk is less likely to result in stigma than the high-risk approach in which children who require intervention are identified through screening and provided with interventions individually. It will be necessary to advance efforts for obesity prevention with whole-of-community efforts that include parties like childcare facilities, educational institutions, government agencies, and health institutions. For example, in Okinawa Prefecture, a school and community have collaborated on introducing a program using elementary school physical education guidance coordinators. Efforts to analyze the effects of that program are underway, and an interim analysis conducted by academia has found it to be effective to a certain degree.
  - Primary care physicians have important roles to play in measures for childhood obesity and obesity disease. Expectations are high for primary care physicians to fulfill their roles as family doctors by paying attention to family socioeconomic issues when examining a child while also keeping the health of the parents and other factors in mind. Given the strong relationship between these health conditions and local food cultures, administrative dieticians also have important roles to play in responding to obesity and obesity disease. It will also be necessary for primary care physicians' medical associations and specialists at municipal governments to strengthen their collaboration so primary care physicians can provide patients with referrals to specialists when obesity disease is suspected.

Obesity and obesity disease in the field of occupational health

- **Expectations for Industrial Safety and Health Act revisions to strengthen occupational health's role in chronic disease control**
  - Only 5% of the workforce serves at large-scale enterprises with over 1,000 employees with industrial physicians on staff. Conversely, enterprises with fewer than 50 employees are not required to have industrial physicians on staff, meaning they tend to have less capacity for providing medical checkups,

health guidance based on checkup results, and recommendations for medical examination. Furthermore, the Industrial Safety and Health Act covers employed workers, so people serving in primary industries are not included in its scope. To ensure working-age adults can benefit from health services fairly, we should set our sights on eliminating disparities in insured health services among insured people that are rooted in occupations and workplace environments, and it will be necessary to consider revising the Industrial Safety and Health Act to that end.

- Employers are obligated to report the prevalence of health concerns detected during employee medical checkups to Labor Standards Inspection Offices, but obesity and obesity disease are not included in those reports. Altering this system in the future to include people whose BMI meets or exceeds the criteria for obesity will make it possible to detect obesity more effectively and clarify obesity rates in companies. The necessary first step will be grasping actual circumstances at companies. In order to visualize the results of such checkups in a manner that gets companies to introduce countermeasures, it will be important to establish systems for disclosing population data from health checkups in an easy-to-understand manner.

➢ **Advancing effective interventions and measures for working-age adults**

- Interest in health among working-age adults is growing, particularly among those who are younger. While some people would like to keep a proper weight to maintain their health, an increasing number of people are prioritizing building muscle mass and or other activities that do not necessarily take overall health into account, especially men. While the act of building muscle mass itself is not undesirable, preconceptions that focus on items like building muscle while ignoring overall balance may distract people from the original goal of maintaining health.

- While companies have made progress in health management initiatives, their main focus has been work style reform and benefits. Obesity rates and metabolic syndrome are the foundation of employee health, but the impact of these initiatives in reducing obesity rates and metabolic syndrome has not been properly evaluated as elements of health management. Promoting measures for obesity and obesity disease in occupational health will require returning to this foundational concept of health and reexamining the nature of health management.

- Most cases of obesity develop from when people are in their 20s, or around the age when they enter the workforce, to their 40s, when specific health checkups begin. As a result, specific health checkups and specific health guidance must face cases of obesity that have already developed, which makes interventions aiming for improvement more difficult. This occurs because the older a person gets, the more fixed their lifestyle habits become, the more their basal metabolism slows, and the more difficult it is for them to lose weight. This means it is more effective to begin measures for obesity in companies when employees are younger. Some companies are currently implementing exercise programs for employees in their 20s and 30s held during working hours that are beginning to show results in reducing the weight for the target groups as a whole. For adults who are middle age or older, while maintaining efforts to encourage weight loss, it is necessary to reduce cerebrovascular disease and heart disease through the proper management of conditions where risk increases with age, like dyslipidemia, diabetes, and hypertension. In this manner, it will be important that further measures include strategies tailored to each age group, and one characteristic of occupational health is that it has the capacity of providing such measures.

- The key points of chronic disease control are “partners” and “meddling.” Expectations are high for the elevation of social capital so colleagues, who are “partners,” will properly “meddle” in each other’s affairs.

➢ **Utilizing digital transformation (DX) to ensure no one is left behind in chronic disease measures, including those for obesity**

- Health checkup attendance rates declined further after the COVID-19 pandemic, so one issue is how to improve uptake among those who have not attended checkups. Health professionals have limited resources, so efforts must be devoted to efficiently elevating health awareness through collaboration among industry, government, academia, and civil society and the use of IT and social networks to

strengthen disease prevention, early detection, and early intervention.

- In light of current issues like birthrate decline and labor shortages and based on the fact that Japan's society is structured in a manner that economic disparities lead to health disparities, there are risks that Japan may face a further expansion of obesity and other chronic diseases. To address this, it will be essential to have the intent to remain close to and protect the health of every community member while strengthening the support proactively provided to vulnerable groups who are more prone to social isolation.

- Using Personal Health Records (PHRs), it has now become possible to track daily changes in weight and blood pressure in real time. Despite the presence of issues like personal information management or securing financial resources for healthcare DX promotion, a new era is approaching in which personal data is gathered using the latest technology and utilized by society for early detection and intervention.

Photographed by: Kazunori Izawa

4. Discussion 2
"A Community-Based Obesity Care System from the Perspective of Those Affected"

Purpose of this panel discussion
Although people living with obesity face a variety of issues, their voices have not yet been gathered and visualized to an adequate degree. This makes it difficult for society to recognize their challenges, and their voices have hardly been reflected in policy. Given this background, in this discussion, we identified issues faced by people living with obesity and examined how to connect those who require interventions to the healthcare they need at the right times. We deepened discussions on the need to provide early detection and intervention in primary healthcare, to develop a multidisciplinary and specialized healthcare provision system, and to achieve further equity in care nationwide. We also examined how to best structure measures for obesity with whole-of-community action with a holistic perspective that encompasses healthcare and support for daily life.

Panelists:

Kazuo Kobayashi	(Japan Physicians Association/ Director, Kobayashi Internal Medicine Clinic)
Atsuhito Saiki	(Professor, Department of Internal Medicine, Graduate School of Medicine, Toho University)
Sayaka Tsuji	(Registered Dietitian, Obesity Treatment Coordinator, Toho University Medical Center Sakura Hospital)
Izumi Hamada	(Vice President, Market Access & External Affairs Division, Members of the Board, Novo Nordisk Pharma Ltd.)
Masaaki Yokota	(Assistant Director-General, Health and Welfare Bureau, City of Chiba)

Moderator: Shotaro Tsukamoto (Senior Associate, Health and Global Policy Institute)

- **Efforts from HGPI in FY2023 to compile the voices of people living with obesity and related parties**

*To promote discussions from the perspectives of those most affected, we shared a portion of our findings to open the discussion.
As part of our FY2023 efforts, HGPI conducted interviews with people living with obesity and compiled a patient journey detailing their experiences and opinions over the entire process leading up to examinations at medical institutions specializing in obesity, and subsequent treatments (HGPI, 2023). Their voices can be arranged into the five categories described below.

- Difficulties encountered before arriving at a specialized obesity treatment facility (because affected parties did not know that obesity is a disease or that that treatment would be covered by insurance, etc.)
- Challenges experienced at other health facilities, such as stigma (for example, being told "Come back after you lose weight" at facilities not specializing in obesity treatment)
- Experiences at specialized obesity treatment facilities (compassionate care, help arranging visits to multiple departments, etc.)
- Circumstances after surgery (developing optimism or hope, finding employment, etc.)
- Comments and opinions about obesity disease itself (e.g., there is no need to revise the name "obesity disease" because it clearly conveys its intended meaning)

- **Delays to interventions caused by insufficient awareness of obesity disease among affected parties and healthcare providers**
  - Many people living with obesity and those close to them do not think of obesity as a disease. They visit a health facility and say, "I am not sick, but can I be examined?" and when they are examined, it is often discovered that they actually do have a health concern, such as irregular urinary protein or irregular menstruation. There are also cases in which health checkups detect no abnormalities other than urinary protein and physicians decide to wait and provide follow-up later, and when the patient visits the hospital seven or eight years later, it is discovered that their kidney function has declined to the point they already need dialysis. In such cases, it is desirable that the patient had visited the hospital earlier to begin the weight loss process.

  - Even if a person meets the criteria for obesity with a BMI of 25 or higher, if other checkup findings are

within normal ranges after a specific health checkup, they are not eligible for specific health guidance. This is a systemic blind spot in interventions for people living with obesity.

- While there has been progress in treatments for obesity that are covered by insurance in recent years, some health institutions have been offering weight loss treatments and similar services that are not covered by insurance and are not always evidence based. Some people serving in clinical settings have reported that this causes people living with obesity to develop the misconception that they cannot receive insurance coverage for treatments that are in fact eligible.

- When physicians in other specialties like orthopedics and obstetrics and gynecology give people living with obesity or other affected parties instructions to lose weight, they should not only say, "Lose weight." Instead, they should provide specific instructions like, "You need to lose this many kilograms to start treatment." It is also desirable that they recommend seeking medical consultations with specialists in obesity treatment.

- The most common health disorder for obesity is type 2 diabetes, so obesity is often seen by diabetologists. However, diabetologists do not always have thorough knowledge of health disorders other than diabetes. For example, they might not know that weight loss can help manage Polycystic Ovary Syndrome (PCOS), which can cause menstrual disorders and infertility. This illustrates the need to broadly inform healthcare professionals that obesity treatment and weight loss can improve many health problems in addition to diabetes.

- According to data from one dialysis clinic, it was reported that almost 10% of people receiving dialysis had a history of having a BMI of 35 or higher (Onozaki, et al. Obes Facts. 2021). Dialysis accounts for a large proportion of social security spending, so the correlation between obesity and dialysis is also important from the perspective of health economics. The data also shows that urinary albumin and other markers for kidney function are not often measured in people with diabetes (Sugiyama, et al. Diabetes Res Clin Pract. 2019). Abnormal urinalysis findings are given less attention than blood tests and this can often lead to delays in patient referrals to nephrologists, so it will also be important to reinforce efforts to raise awareness of urinalysis and kidney disease.

➢ **Challenges for obesity treatment in primary care**

- Almost nobody sees a primary care physician with obesity or obesity disease as their chief complaint. Sometimes, they seek their initial examination for obesity after being consulted about their weight by a family member after being diagnosed with another condition, like hypertension. However, primary care physicians are not paying sufficient attention to obesity and, to begin with, few clinics focus on obesity treatment.

- Measuring body weight in clinics should become common practice, as is the case with blood pressure. Normally, clinics treat obesity complications like hypertension, diabetes, and dyslipidemia, and they do so by following up using data on items like blood pressure, blood glucose, hemoglobin A1c, and lipid metabolism. However, body weight measurements for obesity and obesity disease are rarely taken outside of regular medical checkups and other such opportunities, so it is likely that most cases rely on self-reporting. However, measuring body weight will make it possible to track its relationship with urinary protein, which can be expected to help build recognition among patients and raise awareness toward obesity treatment.

- Simple, effective obesity treatments should be incorporated into routine primary care. Many people who undergo examinations for obesity think, "I have to lose 10kg," but someone who weighs 100kg can actually avoid having to increase a medication dosage or even lower their dosage with a body weight reduction of just 3%, or 3kg. Recommending people to weigh themselves when they take their blood pressure at home can also make it possible to track changes in their body weight. It is important to provide weight management in a manner that reflects the motivation of the affected party. For example, someone who can manage their weight effectively should be provided with positive feedback for continuous

management, while someone who has trouble managing their weight might benefit from having their condition clearly shown to them, such as by using a CT scan to visualize their visceral fat. In this manner, it is important to engage in communication with the affected party to find methods of encouraging behavioral modification that are well-suited to them.

- The 2024 revision of the medical service fee schedule requires the inclusion of target weights in treatment plans when applying for the Lifestyle Disease Management Premium. Progress is then checked every four to six months together with the patient. This has elevated recognition of body weight and it provides an opportunity to raise obesity awareness among primary care physicians.

- Nutritional guidance and weight management are effective methods of treating and providing guidance on lifestyle diseases including obesity. Clinics should actively consider incorporating guidance services provided by registered dietitians. It is possible to apply the Outpatient Nutritional Guidance Premium at clinics and even remotely. Many primary care physicians provide care alone, so it will be important to implement systems for nutritional guidance that are financially sustainable and make effective use of such premiums for the treatment of obesity and for managing related lifestyle diseases.

➢ **Systems and frameworks with the potential to enhance collaboration among hospitals and clinics**

- Expanding obesity treatment coordinators will be important in promoting hospital-clinic collaboration. While primary care physicians and specialists can collaborate more easily if they are acquaintances, many physicians are uncertain if they should provide references to specialists, particularly for obesity, and hesitate to consult them at that stage. Placing obesity treatment coordinators at specialized health institutions creates easily-accessible points of contact for all varieties of inquiries from third parties, and can be effective for primary care physicians.

- The Primary Care Services Reporting System will begin operations in April 2025. As this initiative requires the establishment of systems to treat various diseases and to refer patients to specialists when necessary, it will no longer be acceptable for those involved in it to say, “We do not know about obesity and obesity disease,” and it may lead to the promotion of obesity treatment. However, the Primary Care Services Reporting System requires health institutions with the capacity to provide integrated, continuous treatment for highly-prevalent diseases and other routine treatments to people who require continuous care (which the Ministry of Health, Labour and Welfare defines as the first function of primary care) to report such capacity for 40 diseases in 17 areas. However, obesity is not included among them. Many patients fit the diagnostic criteria for obesity and obesity disease and the actual number of people living with these conditions is likely to be higher than statistics suggest, so it is desirable that the MHLW definition of the first function of primary care is expanded to include obesity in the future.

- In their role as providers of continuous healthcare, it is important that primary care physicians secure referral pathways to connect patients to specialists for conditions that lie outside the scope of the primary care physician’s specialty. For severe obesity in particular, ensuring sufficient access to care will require further disseminating and visualizing information on which health institutions can provide specialized treatment.

➢ **The role of the government in establishing regional obesity healthcare provision systems**

- One role that basic local governments are expected to play in obesity control is making arrangements among stakeholders. Specifically, it will be important for various local government departments like Health and Welfare Divisions and Health Promotion Divisions to collaborate and help guide residents to suitable consultation services or departments at health institutions, schools, or businesses. Another key role of municipalities will be raising awareness to ensure residents possess accurate knowledge about obesity.

- Chiba City, a university, and a pharmaceutical company have signed an agreement to collaborate on measures for obesity and obesity disease. Through their three-way agreement on government, industry, and academia collaboration, Chiba City aims to establish an environment for obesity and obesity disease

and to become a model city for a healthier society. Its initiatives can be categorized into five specific areas: (1) items that help improve understanding of obesity and obesity disease among community members and healthcare providers (by using Chiba City's public relations channels to raise awareness, hosting public lectures, etc.); (2) items related to analysis of obesity and obesity disease among NHI enrollees in Chiba City (by grasping circumstances surrounding people without obesity, with obesity, or with severe obesity using NHI data or specific health checkup data); (3) items related to obesity and obesity disease in Specific Health Checkups and Specific Health Guidance (by examining items to screen for obesity in Specific Health Checkups, by introducing obesity guidance in Specific Health Guidance, etc.); (4) items related to support for children's health (through lifestyle improvement initiatives targeting both diet and exercise for children ages 6 through 12, by examining health-related screening items in health checkups for 3-year-olds, etc.); and (5) other items that contribute to measures for obesity and obesity disease. In its role as a model city, Chiba City would like to gather evidence and disseminate it throughout Japan.

- One effective obesity control measure that local governments can implement for their residents is to create lists of local health institutions that treat obesity and obesity disease. While it may be feasible to rely on a system in which health institutions voluntarily participate in creating lists, such a method may not be fully effective for identifying all health institutions where such treatments are available. To overcome this, it will be necessary for local governments to clarify which treatments each health institution can provide (such as pharmacotherapy or surgical treatment) and prepare lists of health institutions that are easy for residents to use.

- In Chiba City, efforts are underway to proactively provide residents with recommendations to visit health institutions for people who have not attended medical examinations despite specific health checkup results that determine examinations are necessary. Chiba City is also conducting a three-year follow-up program that aims to prevent the need for dialysis among people at high risk of developing diabetic nephropathy or advanced diabetic nephropathy. While it would be ideal for people to possess an awareness toward body weight or health and modify their behavior on their own, they may need a third party to encourage them to take the first step in doing so. In its current state, the main purpose of conducting specific health checkups is to screen for metabolic syndrome. In the future, Chiba City would like to research and develop more effective methods of approaching obesity and obesity disease through its collaborative agreement.

- One challenge municipalities face is determining how to enhance the impact of specific health checkups and specific health guidance efficiently despite tight financial circumstances as the insurers for National Health Insurance. To address this, local governments have high expectations for the national Government to conduct detailed analyses of success stories and challenges in past efforts for chronic disease control and to share optimal policies, particularly with specific examples of financial support and efficient methods of approach.

➢ **Disseminating and raising awareness of accurate information on diseases and treatments**

- One role of pharmaceutical companies in contributing to treatment is through developing and marketing pharmaceuticals, but they also recognize that it will be important for them to take part in responding to obesity by collaborating with people living with obesity and other affected parties, local governments, and health institutions to disseminate accurate information on obesity, to encourage suitable treatments, and to contribute to elevating QOL.

- Many people do not know about surgical treatment options or believe that weight loss is something achieved on one's own, without recognizing that this is different from weight loss achieved under medical guidance from a hospital. It seems there is a need to raise awareness toward obesity disease itself and to disseminate correct information regarding obesity treatment. First of all, it is important to receive a medical examination at an appropriate health institution to obtain an objective grasp of one's physical state through blood tests or other examinations, and to receive dietary guidance from a specialist. An important aspect of obesity treatment is establishing a suitable living environment while consulting with a healthcare provider in an ongoing manner.

- In the area of kidney disease, the Japan Kidney Association and a pharmaceutical company launched a joint mass media advertising campaign to raise awareness of the importance of an indicator of kidney function called glomerular filtration rate (GFR). Through television commercials and other media, they have been communicating the message, "Please consult a doctor if your GFR is 59 or below." This helped raise awareness of GFR and the need to seek a medical consultation early. It may be possible to adopt a similar approach for obesity control. The criteria for obesity (a BMI of 25 or more) is particularly important for Japanese people. For example, it might be effective if a health-related organization and a pharmaceutical company were to collaborate on an awareness campaign with the message, "Having a BMI of 25 or more increases your risk of lifestyle diseases," while transmitting appropriate information on obesity and health risks.

- The concept of cardiovascular-kidney-metabolic (CKM) health was introduced by the American Heart Association (AHA) in 2023 (Ferdinand KC, 2024). It refers to the relationships among the heart, kidneys, and metabolic health, particularly the interplay among metabolic risk factors like visceral fat accumulation, chronic kidney disease (CKD), and the cardiovascular system. CKM health has significant impacts on morbidity and mortality for various related diseases and has a high associated incidence with CVD and cardiovascular mortality. It is desirable that primary care physicians and other healthcare professionals will inform the broader public about CKM health alongside obesity and obesity disease.

➢ **Understanding psycho-socioeconomic issues experienced by people living with obesity and other affected parties**

- Health issues like mental distress or sleep apnea that accompany obesity and obesity disease often have an impact on work and can cause some people to miss work or even leave the workforce. There are also times when issues behind the mental distress like developmental disorders or intellectual disabilities go overlooked, making it important to have a thorough understanding of patients' conditions on an individual level.

- Some people living with obesity may experience psychological issues like overeating, but there is currently no data on how many of these cases exist. Furthermore, efforts to diagnose obesity disease have yet to become widespread, making it difficult to obtain accurate statistical information from medical claims data, specific health checkup data, and other databases. However, clearly identifying the actual causes of obesity and its complications using data will be a vital step in considering which approaches will be effective.

- It can be difficult to fully grasp the psycho-socioeconomic issues patients face only through medical examinations provided at health institutions, so it will be necessary to connect and visualize people living with obesity or obesity disease through networks that include government initiatives to determine how many people are experiencing such issues. If such data can be obtained and linked to health data, it will also be possible to gauge the benefits of obesity treatment, such as the degree of economic benefit provided by pharmacotherapy or surgical treatments that achieve social recovery for affected parties.

➢ **Providing people living with severe obesity with multidisciplinary and specialized obesity treatment in an equitable manner**

- Obesity disease can result in a wide variety of health concerns, so it requires a multidisciplinary response that involves physicians from each relevant field and various other healthcare professionals such as nurses, registered dieticians, physical therapists, pharmacists, social workers, and clinical psychologists.

- "Team treatment" sounds effective, but it is something that cannot function properly only by having multiple healthcare professionals on hand. For example, responding to a patient with a body weight of 150kg who must decrease their body weight to 80kg for a necessary orthopedic knee surgery requires providing surgical and pharmacological treatment for obesity and for every healthcare professional involved to pool their wisdom for the patient to receive the orthopedic surgery they need. This means the team providing orthopedic surgery and the team treating obesity must communicate with each other and develop a detailed treatment plan. This is multidisciplinary treatment in its truest sense.

- In many cases, people living with severe obesity also experience other issues like various comorbid health concerns, mental distress, family concerns, or financial problems, and unraveling their complex circumstances requires that health professionals work together. However, in Japan's current healthcare provision system, departments are divided by organ, and patients must visit different departments on different days of the week. Providing care in a scattered manner such as this creates major burdens for patients and high hurdles for medical examinations, so methods must be devised to coordinate care across departments, such as by arranging schedules so examinations in multiple departments can be performed on the same day.

- Obesity treatment coordinators listen to patients' problems and work together with them to create strategies for continuing treatment. For example, their jobs might involve making appointments or rescheduling with many departments, or attending medical examinations together with patients to ask physicians what patients cannot ask. Obesity treatment coordinators provide a centralized consultation service that facilitates patient communication and treatment adherence. In addition, allowing coordinators to handle cross-disciplinary arrangements provides opportunities to advance multi-disciplinary collaboration among healthcare professionals like physicians, nurses, and dieticians.

- The number of hospitals that can provide surgical treatment is limited, but if patients have facilities nearby where they can receive follow-up after surgery, it may be acceptable if the medical facility providing surgical treatment is somewhat far away. Rather than increasing the number of facilities, a more realistic measure for achieving equity in specialized obesity treatment may be to improve systems for follow-up that encourage collaboration among health institutions.

➢ **Promoting the appropriate use of drugs**

- Pharmaceutical companies follow standards set by the Optimal Clinical Use Guidelines when selling obesity drugs to health institutions, but biosimilars for certain drugs such as those for diabetes can be purchased online, and there have been reports of these causing health damage. While working to grasp needs in real-world healthcare settings, initiatives to encourage the optimal use of medicines will also be advanced to improve this situation.

- Ensuring the appropriate use of obesity drugs will be an essential step in making sure patients can enjoy the proper benefits of those drugs. However, certain restrictions in the Optimal Clinical Use Guidelines do not reflect real-world clinical circumstances, and these drugs are not being delivered to the patients who need them. An environment in which obesity drugs can be prescribed to the right patients must be created.

- Currently, drugs with the same active ingredients as obesity drugs are being widely prescribed by primary care physicians to treat diabetes, and most primary care physicians are well-informed and experienced with their effects on weight loss and their clinical effectiveness. A framework should be built that ensures these drugs are prescribed more appropriately to the people who need them that ensures proper use while relaxing restrictions meant to avoid their overprescription.

- When someone starts seeing weight loss success through pharmacotherapy for obesity, they develop a positive outlook toward treatment and it deepens trust between the patient and the primary care physician. This makes it easier to formulate specific treatment plans like, "Take a break from the medication once you lose 5kg." Expectations are high for future guidelines and systemic reforms to enable prescription practices that suit such real-world clinical circumstances.

➢ **Supporting treatment adherence and continuous care**

- It can be difficult for patients to return to their communities after undergoing pharmacotherapy or surgical treatment at a medical institution specializing in obesity if there are no clinics that can provide follow-up located nearby. It will be necessary to build systems that enable ongoing support in communities. For example, such systems might involve collaboration with local clinics to provide patients with examinations from specialists every six to twelve months.

- Efforts to advance a two-person system in which primary care physicians and nephrologists cooperate in providing follow-up are currently underway in the area of kidney disease. However, because attending examinations at a specialist health institution can place heavy burdens on patients, it may be acceptable to consider more moderate forms of collaboration when their condition is stable. It may be possible to implement a similar system for obesity in which primary care physicians would provide follow-up after receiving reverse referrals from specialists.

- Being provided with strict guidance to prevent weight rebound as part of obesity treatment can lead to psychological burdens, particularly for people living with mental health problems. This can cause people to stop seeing their primary care physician. As primary care physicians have many points of contact with patients for blood pressure control, vaccinations, and other care, primary care physicians have important roles to play in health management for patients. They must develop good relationships with patients and serve as a bulwark that prevents patients from dropping out of treatment through their interactions over the course of routine medical services.

Photographed by: Kazunori Izawa

5. Acknowledgments
We express our deepest gratitude to everyone who lent their cooperation. Please note that these recommendations were compiled by HGPI in its capacity as an independent health policy think tank, and that they do not in any way represent the views of any related party who assisted in their creation, or of the organizations to which those parties belong.

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