

Health and Global Policy Institute (HGPI)
Cardiovascular Disease Control Promotion Project

Enhancing Health Checkups for More Effective Early Cardiovascular Disease Detection and Intervention

Lessons From a Survey on Post-Checkup
Care-Seeking Behavior Among Working-Age Adults

August 2026

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| Introduction

Introduction

In Japan, measures for cardiovascular disease (CVD) have advanced steadily under the Basic Act on Countermeasures for Stroke, Heart Disease and Other CVDs to Extend Healthy Life Expectancies, which was enacted in 2019. After the first phase of the National Plan for the Promotion of Measures Against Cerebrovascular and Cardiovascular Diseases was formulated in 2020, each prefecture has established its own Prefectural Plan for CVD Control that reflects local conditions. With progress in areas such as the launch of model projects for Integrated Centers for Stroke and Heart Disease Support in 47 prefectures in FY2025, healthcare provision systems and consultation support systems are beginning to take shape. However, CVD has the tendency to progress without subjective symptoms, so in addition to establishing these systems, making early risk identification and early intervention more effective will be vital for the prevention of CVD progression. In particular, general health checkups and screenings conducted at workplaces, in schools, or as part of community health (hereafter referred to collectively as “health checkups”) provide an opportunity for the early identification of CVD risk and serve as a pivotal point for linking affected parties to appropriate care, but substantial progress will be necessary to establish a framework that ensures people seek the care they need after a health checkup. In addition to improving the rate of uptake for health checkups, viewing the entire process from attending health checkups to seeking medical care as integrated and adopting a perspective to enhance its effectiveness will be essential.

A recent big data analysis on working adults whose health checkups detected atrial fibrillation found that they are approximately 5 and 18 times more likely to be hospitalized for a cerebral infarction or heart failure in the future.¹⁾ It has also been shown that when people whose health checkups detect a high risk of progression seek medical care within three months, they have a significantly lower risk of hospitalization for stroke or heart failure than people who do not seek a consultation.²⁾ Furthermore, it has been reported that 66% of these high-risk individuals did not visit healthcare facilities for consultations within one year.³⁾ This finding suggests that risks detected during health checkups are not being effectively connected to subsequent consultations or the prevention of progression. Meanwhile, among studies being conducted to address these challenges, a large-scale cluster-randomized intervention study involving National Health Insurance (NHI) enrollees has produced noteworthy results. It showed that planned health guidance provided by public health nurses was more effective at encouraging medical care-seeking behavior among people whose health checkup results identified them as high risk, and that their guidance helped improve control of blood pressure or blood glucose.⁴⁾ As these examples show, issues related to consultation attendance after health checkups are diverse, and include the content of consultation recommendations, how those recommendations are conveyed, the design of paths to encourage consultations, the data linkage infrastructure, systems for supporting medical treatment in the workplace, and ensuring that the health checkups which form the foundation for all of these are of high quality. Rather than attributing these issues solely to the awareness or behaviors of individuals, they must be viewed as challenges that span both the system and how it is operated.

Against this backdrop, aiming to identify issues related to post-health checkup CVD consultation uptake and to examine solutions to those issues, HGPI conducted interviews with parties such as people living with CVDs, others with lived experience with CVDs, healthcare professionals, local government representatives, and companies. We also conducted a survey of working-age adults ages 30 to 59 to identify factors that drive behaviors related to seeking medical care for CVDs after health checkups. Based on findings from the interviews and survey, we then hosted meetings of experts from industry, government, academia, and civil society for multi-faceted discussions on issues and countermeasures for the phase in which people seek medical care after health checkups. Based on those discussions, these recommendations present feasible measures from the following four perspectives: (1) promoting post-health checkup consultation recommendations with a basis in evidence; (2) refining target groups for priority intervention and developing a data linkage infrastructure; (3) strengthening workplace support systems that help people seek medical care; and (4) achieving equitable standards of quality for health checkups to create a foundation for helping people seek care after checkups. Ensuring that health checkups are not only opportunities for medical care but also serve as an effective mechanism that guides people to early detection, treatment, and prevention of CVD progression will be important for future CVD control. It is our sincere hope that these recommendations encourage collaboration among local governments, insurers, the private sector, medical facilities, and other relevant parties; that they help build regional bonds; and that they help produce a concrete system design and operational improvements for more effective post-health checkup medical care.

*In the context of post-checkup care-seeking behavior, these recommendations use the terms “medical care” or “consultation” to describe services received at a medical facility (such as reexamination, closer examination, consultation, or treatment) in response to recommendations to seek further medical attention (for reexamination, more detailed testing, or medical care) after a health checkup.

1) Mori, Y., Sawano, M., Kohsaka, S., Tsugawa, Y., Yanagita, M., & Fukuma, S. (2025). Screening-detected atrial fibrillation and cardiovascular outcomes in working-age adults. *Circulation*, 152(19), 1338–1347.
<https://doi.org/10.1161/CIRCULATIONAHA.125.074433>

2) Dong, J.-Y., Iso, H., Muraki, I., Tanaka, M., & Imano, H. (2024). Timing of clinic visits after health checks and risk of hospitalization for cardiovascular events and all-cause death among the high-risk population. *Atherosclerosis*, 388, 117409.
<https://doi.org/10.1016/j.atherosclerosis.2023.117409> <https://doi.org/10.1016/j.atherosclerosis.2023.117409>

3) Iso, H. (2022). Cohort study on preventive effects of medical facility visits among high-risk individuals for advanced lifestyle diseases –Interim report. Program and Abstracts of the 8th Japan Health Insurance Association Research Forum (pp. 8–9). Japan Health Insurance Association.

4) Iso, H., Noguchi, M., Yokoyama, T., Yoshida, T., Saito, I., Shintani, A., Sairenchi, T., Nishizawa, H., Imano, H., Kitamura, A., & Shimomura, I. (2023). Effect of a community-based program to accelerate referral to physicians for individuals at high-risk of lifestyle-related diseases: A cluster randomized trial. *Journal of Atherosclerosis and Thrombosis*, 30(1389), 1389–1406.
<https://doi.org/10.5551/jat.64100>

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| Recommendations

Promoting post-health checkup consultation recommendations with a basis in evidence

Build evidence for methods of providing consultation recommendations that encourage people to seek care soon after checkups, and strengthen efforts to introduce those methods in ways that suit the characteristics and needs of local governments and insurers

It has been pointed out that CVD tends to progress without subjective symptoms, and that it is difficult to encourage people to seek medical care simply by notifying them of health checkup results. With this backdrop, the Ministry of Health, Labour and Welfare (MHLW) has issued standards for and sample phrases to use in post-health checkup consultation recommendations, and local governments and other insurers are now advancing efforts to provide consultation recommendations, including in real-world clinical settings. However, as findings from our survey show, factors that prevent people from seeking medical care after health checkups vary greatly by each target group's characteristics and living environments. Instead of simply implementing uniform measures, enhancing post-health checkup medical care in the future will require clarifying which information presentation and support methods are effective for which target groups, organizing such evidence in a manner that facilitates the use of those methods by local governments and insurers, and taking steps to ensure those methods are adopted.

1-1

Taking the psychological, physical, and economic barriers to seeking medical care into account, build evidence on the best methods of presenting information and providing care-seeking support to encourage behavioral change

Currently, consultation recommendations are provided in accordance with standards such as the national Government's guidance for specific health checkups titled the "Standard Health Checkup and Health Guidance Program (FY2024 version)." That program provides a framework for conveying results according to assessment categories and for providing consultation recommendations based on physician judgment. However, many health checkup result notifications only include lists of test values and simplified assessments. These limitations make it difficult to convey overall future risk in an intuitive manner. Our survey also found that certain groups do not understand what checkup findings mean or do not perceive checkup results as health issues that require immediate action. Also, some conditions that cause CVDs like hypertension, hyperglycemia, and dyslipidemia tend to progress asymptotically. The absence of pain or discomfort means people do not feel endangered, which can create psychological barriers to seeking medical attention. In addition to individual attitudes, factors that prevent people from seeking medical care after a health checkup can also vary due to their type of health insurance and their living environment, which determines medical facility access. Our survey findings suggest that while respondents with employee health insurance emphasize the importance of access to reexamination during working hours, NHI enrollees have relatively high needs for support in finding healthcare institutions and for guidance to consultations. We also found that respondents emphasize different factors according to the size of their place of residence. Important factors for triggering medical care-seeking behavior included which parties convey health checkup results, whether an estimated cost is included, how future risk is presented, and whether consultations can be attended during working hours. Given these findings, while taking various studies and verifications on health checkup and consultation promotion into account, steps must be taken to verify and accumulate evidence on which information presentation and consultation support methods maximize behavioral change when tailored to the characteristics of each target group.

1-2

Once evidence is established, implement it in a manner that is tailored to the characteristics of municipalities and insurers and link it to continuous operational improvements

Effectively encouraging post-health checkup behavioral change will require implementing and utilizing evidence-based consultation recommendations (described above) in real-world care settings. However, many consultation recommendation programs from local governments and employee insurers only use a uniform approach to recommendations, and efforts to tailor recommendations to the characteristics of each target group or to regional and workplace characteristics are still lacking. In the future, it will be important to arrange evidence in easy-to-utilize formats and disseminate it through model projects, guides, and other such methods so municipalities and insurers can provide consultation recommendations flexibly according to enrollee characteristics such as region, occupation, or size of employer. When doing so, insurers should make proactive use of existing financial resources and frameworks such as the Municipal NHI "Health Up" Program in the area of CVDs, and position evidence-based recommendation methods among target initiatives. We hope to see this operational framework undergo continuous evaluation and review with the PDCA cycle to encourage early medical consultations after health checkups.

Perspective 2

Refining target groups for priority intervention and developing a data linkage infrastructure

Clarify target groups for priority intervention and build a data linkage infrastructure that supports consultation recommendations

limited nature of human and financial resources, determining who to prioritize for interventions will also be a vital part of actively promoting post-health checkup consultation recommendations. The current system includes thresholds for recommending consultations, and some insurers (such as local governments and health insurance societies) are actively implementing programs to encourage people to attend post-health checkup consultations. On the other hand, constraints on human and financial resources make it difficult for many insurers to take adequate measures. Therefore, providing effective and efficient consultation recommendations will require integrated action on two issues. First, for advanced CVD prevention, after verifying that current standards are adequate, steps must be taken to stratify and further examine standards based on target population and risk levels. Second, regarding health checkup data and treatment information that supports these decisions, information coordination among parties such as healthcare institutions, local governments, and employee health insurers should be strengthened to establish an environment that ensures rapid access to the necessary data for accurately determining the need for intervention.

2-1

Verify existing standards for consultation recommendations and refine criteria for identifying target groups for priority intervention

While certain local governments have actively pursued consultation recommendation programs for people whose health checkups identify them as at-risk for CVD in recent years,⁵ those programs often use uniform methods when reaching out to people who have not sought care. Maximizing results in advanced CVD prevention with limited human and financial resources will require greater clarification of who should be prioritized in efforts to connect people with abnormal checkup results to medical care. Therefore, we must verify that the basis for setting existing consultation recommendation thresholds is consistent with medical guidelines and determine if those thresholds are adequate for advanced CVD prevention. This evaluation should include examining how thresholds can be best applied in light of personal risk factors like comorbidities or lifestyle. At the same time, we must give further consideration to approaches for establishing multi-tiered recommendation criteria as well as determining order of priority based on the risks of each target group.

2-2

Electronically link data held by healthcare institutions and local governments and emphasize human resources

One prerequisite for appropriately selecting and supporting high-priority target subjects with recommendations for consultations related to CVD will be having a framework for the electronic management and utilization of individual health checkup data. However, the digitalization or individual management of health checkup test data is not mandatory. While such data is used in lieu of health checkup data in the system that allows for workplace health checkup findings to be used to exempt individuals from specific health checkups, there are still cases in which healthcare institutions rely on paper data collection methods or handle data in a case-by-case manner. Both of these factors increase administrative burdens for local governments. These administrative tasks are diverting human resources that originally should have been directed toward providing personal support to untreated or high-risk priority patients or groups. Therefore, it is urgent we accelerate efforts to digitalize medical examination and health checkup data, link data among healthcare institutions and local governments, and create a system that allows for the efficient lookup of health checkup results or treatment status. Advancing efforts to create such a system will make it possible to focus resources on reaching out to patients who require early intervention.

2-3

Eliminate fragmentation in data caused by people changing jobs or retiring, and strengthen coordination among insurers

The gaps in health data that emerge when people switch insurance providers pose major challenges for the continuous monitoring of their health status. The change in insurer that occurs after a job change or retirement makes it difficult to ensure that health checkup results, treatment histories, and other personal health information can be continuously transferred, hindering efforts to smoothly provide high-risk individuals with consultation recommendations or to stay up-to-date on their current condition. Linking data across insurers will be essential for addressing such issues. Specifically, it will be necessary to establish a foundation for the continuous sharing or utilization of health checkup or medical claims data under the leadership of the national Government. This effort should also include collaboration among local governments (which are responsible for NHI) and the Japan Health Insurance Association (JHIA) and other providers of employee health insurance that operate on a national scale, as well as encouraging the use of the My Number health insurance card.

Strengthening workplace support systems that help people seek medical care

Establish support systems that take company sizes and workstyles into account and that encourage people to seek medical care after workplace health checkups

Many working-age adults are provided with opportunities for health checkups through the workplace. Because the workplace environment has a significant impact on subsequent medical care-seeking behavior, the workplace provides an important foundation for CVD prevention and early treatment. To a certain extent, the current system provides a framework for evaluating the efforts of insurers. However, the division of roles among companies, insurers, and occupational health staff in the workplace means that post-checkup support for consultations is not always managed in a coordinated manner. There are also major differences in occupational health resources and support systems depending on company size. Small-scale companies in particular encounter limitations when implementing independent efforts. Within this context, collaboration among industry and insurers must be strengthened, consultation support systems that allow people to balance work and medical care must be developed, and support models that are feasible for companies of any size must be disseminated. During that dissemination, it will be important to leverage industry associations, public occupational health resources, and existing infrastructure for collaboration.

3-1

Strengthen links between health and productivity management and health data, and establish support systems that enable people to balance treatment and work

Because working-age adults spend most of their time in the workplace, the workplace is an important foundation for supporting prevention and early treatment for CVDs. Our survey found that “time of reexamination” had a significant impact on medical care-seeking behavior for respondents covered by employee health insurance, which suggests that being able to strike a balance between work and medical care is crucial for consultation uptake. In Japan’s current system, “rate at which people who meet criteria for recommendations to seek prompt medical care actually seek care at healthcare institutions” is included among the comprehensive evaluation metrics for adjustments in the Medical Care Assistance for the Elderly Aged 75 and Over system, thereby establishing a framework to evaluate efforts to guide people from health checkups to consultations. However, in the workplace, consultation recommendations do not always lead to actual medical treatment, even when abnormalities are detected at health checkups. Some people fail to seek care because they are too busy or have few subjective symptoms, while others find it difficult to attend consultations during working hours. There are also times when different offices have different systems for collaboration among companies and insurers, or varying levels of involvement from occupational physicians and occupational health staff. Addressing these issues will require introducing joint efforts from companies and insurers to clarify the division of roles and foster information coordination among human resources departments, occupational health staff, and insurers; establishing systems that allow employees to receive medical care during working hours; and creating routes that provide easier access to care. Rather than focusing only on treatment outcomes in insurer evaluation, it will be vital to assign more weight to metrics related to improving consultation uptake, as well as to provide insurers with incentives to encourage consultations. Visualizing the results of corporate initiatives so management can understand and accept their impact from a managerial perspective will be important for accelerating these efforts. To accomplish this, short- and medium-term indicators must be combined with long-term outcome measures, such as the degree of contribution to disease risk, and methods that make it possible to confirm effectiveness early on must be devised.

3-2

Establish and disseminate treatment support models that can be implemented throughout the workforce, including at small and medium-sized enterprises (SMEs)

Given the limited human and financial resources available at SMEs, especially small enterprises, it is often challenging for them to allocate resources to occupational health systems or to establish their own treatment support systems. The majority of Japanese companies are SMEs, most of which are small enterprises.⁶⁾ Small enterprises with limited occupational health resources must be positioned as important targets to elevate standards for post-health checkup consultation recommendations among all workplaces. As part of that effort, instead of relying solely on independent initiatives from each company, links among insurers, industry associations, and companies must be leveraged to build a framework that can be implemented at any company, regardless of size. One option may be to expand this framework through industry organizations with the assumption that health risks faced by employees are risks or losses that are specific to each sector. In certain sectors, under frameworks provided by industry, government, and academia, there are already operational models in place to conduct screening for major diseases or to encourage post-health checkup consultations in a manner that is tailored to the characteristics of each industry. There is great potential for such frameworks to be expanded outward to other industries with similar conditions.

At the same time, it will be crucial to utilize existing public occupational health resources to support small enterprises. As Comprehensive Occupational Health Support Centers and Regional Occupational Health Support Centers provide companies with fewer than 50 employees with free guidance or advice on health management based on health checkup results, they can be positioned as a public infrastructure for upholding medical consultation support at small enterprises. However, in a survey conducted by the Japan Organization of Occupational Health and Safety (JOHAS) in FY2024, 85.9% of responding industry associations had never heard of these Centers,⁷⁾ which suggests that industry associations are not effectively providing access to the Centers. While individual small enterprises can use those Centers on their own, this is unlikely to result in widespread use in the workforce. Therefore, industry associations should be positioned as points of entry for these Centers, and a system should be established in which both parties collaborate in promoting awareness and encouraging use of the Centers.

In addition, utilizing the existing infrastructure for sharing best practices and practical knowledge will be important in expanding such initiatives across the workforce. The Secretariat of the Kenko Investment for Health (KIH) Certification aggregates and disseminates best practices from various companies through its portal site, while the Health & Productivity Management Alliance serves as a platform for collaboration with academia that surpasses the boundaries separating industries, occupations, and companies. While leveraging these communication infrastructures and collaboration opportunities, we must steadily build an environment in which know-how on data utilization, effective intervention methods, and operational models for promoting medical consultations that are tailored to each sector can be shared and expanded throughout the workforce.

Perspective 4

Achieving equitable standards of quality for health checkups to create a foundation for helping people seek care after checkups

Advance efforts to make health checkups equitable in terms of quality to serve as the foundation for post-checkup treatment support

In addition to establishing the support systems described above, an important aspect of steadily advancing post-health checkup consultation support will be creating an environment that enables the necessary health checkup results (that meet specific standards regardless of where checkups are conducted) to be obtained and utilized continuously for decision-making and support. This survey found that the types of health checkup facilities are not uniform. We identified a variety of facilities that conduct checkups, including specialized checkup facilities and local healthcare institutions. Given the diversity of health checkup providers, equitable standards of quality for health checkups should be encouraged to provide a shared foundation for the effective implementation of the recommendations described in previous sections. Therefore, in addition to making effective use of existing certification systems and accuracy management frameworks, it will be necessary to further advance measures for equity in health checkup quality by expanding healthcare digital transformation (DX) to promote the use of health checkup data.

4-1

Ensure health checkups are high-quality by utilizing existing certification systems and quality control frameworks

Ensuring that health checkups meet certain quality standards and that their results are usable regardless of where checkups are conducted are key conditions for ascertaining who to prioritize for guidance to treatment based on checkup results. As equipment, physician specialties, and systems vary among facilities providing health checkups, creating an environment in which all facilities meet certain quality standards for health checkups will also be important. Certification systems and quality control initiatives for health checkup facilities have been introduced by organizations such as the Japan Society of Health Evaluation and Promotion or the Japan Society of Ningen Dock and Preventive Medical Care, and we hope to see more widespread use of existing frameworks such as these in the future. At the same time, promoting awareness of certification systems and quality control initiatives among local governments, insurers, and people receiving health checkups will be useful in encouraging the spread of high-quality checkups.

4-2

Advance efforts to leverage health checkup data (including for longitudinal comparisons) and encourage its practical application in clinical settings through healthcare digital transformation

There are high expectations that analyzing health checkup results to track changes over multiple years will lead to more accurate risk assessments. Data integration is making it possible for individuals to track changes in their health over time, even if the facility where they receive health checkups varies from year to year. This is thanks to progress in tools like Mynportal, which allows users to view annual trends in information such as specific health checkup information. On the other hand, the usefulness of health checkup results varies depending on the characteristics of the item in question. For example, changes are easy to track when using numerical data like blood pressure or blood test results, but opportunities to use accumulated test results are more limited for tests like the electrocardiogram, where directly referring to the waveform itself is important for diagnosis. Given these differences, we must consider how to best share data according to the characteristics of each item checked. In addition to promoting the establishment of a data infrastructure, it will also be important to examine how to best encourage and support the effective use of data at healthcare institutions or facilities providing health checkups and provide incentives related to operations so the health checkup data that is accumulated can be used for actual risk assessment and decision-making, thus further improving health checkup quality.

5) MHLW. (2025). FY2024 National Health Insurance Health Up (Support) Program: Case Studies of Advanced Model Projects. <https://www.mhlw.go.jp/content/001463828.pdf>

6) The Small and Medium Enterprise Agency. (2023). "Number of Small and Medium-Sized Enterprises and Business Operators: Survey Results on the Number of SMEs and Small-Scale Business Operators (as of June 2021)." https://www.chusho.meti.go.jp/koukai/chousa/chu_kigyocnt/2023/231213chukigyocnt.html

7) Industrial and Occupational Health Department, Occupational Health Division, Japan Organization of Occupational Health and Safety (JOHAS). (2025). FY2026 Comprehensive Support Project for Occupational Health Programs: Outcome Survey Report. https://www.johas.go.jp/wp-content/uploads/2026/03/R6sanpo_outcomehoukokusyo.pdf



Survey Findings

“Survey on Post-Checkup Care-Seeking Behavior
Among Working-age Adults at Risk for Cardiovascular Disease”

1

Summary

Survey Overview

This survey was conducted on men and women ages 30 to 59 whose health checkup results included abnormal findings related to CVD to compare factors that influence medical care-seeking behavior, such as undergoing reexamination or visiting a healthcare institution for consultation after a health checkup. The survey was conducted online in February 2026 and received valid responses from 432 respondents (216 in the group that sought consultations and 216 in the group that did not). Respondents who visited a healthcare institution within one year of receiving a recommendation for consultation were defined as the “consultation group,” while respondents who took more than one year or who did not visit a healthcare institution were defined as the “non-consultation group.” In addition to comparing the two groups, we also used choice-based conjoint analysis to analyze factors that influence care-seeking behavior.

Key Findings

Characteristics of the consultation and non-consultation groups

Among the consultation group, the proportion of respondents with primary care physicians or who participated in community activities was significantly higher than the non-consultation group. This suggests that being connected to the healthcare system or the community may be associated with the decision to seek a medical consultation.

The following findings emerged when comparing respondents (432 people) based on whether or not they had attended a consultation.

- Has a primary care physician: consultation group, 81.9%; non-consultation group, 44.0%
- Participates in community activities one or more times per month: consultation group, 32.9%; non-consultation group, 11.1%
- Experienced severe subjective symptoms: consultation group, 12.0%; non-consultation group, 3.7%
- Experienced no subjective symptoms: consultation group, 55.6%; non-consultation group, 66.7%
- Has no plans to improve lifestyle habits: All respondents, 17.1%; Men, ages 50 to 59, 21.9% (highest among all genders and age groups)

Overall Preference Patterns Based on Conjoint Analysis

The relative importance of the six attributes was as follows.

Attribute	Importance (Overall)
Person recommending reexamination	28.8%
Presentation of estimated cost	19.9%
Presentation of risk information	15.3%
Time of reexamination	14.4%
Healthcare institution location method	14.0%
Presentation of reexamination period on results notification	7.6%

For each attribute, the levels that showed markedly positive utility values (i.e. factors that encourage care-seeking behavior) were “results notification sent to home or workplace only,” price listed as “around 3,000 to 5,000 yen,” “notification includes risk of onset or treatment cost simulation if condition goes ignored,” and “consultations available during working hours.” Conversely, the levels that showed negative utility values (i.e. factors hindering care-seeking behavior) were “consultation recommendations provided by nurse or public health nurse in-person or by phone,” “lack of information regarding cost,” and “need to search for a healthcare institution and make an appointment on one’s own.”

When comparing the consultation group and the non-consultation group, the consultation group showed higher positive utility for price listed as “around 3,000 to 5,000 yen” and “notification includes risk of onset or treatment cost simulation if condition goes ignored,” while the non-consultation group showed relatively higher positive utility for “notification of results only.” Focusing on costs, utility values for prices listed as “around 3,000 to 5,000 yen,” “up to around 10,000 yen,” and “no estimated costs listed” decreased in that order, indicating a clear preference for the provision of specific cost figures.

Preference Patterns by Segment

Preference patterns varied by type of insurance coverage. Primary subscribers to employee health insurance assigned higher relative importance to “person recommending reexamination” than other groups. They also tended to emphasize “time of reexamination.” Compared to employee health insurance enrollees, NHI enrollees tended to assign higher importance to “healthcare institution location method” and “presentation of estimated cost.” Among dependent employee health insurance subscribers, preferences were characterized by a greater negative utility for the “need to search for a healthcare institution and make an appointment on one’s own” compared to primary subscribers to employee health insurance.

We also observed differences in preference patterns by place of residence. Among respondents in the non-consultation group, “time of reexamination” was more important for those living in large cities than it was for other members of the non-consultation group, while “presentation of estimated cost” was more important among respondents living in small- and medium-sized cities than it was for those residing in large cities. Preferences may vary among people who have not attended medical consultations according to the size of their place of residence.

We also observed differences in preference patterns based on the presence or absence of subjective symptoms and consultation history. The segment of the non-consultation group that reported severe symptoms assigned more importance to “methods of searching for healthcare institutions” and “time of reexamination” compared to other segments, while placing relatively less importance on the “presentation of estimated costs.” This segment may tend to place relatively greater emphasis on factors related to access and time.

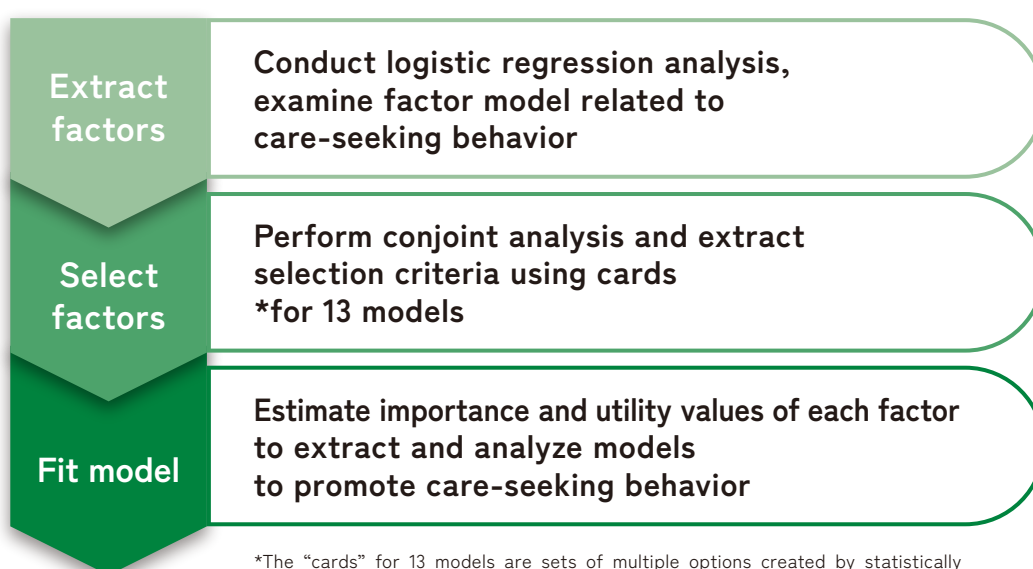
In addition to shared factors like cost, person serving as source of information, and indications of risk, these findings suggest that tailored interventions which reflect health insurance status, place of residence, and presence or absence of subjective symptoms may be effective in encouraging post-health checkup care-seeking behavior.

It is important to note that this survey was conducted using an online panel, so it is likely to reflect the preferences of groups accustomed to utilizing information using digital technology. Therefore, caution should be exercised when interpreting these findings to avoid overgeneralization.

2 Survey Overview

Objective

To compile these recommendations, we conducted a quantitative survey to examine effective, data-based measures for encouraging individuals with health checkup findings related to CVD to attend reexaminations or medical consultations. To identify the characteristics of people who seek medical consultations and combinations of approaches that might actually contribute to care-seeking behavior, we combined a preliminary analysis using logistic regression with choice-based conjoint analysis (CBC; hereinafter “conjoint analysis”).



*The “cards” for 13 models are sets of multiple options created by statistically combining attributes and levels related to reexamination recommendations.

Fig.1 Overall Survey Design

Survey Structure

This survey was conducted in two phases: the preliminary survey and the main survey. In the preliminary survey, we performed a logistic regression analysis to identify candidate factors associated with post-health checkup care-seeking behavior. The conjoint analysis for the main survey was designed using the findings from that analysis. We then conducted the main survey and its analysis.

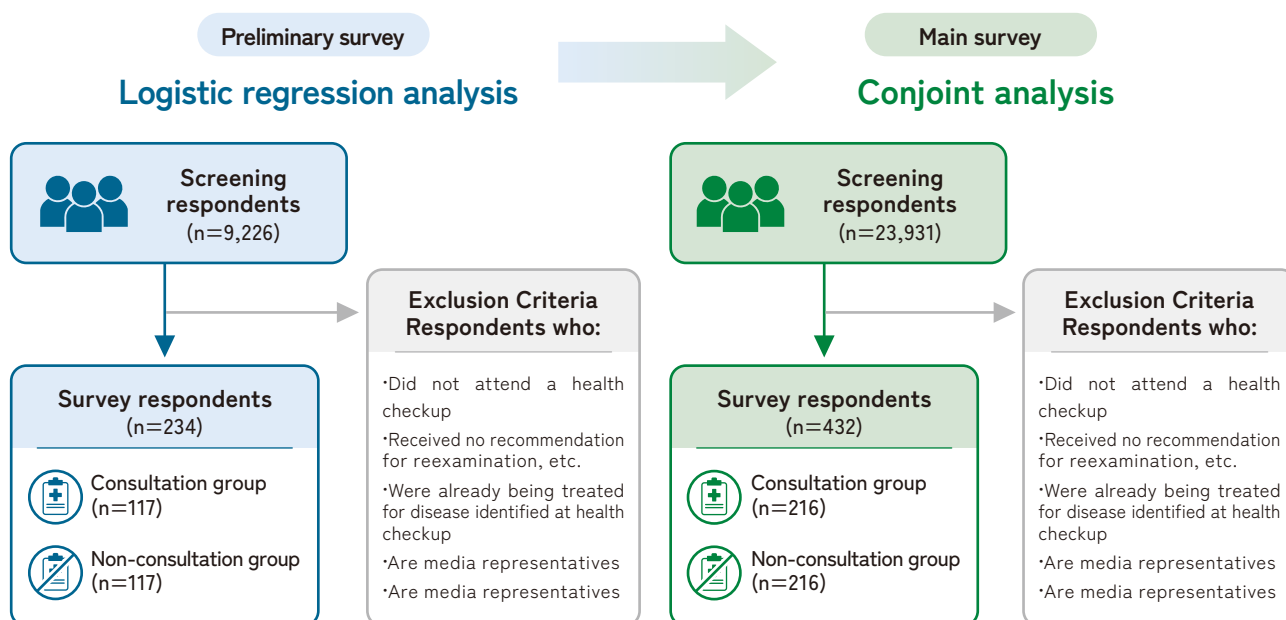


Fig.2 Survey Structure and Respondent Flowchart

Introducing the Conjoint Analysis

To compare and estimate the impact of various conditions on care-seeking behavior, this survey used conjoint analysis in which respondents were presented with sample consultation recommendation notifications containing different combinations of conditions (cards) and then asked to select the option where it would be easiest for them to seek care. Respondents were presented with three consultation recommendation packages and the option “none of the above” for each question. We then estimated the relative importance of each attribute and utility values by level based on respondents’ choices.

3

Survey Methodology

*The term “survey” in the following text refers to the conjoint analysis (the main survey).

Participants

Participants were selected from an online panel of men and women ages 30 to 59 residing in Japan and who underwent a Specific Health Checkup or routine health checkup provided in accordance with the Industrial Safety and Health Act (excluding extensive “human dock” examinations) between January and December 2024, and who were subsequently recommended reexamination, closer examination, or treatment for items related CVD based on checkup results. Participants who visited a healthcare institution within one year of receiving such a recommendation were defined as the “consultation group,” while those who visited a healthcare institution over one year later or who did not visit a healthcare institution were defined as the “non-consultation group.” Sampling was distributed according to population composition ratios based on the FY2020 National Census and adjusted by age, gender, and place of residence.

Data Collection

The survey was conducted via a self-administered online questionnaire. After a screening survey was used to confirm whether participants had attended a health checkup and if any CVD-related issues had been identified, the main survey was distributed to eligible participants. A total of 23,931 people responded to the screening survey, yielding 432 valid responses. The survey period was from February 16 to February 20, 2026.

Survey Items

The survey items were composed of various background characteristics including: health checkup attendance; CVD-related findings; post-checkup consultation attendance; presence of a primary care physician; community involvement; intention to improve lifestyle habits; subjective symptoms; understanding, sense of urgency, or information-seeking behavior after receiving checkup results; health literacy; type of health insurance; employment status; annual income; and educational background. We also established the following six attributes for the conjoint analysis of factors promoting post-health checkup care-seeking behavior, described below.

Attributes	Levels
Person recommending reexamination	• Reexamination recommended in-person or over the phone by physician • Reexamination recommended in-person or over the phone by nurse or public health nurse • Reexamination recommended only through results notification (paper or digital) sent to the home or workplace
Presentation of risk information	• Notification only presents risk in numbers and grades from A to E • Notification shows changes in test results over time with graphs • Notification includes risk of onset or treatment cost simulation if condition goes ignored
Healthcare institution location method	• One finds a healthcare institution and makes an appointment on one’s own • A list of healthcare institutions near the home or workplace is provided with checkup results, and one makes an appointment on one’s own • Upon request, a coordinator finds a healthcare institution and helps schedule a reexamination
Presentation of estimated cost	• Around 3,000 to 5,000 yen (a similar amount to municipal cancer screenings, such as for colorectal or lung cancer) • Up to around 10,000 yen (a similar amount to an endoscopy for stomach cancer screening or imaging for breast cancer screening) • No specific information on estimated cost listed

Attributes	Levels
Presentation of reexamination period on results notification	• A specific timeframe is listed (e.g., “We recommend attending a consultation within three months”) • No specific timeframe is listed (only vague descriptions like, “Soon”)
Time of reexamination	• During working hours (considered part of work) • Outside working hours (not considered part of work) *Full-time homemakers and unemployed respondents were asked about weekdays or weekends instead of during or after working hours

Table 1 Conjoint Cards (Attributes and Levels)

The conjoint analysis cards presented respondents with three options combining each attribute and level and the option, “None of the above.” Respondents were asked to then choose the option where it would be easiest for them to seek care.

Ethical Considerations

This survey was conducted among people who consented to participate after being shown an on-screen explanation on the objectives of the study, the intended use of responses, the voluntary nature of participation, the option to withdraw at any time during the survey, and that data would be collected and analyzed in a way that individual respondents could not be identified. Personal information that could be used to identify respondents (such as name or address) was not collected, and the analysis was conducted using anonymized data.

Analytical Method

In this survey, we used descriptive statistics and cross-tabulations to compare the background characteristics and perceptions of health checkup results between the consultation and non-consultation groups. For the conjoint analysis, we adopted a Choice-Based Conjoint (CBC) model to obtain orthogonal, closed-ended individual data. Using a full-profile format, respondents were presented with three consultation recommendation packages and a “none of the above” option across seven choice tasks. We estimated utility values via the hierarchical Bayesian (HB) method, calculated relative importance scores, and conducted comparisons by segment. Model fit was verified using McFadden’s R^2 .

Limitations

The online nature of this survey limited respondents to internet users, introducing potential sampling bias. In addition, this study employed a retrospective design relying on self-reported health checkup results and follow-up consultation timelines. Because time had passed between when participants were informed of health checkup results and when they responded to this survey, results may reflect preferences formed after participants’ sense of urgency had diminished or may be impacted by measurement errors due to self-reporting. As this is a cross-sectional study, a causal relationship between care-seeking behavior and the various factors cannot be directly inferred. Furthermore, as an online panel survey, the sample may be biased toward a demographic that is relatively health-conscious or accustomed to using digital technology to gather and utilize information. Conjoint analysis is a method based on stated preferences and does not fully reflect actual care-seeking behavior.

4 Survey Findings

1. Respondent Characteristics

Main respondent characteristics are given in Table 2.

Variable	Total (n=432)	Non-consultation group (n=216)	Consultation group (n=216)	Test	p-Value
Demographic variables					
Age, mean (SD), in years	48.2 (7.5)	49.3 (7.0)	47.1 (7.8)	MWU	0.0041
Gender				x²	1.000
Male	302 (69.9)	151 (69.9)	151 (69.9)		
Female	130 (30.1)	65 (30.1)	65 (30.1)		
Educational background				x²	0.103
High school	109 (25.3)	63 (29.3)	46 (21.3)		
Vocational school	43 (10.0)	23 (10.6)	20 (9.3)		
Technical/junior college	33 (7.6)	12 (5.6)	21 (9.7)		
University	204 (47.3)	98 (45.4)	106 (49.1)		
Graduate school	30 (6.9)	11 (5.1)	19 (8.8)		
Other	7 (1.6)	4 (1.9)	3 (1.4)		
Declined to respond	6 (1.4)	5 (2.3)	1 (0.5)		
Employment status				x²	0.216
Full-time employee or executive	274 (63.4)	135 (62.5)	139 (64.4)		
Civil servant/Public organization employee	42 (9.7)	14 (6.5)	28 (13.0)		
Self-employed	18 (4.3)	11 (5.1)	7 (3.3)		
Part-time employee	50 (11.6)	26 (12.0)	24 (11.1)		
Contract/dispatch employee	16 (3.7)	9 (4.3)	7 (3.3)		
Full-time homemaker	12 (2.8)	9 (4.3)	3 (1.4)		
Unemployed	20 (4.6)	12 (5.6)	8 (3.7)		
Weekly working hours				x²	0.599
Under 40 hours (avg. under 8 hours/day)	135 (31.3)	66 (30.6)	69 (31.9)		
40 to 60 hours (avg. 8 to 12 hours/day)	235 (54.4)	117 (54.3)	119 (55.1)		
60 to 80 hours (12 to 16 hours/day)	29 (6.7)	14 (6.5)	15 (6.9)		
Over 80 hours (over 16 hours/day)	8 (1.9)	6 (2.8)	2 (0.9)		
Household income				x²	0.508
Under 2 million yen	63 (14.6)	35 (16.3)	28 (13.0)		

Variable	Total (n=432)	Non-consultation group (n=216)	Consultation group (n=216)	Test	p-Value
2 million to under 3 million yen	40 (9.3)	20 (9.3)	20 (9.3)		
3 million to under 4 million yen	47 (10.9)	23 (13.4)	18 (8.3)		
4 million to under 5 million yen	54 (12.5)	29 (12.0)	25 (13.0)		
5 million to under 6 million yen	43 (10.0)	21 (9.7)	22 (10.3)		
6 million to under 7 million yen	29 (6.7)	15 (6.9)	14 (6.5)		
7 million to under 8 million yen	33 (7.6)	15 (6.9)	18 (8.3)		
8 million to under 9 million yen	34 (7.9)	23 (10.6)	11 (5.1)		
9 million to under 10 million yen	18 (4.3)	11 (5.1)	7 (3.3)		
10 million to under 15 million yen	15 (3.5)	8 (3.7)	7 (3.3)		
15 million yen or more	10 (2.3)	2 (0.9)	8 (3.7)		
Declined to answer/Don't know	42 (9.7)	22 (10.3)	20 (9.3)		
Insurance coverage type				x²	0.315
Employee health insurance (self)	265 (61.3)	135 (62.5)	130 (60.3)		
Employee health insurance (as dependent)	78 (18.1)	33 (15.3)	45 (20.8)		
National Health Insurance (NHI)	68 (15.7)	34 (15.7)	34 (15.7)		
Other	1 (0.3)	1 (0.5)	9 (0.0)		
None of the above/I forgot	20 (4.6)	13 (6.0)	7 (3.3)		
Subjective Symptoms at Health Checkup				x²	0.003
Severe symptoms	34 (7.9)	8 (3.7)	26 (12.0)		
Some symptoms	134 (31.0)	64 (29.6)	70 (32.4)		
No symptoms	264 (61.1)	144 (66.7)	120 (55.6)		
Number of conditions identified at health checkup, average (SD), cases	2.3 (1.7)	2.0 (1.1)	2.6 (2.1)	MWU	0.026
Health Checkup Facility				x²	0.401
Specialized checkup facility (including "human dock")	163 (37.7)	83 (38.4)	80 (37.0)		
Local healthcare institution (clinic, etc.)	127 (29.4)	56 (25.9)	71 (32.9)		
Major healthcare institution (university hospital, etc.)	33 (7.6)	16 (7.4)	17 (7.9)		
On-site checkup at workplace	106 (24.5)	60 (27.8)	46 (21.3)		
Other	3 (0.7)	1 (0.5)	2 (0.9)		
Conditions identified at health checkup (multiple response)					
Hypertension	261 (60.4)	130 (60.3)	131 (60.6)	x ²	1.000
Arrhythmia	65 (15.0)	26 (12.0)	39 (18.1)	x ²	0.106
Abnormal ECG	105 (24.3)	43 (19.9)	62 (28.7)	x ²	0.044
Valvular heart disease	13 (3.0)	1 (0.5)	12 (5.6)	Fisher	0.003

Variable	Total (n=432)	Non-consultation group (n=216)	Consultation group (n=216)	Test	p-Value
Cardiac hypertrophy	24 (5.6)	13 (6.0)	11 (5.1)	χ^2	0.834
Other heart disease	41 (9.5)	18 (8.3)	23 (10.6)	χ^2	0.511
Other CVD	16 (3.7)	9 (4.3)	7 (3.3)	Fisher	0.338
Low HDL cholesterol	33 (7.6)	9 (4.3)	24 (11.1)	χ^2	0.011
High LDL cholesterol	128 (29.6)	62 (28.7)	66 (30.6)	χ^2	0.752
High triglycerides	97 (22.5)	44 (20.4)	53 (24.5)	χ^2	0.356
Hereditary lipid disorder (i.e.familial hypercholesterolemia)	18 (4.3)	6 (2.8)	12 (5.6)	χ^2	0.229
Other lipid disorder	1 (0.3)	1 (0.5)	0 (0.0)	Fisher	1.000
Hyperglycemia	68 (15.7)	26 (12.0)	42 (19.4)	χ^2	0.048
Abnormal glucose levels in urine	44 (10.3)	18 (8.3)	26 (12.0)	χ^2	0.266
Diabetes	45 (10.4)	14 (6.5)	31 (14.4)	χ^2	0.012
Other glucose metabolism disorders	3 (0.7)	0 (0.0)	3 (1.4)	Fisher	0.248
Condition not listed above	32 (7.4)	19 (8.8)	13 (6.0)	χ^2	0.358
Forgot/Don't know	3 (0.7)	2 (0.9)	1 (0.5)	Fisher	0.622
Has a primary care physician				χ^2	<0.001
Yes	272 (63.0)	95 (44.0)	177 (81.9)		
No	160 (37.0)	121 (56.0)	39 (18.1)		
Frequency of Participation in Community Activities				χ^2	<0.001
2 or more times per week	15 (3.5)	2 (0.9)	13 (6.0)		
About once per week	18 (4.3)	3 (1.4)	15 (6.9)		
2 to 3 times per month	17 (3.9)	5 (2.3)	12 (5.6)		
About once per month	45 (10.4)	14 (6.5)	31 (14.4)		
About once every 6 months	78 (18.1)	33 (15.3)	45 (20.8)		
Never or almost never participates	259 (60.0)	159 (73.6)	100 (46.3)		
Healthcare-related behaviors and willingness to improve health				χ^2	0.005
I have no plans to improve lifestyle habits	74 (17.1)	49 (22.7)	25 (11.6)		
I plan to improve lifestyle habits within 6 months	126 (29.3)	67 (31.0)	59 (27.3)		
I will begin improving gradually soon	71 (16.4)	34 (15.7)	37 (17.1)		
I am already working to improve (less than 6 months)	59 (13.7)	30 (13.9)	29 (13.4)		
I am already working to improve (for 6 months or longer)	102 (23.6)	39 (18.1)	63 (29.3)		

Table 2 Respondent Characteristics (by Care-Seeking Behavior, n = 432)

MWU: Mann-Whitney U test;

 χ^2 : chi-square test;

Fisher: Fisher's exact test. P-values are included solely as a reference to illustrate distributional differences between the consultation and non-consultation groups. Since the purpose of this study is descriptive analysis, these values are not interpreted as confounding or as indicators of statistical significance

2. Summary of Findings by Respondent Characteristic

2-1 Has a primary care physician

- The majority of respondents (63.0%) indicated that they have a primary care physician.
- The percentage of respondents with a primary care physician in the consultation group (81.9%) was almost twice as high as those in the non-consultation group (44.0%).
- A high percentage of respondents participated in community activities at least once every six months (80.9%) and were already working to improve their lifestyle habits (74.5%). These respondents also tended to have primary care physicians.

		n=	Has primary care physician	Does not have primary care physician
Total		432	63.0	37.0
Care History	Non-consultation group	216	44.0	56.0
	Consultation group	216	81.9	18.1
Age Group	Male, ages 30-49	142	61.3	38.7
	Male, ages 50-59	160	61.3	38.8
	Female, ages 30-49	80	73.8	26.3
	Female, ages 50-59	50	56.0	44.0
Primary Care Physician	Has primary care physician	272	100.0	
	Does not have primary care physician	160		100.0
Community Participation	Participates (Once or more per six months)	173	80.9	19.1
	Almost never participates	259	51.0	49.0
Health Checkup Facility	Specialized checkup facility (including "Human dock")	163	58.3	41.7
	Local healthcare institution (clinic, etc.)	127	74.0	26.0
	Major healthcare institution (university hospital, national hospital, etc.)	33	60.6	39.4
	On-site checkup at workplace	106	56.6	43.4
Intent to Improve Lifestyle Habits	No plans to improve	74	36.5	63.5
	Plans to improve/ gradually improve within 6 months	197	63.5	36.5
	Already working to improve	161	74.5	25.5
Working Hours and Night Shifts	Under 40 hours/week (almost no OT) with night shifts	28	67.9	32.1
	Under 40 hours/week (almost no OT), no night shifts	107	67.3	32.7
	40+ hours per week with night shifts	83	72.3	27.7
	40+ hours per week, no night shifts	190	57.4	42.6
Insurance Coverage	Employee insurance (association, union, mutual aid, etc.) (self)	265	60.8	39.2
	Employee insurance (association, union, mutual aid, etc.) (dependent)	78	67.9	32.1
	NHI	68	67.6	32.4

*n=30 or less are in gray as reference values

(%)

Chart 3 Presence of Primary Care Physician By Respondent Characteristic

2-2

Frequency of community participation or connecting with other community members

- The majority of respondents do not participate in community activities. When asked about their frequency of “connecting with other community members and community activity participation(neighborhood associations, volunteer work, festivals, disaster preparedness, child-rearing, senior support, etc.),” 60.0% of respondents selected “never or almost never participate.”
- Examining responses by consultation uptake, we find that 73.6% of the non-consultation group responded “never or almost never participate,” while the consultation group had a relatively higher proportion of respondents who participated “about once per month” or more.

		n=	2+ times/week	Around 1 time/week	Around 2-3 times/month	Around 1 time/month	Around once per 6 months	Never/ Almost never
Total			3.5	4.2	3.9	10.4	18.1	60.0
Care History	Non-consultation group	216	1.4	0.9	2.3	6.5	15.3	73.6
	Consultation group	216	6.0	6.9	5.6	14.4	20.8	46.3
Age Group	Male, ages 30-49	142	4.9	6.3	8.5	14.1	19.0	47.2
	Male, ages 50-59	160	1.3	1.3	1.3	9.4	20.0	67.5
	Female, ages 30-49	80	7.5	8.8	3.8	8.8	12.5	58.8
	Female, ages 50-59	50	2.0	6.0		18.0		74.0
Primary Care Physician	Has primary care physician	272	5.1	6.3	5.9	14.3	19.9	48.5
	Does not have primary care physician	160	0.6	0.6	0.6	15.0		79.4
Community Participation	Participates (Once or more per six months)	173	8.7	10.4	9.8	26.0		45.1
	Almost never participates	259						100.0
Health Checkup Facility	Specialized checkup facility (including “Human dock”)	163	6.1	4.3	3.1	11.7	18.4	56.4
	Local healthcare institution (clinic, etc.)	127	2.4	8.7	7.1	13.4	16.5	52.0
	Major healthcare institution (university hospital, national hospital, etc.)	33	6.1	9.1	6.1	6.1		72.7
	On-site checkup at workplace	106	6.6			22.6		70.8
Intent to Improve Lifestyle Habits	No plans to improve	74	4.1	1.4	6.8	10.8		77.0
	Plans to improve/ gradually improve within 6 months	197	1.0	6.6	7.6	10.2	18.3	56.3
	Already working to improve	161	6.2	2.5	1.2	12.4	21.1	56.5
Working Hours and Night Shifts	Under 40 hours/week (almost no OT) with night shifts	28	7.1	7.1	10.7	3.6	28.6	42.9
	Under 40 hours/week (almost no OT), no night shifts	107	2.8	1.9	0.9	5.6	15.0	73.8
	40+ hours per week with night shifts	83	8.4	8.4		14.5	21.7	10.8
	40+ hours per week, no night shifts	190	2.1	1.5	0.5	8.9	22.1	64.7
Insurance Coverage	Employee insurance (association, union, mutual aid, etc.) (self)	265	2.6	3.0	3.8	9.4	21.5	59.6
	Employee insurance (association, union, mutual aid, etc.) (dependent)	78	7.7	6.4	2.6	12.8	9.0	61.5
	NHI	68	2.9	7.4	5.9	10.3	17.6	55.9

*n=30 or less are in gray as reference values

(%)

Fig.4 Frequency of Connecting With Other Community Members or Community Participation by Respondent Characteristic

2-3

Settings or facilities where respondents received consultations

- “Specialized checkup facility (including ‘human dock’)” accounted for the highest percentage overall (37.7%), followed by “local healthcare institution” (29.4%). Together, these two options accounted for approx. 70% of the total.
- Respondents without primary care physicians had a higher-than-average rate of specialized checkup facility usage (42.5%). Meanwhile, among respondents with primary care physicians, “specialized health screening facility” (34.9%) and “local healthcare institution” (34.6%) were almost tied.

			Specialized checkup facility (including “Human dock”)	Local healthcare institution (clinic, etc.)	Major healthcare institution (university hospital, national)	On-site checkup at workplace	Other	
n=								
Total			432	37.7	29.4	7.6	24.5	0.7
Care History	Non-consultation group	216	38.4	25.9	7.4		27.8	0.5
	Consultation group	216	37.0	32.9	7.9		21.3	0.9
Age Group	Male, ages 30-49	142	38.0	28.2	7.7		26.1	
	Male, ages 50-59	160	36.3	30.0	6.3		26.3	1.3
	Female, ages 30-49	80	37.5	28.8	10.0		22.5	1.3
	Female, ages 50-59	50	42.0	32.0	8.0		18.0	
Primary Care Physician	Has primary care physician	272	34.9	34.6	7.4		22.1	1.1
	Does not have primary care physician	160	42.5	20.6	8.1		28.8	
Community Participation	Participates (Once or more per six months)	173	41.0	35.3	5.2		17.9	0.6
	Almost never participates	259	35.5	25.5	9.3		29.0	0.8
Health Checkup Facility	Specialized checkup facility (including “Human dock”)	163	100.0					
	Local healthcare institution (clinic, etc.)	127	100.0					
	Major healthcare institution (university hospital, national hospital, etc.)	33	100.0					
	On-site checkup at workplace	106	100.0					
Intent to Improve Lifestyle Habits	No plans to improve	74	41.9	20.3	5.4		32.4	
	Plans to improve/ gradually improve within 6 months	197	36.5	32.5	8.1		22.3	0.5
	Already working to improve	161	37.3	29.8	8.1		23.6	1.2
Working Hours and Night Shifts	Under 40 hours/week (almost no OT) with night shifts	28	46.4	28.6	3.6		21.4	
	Under 40 hours/week (almost no OT), no night shifts	107	36.4	30.8	11.2		19.6	1.9
	40+ hours per week with night shifts	83	41.0	33.7	7.2		18.1	
	40+ hours per week, no night shifts	190	36.3	24.2	6.8		32.1	0.5
Insurance Coverage	Employee insurance (association, union, mutual aid, etc.) (self)	265	38.5	27.2	8.3		25.3	0.8
	Employee insurance (association, union, mutual aid, etc.) (dependent)	78	42.3	30.8	5.1		21.8	
	NHI	68	29.4	38.2	8.8		22.1	1.5

*n=30 or less are in gray as reference values

(%)

Fig.5 Health Checkup Facility by Respondent Characteristic

2-4

Attitudes toward improving lifestyle habits as a result of health checkups

- We asked, “Do you intend to try improving your lifestyle habits (such as exercise or diet) as a result of your health checkup?” Among all respondents, the top two answers were “I plan to improve lifestyle habits within 6 months” (29.2%) and “I am already working to improve (for 6 months or longer)” (23.6%).
- Among the consultation group, the most common response was “I am already working to improve (for 6 months or longer)” (29.2%). The proportion of the non-consultation group that selected “I have no plans to improve lifestyle habits” was relatively high (22.7%).
- By gender and age group, 7.5% of women ages 30 to 49 responded “I have no plans to improve lifestyle habits.” This is significantly lower than the overall average of 17.1%, suggesting that members of this segment may possess high health awareness. In contrast, 21.9% of men ages 50 to 59 said they “have no plans to improve lifestyle habits.” This was the highest rate among all genders and age groups, which suggests that members of this segment are not motivated to improve their health.

			n=					
			No plans to improve	I plan to improve (in around 6 months)	I will begin improving gradually soon (in around 1 month)	Already working to improve (less than 6 months)	Already working to improve (for 6 months or longer)	
Total			432	17.1	29.2	16.4	13.7	23.6
Care History	Non-consultation group	216	22.7	31.0	14.4	13.9	18.1	
	Consultation group	216	11.6	27.3	18.5	13.4	29.2	
Age Group	Male, ages 30-49	142	19.0	31.0	16.9	10.6	22.5	
	Male, ages 50-59	160	21.9	23.1	13.8	17.5	23.8	
	Female, ages 30-49	80	7.5	36.3	23.8	11.3	21.3	
	Female, ages 50-59	50	12.0	32.0	12.0	14.0	30.0	
Primary Care Physician	Has primary care physician	272	9.9	27.6	18.4	15.8	28.3	
	Does not have primary care physician	160	29.4	31.9	13.1	10.0	15.6	
Community Participation	Participates (Once or more per six months)	173	9.8	27.2	22.5	15.0	25.4	
	Almost never participates	259	22.0	30.5	12.4	12.7	22.4	
Health Checkup Facility	Specialized checkup facility (including “Human dock”)	163	19.0	28.8	15.3	11.7	25.2	
	Local healthcare institution (clinic, etc.)	127	11.8	28.3	22.0	13.4	24.4	
	Major healthcare institution (university hospital, national hospital, etc.)	33	12.1	30.3	18.2	12.1	27.3	
	On-site checkup at workplace	106	22.6	30.2	11.3	17.0	18.9	
Intent to Improve Lifestyle Habits	No plans to improve	74	100.0					
	Plans to improve/ gradually improve within 6 months	197	64.0					
	Already working to improve	161	36.6					
Working Hours and Night Shifts	Under 40 hours/week (almost no OT) with night shifts	28	10.7	28.6	32.1	7.1	21.4	
	Under 40 hours/week (almost no OT), no night shifts	107	15.9	31.8	8.4	15.0	29.0	
	40+ hours per week with night shifts	83	19.3	24.1	22.9	9.6	24.1	
	40+ hours per week, no night shifts	190	17.9	30.5	15.3	14.7	21.6	
Insurance Coverage	Employee insurance (association, union, mutual aid, etc.) (self)	265	16.6	32.8	13.6	13.2	23.8	
	Employee insurance (association, union, mutual aid, etc.) (dependent)	78	14.1	20.5	25.6	17.9	21.8	
	NHI	68	17.6	30.9	20.6	7.4	23.5	

*n=30 or less are in gray as reference values

(%)

Fig.6 Healthcare-Related Behaviors and Willingness to Improve Health by Respondent Characteristic

2-5

Health conditions identified at health checkups and presence of subjective symptoms

- Overall, 61.1% of respondents reported having no subjective symptoms.
- Examining the presence of subjective symptoms by consultation attendance, 12.0% of the consultation group reported having severe subjective symptoms. This is over three times higher than the proportion of the non-consultation group with severe symptoms (3.7%).

		n=	I noticed severe symptoms	I noticed some symptoms	I had no symptoms
Total		432	7.9	31.0	61.1
Care History	Non-consultation group	216	3.7	29.6	66.7
	Consultation group	216	12.0	32.4	55.6
Age Group	Male, ages 30-49	142	11.3	26.8	62.0
	Male, ages 50-59	160	4.4	33.1	62.5
	Female, ages 30-49	80	11.3	32.5	56.3
	Female, ages 50-59	50	4.0	34.0	62.0
Primary Care Physician	Has primary care physician	272	10.7	33.5	55.9
	Does not have primary care physician	160	3.1	26.9	70.0
Community Participation	Participates (Once or more per six months)	173	13.3	37.0	49.7
	Almost never participates	259	4.2	27.0	68.7
Health Checkup Facility	Specialized checkup facility (including "Human dock")	163	10.4	28.2	61.3
	Local healthcare institution (clinic, etc.)	127	6.3	37.8	55.9
	Major healthcare institution (university hospital, national hospital, etc.)	33	12.1	45.5	42.4
	On-site checkup at workplace	106	4.7	22.6	72.6
Intent to Improve Lifestyle Habits	No plans to improve	74	6.8	16.2	77.0
	Plans to improve/ gradually improve within 6 months	197	8.6	36.0	55.3
	Already working to improve	161	7.5	31.7	60.9
Working Hours and Night Shifts	Under 40 hours/week (almost no OT) with night shifts	28	17.9	35.7	46.4
	Under 40 hours/week (almost no OT), no night shifts	107	4.7	37.4	57.9
	40+ hours per week with night shifts	83	15.7	37.3	47.0
	40+ hours per week, no night shifts	190	5.3	22.1	72.6
Insurance Coverage	Employee insurance (association, union, mutual aid, etc.) (self)	265	5.7	27.2	67.2
	Employee insurance (association, union, mutual aid, etc.) (dependent)	78	11.5	35.9	52.6
	NHI	68	13.2	38.2	48.5

*n=30 or less are in gray as reference values

(%)

Fig.7 Presence of Subjective Symptoms by Respondent Characteristic

2-6 Health literacy

- Of all respondents, 21.5% agreed or strongly agreed with the statement, “I did not fully understand the meaning of my health checkup findings.” This suggests that even when health checkups detect the need for reexamination or more detailed testing, a certain number of respondents do not fully understand the significance or seriousness of such findings. We must note that among all segments, this rate was highest among those who work 40 hours or more per week at late-night shifts (32.5%).
- When asked to rate the statement, “I felt that my health checkup findings needed immediate attention,” 45.6% of respondents agreed or strongly agreed.
- When asked to rate the statement, “I thought about how to respond to my checkup findings by looking up related information to compare,” 48.8% of all respondents agreed or strongly agreed, making it the top response. This suggests that around half of respondents actively gather and compare information on their own after receiving health checkup results.

Item	n=	Does not apply at all	Does not apply very much	Neither	Applies somewhat	Applies very much
I did not fully understand the meaning of my health checkup findings.	432	20.1	31.5	26.9	16.0	5.6
I felt that my health checkup findings needed immediate attention.	432	6.9	18.3	29.2	34.0	11.6
I thought about how to respond to my checkup findings by looking up related information to compare	432	6.7	13.2	31.3	37.7	11.1

(%)

Table 3 Overview of Health Literacy

n=30 or more		n=	Does not apply - Total		Neither	Applies - TotalAge		Does not apply - Total	Applies - Total
■ ≥+10 pt vs. Total	■ ≥-5 pt vs. Total		Does not apply at all	Does not apply very much		Applies somewhat	Applies very much		
■ ≥+5 pt vs. Total	■ ≥-10 pt vs. Total								
Total		432	20.1	31.5	26.9	16.0	5.6	51.6	21.5
Care History	Non-consultation group	216	16.2	28.2	31.9	17.1	6.5	44.4	23.6
	Consultation group	216	24.1	34.7	21.8	14.8	4.6	58.8	19.4
Age Group	Male, ages 30-49	142	19.0	22.5	30.3	23.2	4.9	41.5	28.2
	Male, ages 50-59	160	21.3	33.8	26.9	11.3	6.9	55.0	18.1
	Female, ages 30-49	80	21.3	38.8	26.3	10.0	3.8	60.0	13.8
	Female, ages 50-59	50	18.0	38.0	18.0	20.0	6.0	56.0	26.0
Primary Care Physician	Has primary care physician	272	22.8	33.1	23.5	14.7	5.9	55.9	20.6
	Does not have primary care physician	160	15.6	28.8	32.5	18.1	5.0	44.4	23.1
Community Participation	Participates (Once or more per six months)	173	17.9	31.8	26.6	17.3	6.4	49.7	23.7
	Almost never participates	259	21.6	31.3	27.0	15.1	5.0	52.9	20.1
Health Checkup Facility	Specialized checkup facility (including “Human dock”)	163	18.4	32.5	27.0	17.2	4.9	50.9	22.1
	Local healthcare institution (clinic, etc.)	127	22.8	26.0	28.3	18.1	4.7	48.8	22.8
	Major healthcare institution (university hospital, national hospital, etc.)	33	18.2	39.4	27.3	12.1	3.0	57.6	15.2
	On-site checkup at workplace	106	20.8	33.0	25.5	13.2	7.5	53.8	20.8
Intent to Improve Lifestyle Habits	No plans to improve	74	25.7	24.3	32.4	10.8	6.8	50.0	17.6
	Plans to improve/ gradually improve within 6 months	197	12.7	33.0	31.0	18.3	5.1	45.7	23.4
	Already working to improve	161	26.7	32.9	19.3	15.5	5.6	59.6	21.1
Working Hours and Night Shifts	Under 40 hours/week (almost no OT) with night shifts	28	7.1	32.1	35.7	14.3	10.7	39.3	25.0
	Under 40 hours/week (almost no OT), no night shifts	107	28.0	33.6	13.1	20.6	4.7	61.7	25.2
	40+ hours per week with night shifts	83	18.1	28.9	20.5	19.3	13.3	47.0	32.5
	40+ hours per week, no night shifts	190	18.4	31.1	35.3	12.6	2.6	49.5	15.3
Insurance Coverage	Employee insurance (association, union, mutual aid, etc.) (self)	265	20.4	32.1	25.3	17.0	5.3	52.5	22.3
	Employee insurance (association, union, mutual aid, etc.) (dependent)	78	14.1	37.2	28.2	15.4	5.1	51.3	20.5
	NHI	68	22.1	27.9	27.9	16.2	5.9	50.0	22.1

*n=30 or less are in gray as reference values

(%)

Fig.8 Health Literacy by Respondent Characteristic – Percentage of Respondents Who Selected, “I did not fully understand the meaning of my health checkup findings”

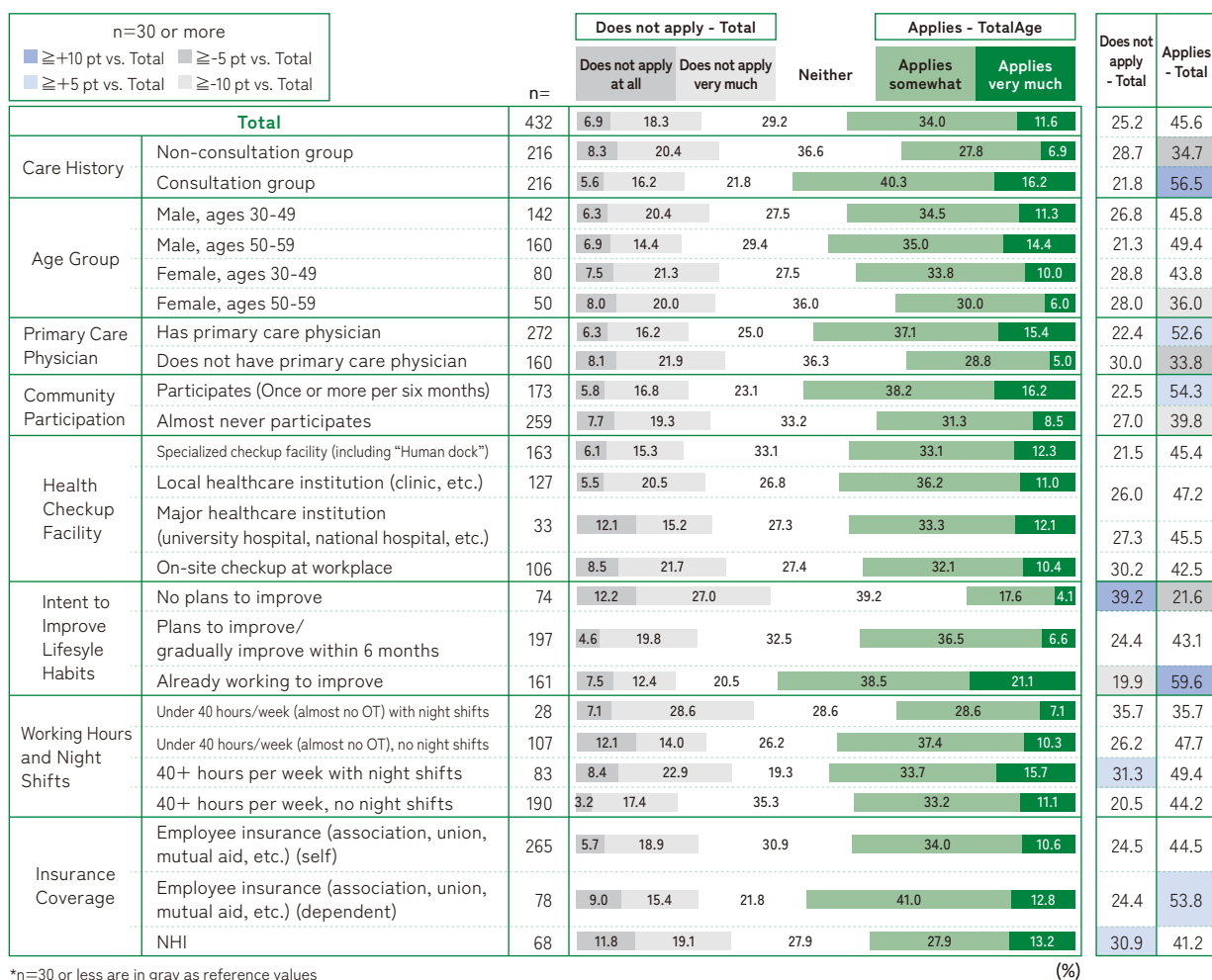


Fig.9 Health Literacy by Respondent Characteristic - Percentage of Respondents Who Selected, "I felt that my health checkup findings needed immediate attention"

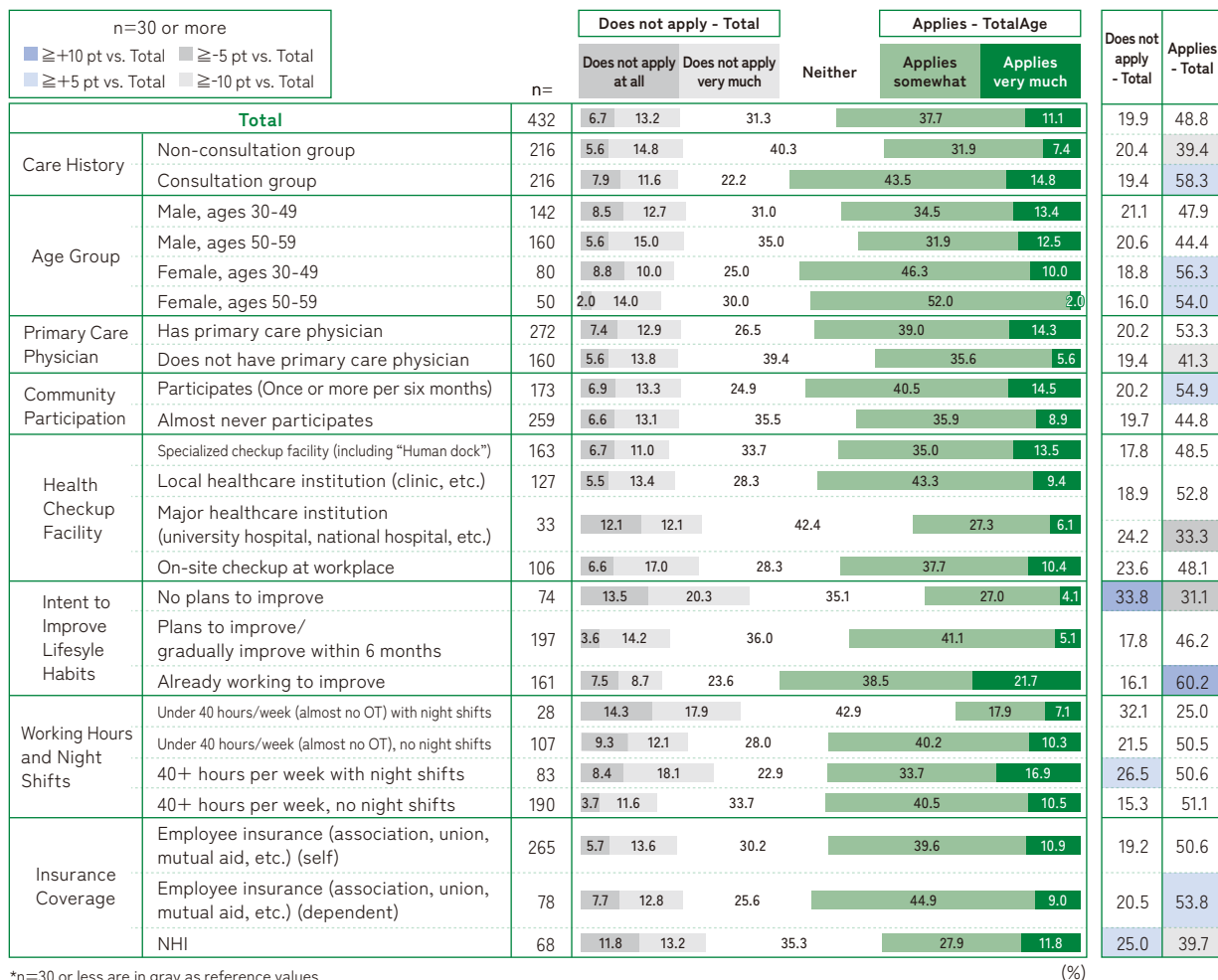


Fig.10 Health Literacy by Respondent Characteristic - Percentage of Respondents Who Selected, "I thought about how to respond to my checkup findings by looking up related information to compare"

3. Conjoint Analysis Results (Factors that Encouraged Care-Seeking Behavior)

3-1 Overall

Relative Importance of Each Attribute

*Higher percentages correspond to a greater effect on encouraging care-seeking behavior.

● “Person recommending reexamination” had the highest relative importance (28.8%), followed by “presentation of estimated cost” (19.9%) and “presentation of risk information” (15.3%). Across the six attributes, participants tended to emphasize who recommends a consultation and its estimated cost when deciding whether to seek care.

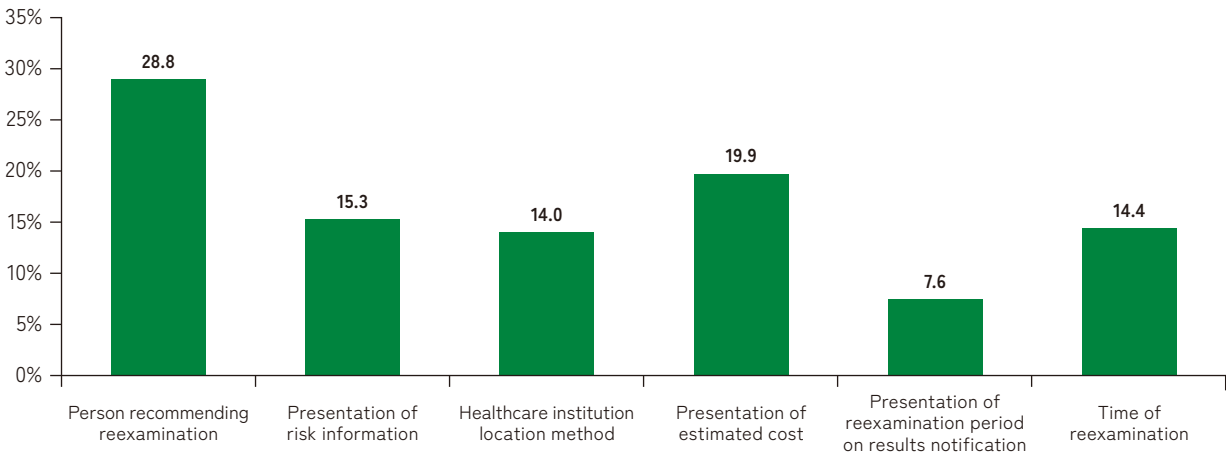


Fig.11 Relative Importance of Each Attribute

Utility Values of Each Attribute

*Positive values on the vertical axis correspond to a greater effect on encouraging care-seeking behavior.

- Person recommending reexamination: Within this attribute, “Reexamination recommended only through results notification (paper or digital) sent to the home or workplace” yielded the highest utility, establishing it as the preferred level for encouraging care-seeking behavior. It may be because this study utilized an online panel, respondents tended to prefer passive formats of consultation recommendations, such as by being provided with results notifications.
- Presentation of estimated cost: “Around 3,000 to 5,000 yen” yielded strong positive utility, whereas “no specific information on estimated cost listed” yielded low utility. We observed a preference that cost be clearly disclosed, suggesting that cost uncertainty may serve as an obstacle for consultation uptake. Among all factors, this factor had the widest range of utility values as well as the most influence on care-seeking behavior.
- Presentation of risk information: “Notification includes risk of onset or treatment cost simulation if condition goes ignored” had the highest utility value for this attribute and may encourage care-seeking behavior.
- Presentation of reexamination period: “A specific timeframe is listed” yielded positive utility, but the gap in utility values was smaller than for other factors. This suggests that indicating specific periods for reexamination may have limited impact.
- Time of reexamination: “During working hours” yielded a positive utility value, whereas “outside working hours” showed a substantially negative utility value.

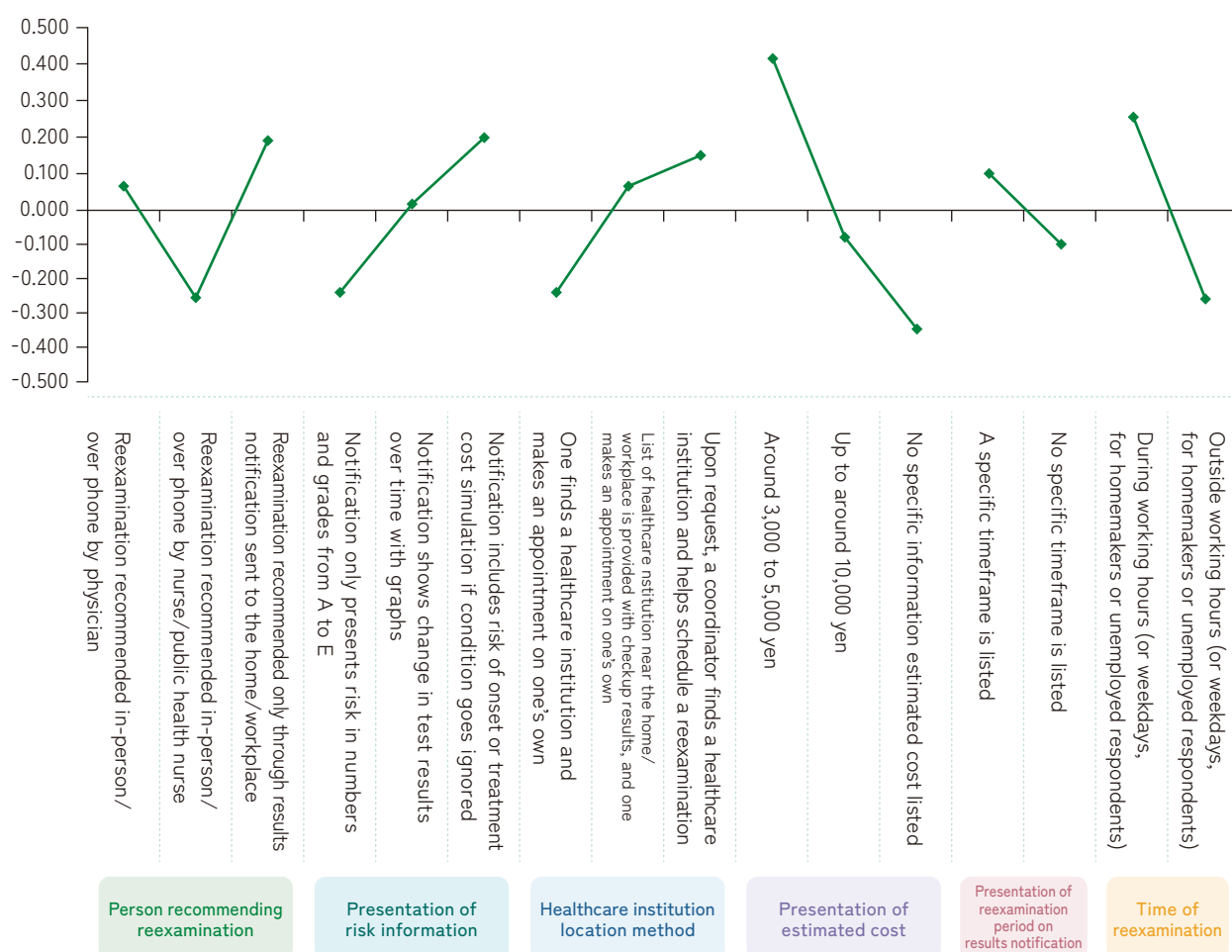


Fig.12 Utility Values of Each Attribute

3-2

Presence or absence of care-seeking behavior

Analysis Sample Composition (Sample Size and Percentage)

Analysis category	Sample size	Percentage Breakdown
Total	432	100.0%
Non-consultation group	216	50.0%
Consultation group	216	50.0%

Relative Importance of Each Attribute

Both the consultation and non-consultation groups valued the following attributes, in descending order: person recommending reexamination, presentation of estimated cost, and presentation of risk information.

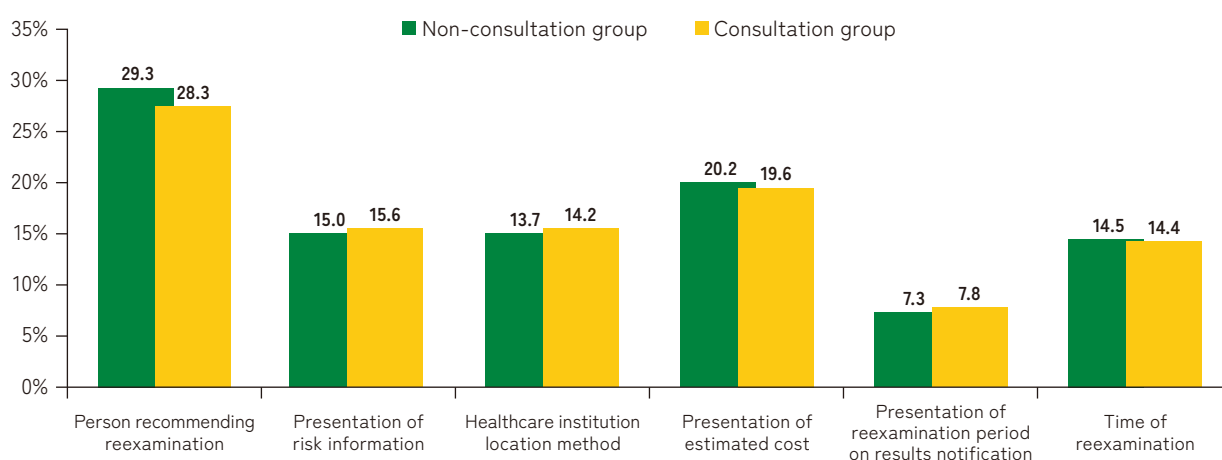


Fig.13 Relative Importance of Each Attribute by Consultation Uptake

Utility Values of Each Level

- Person recommending reexamination: “Reexamination recommended only through checkup results notification sent to the home or workplace” yielded a higher positive utility value for the non-consultation group (0.219) than for the consultation group (0.156).
- Presentation of estimated cost: Listing a specific cost of “around 3,000 to 5,000 yen” yielded a positive utility value for both the consultation group (0.45) and non-consultation group (0.37), with a higher utility value for the former group. Conversely, “no specific information on estimated cost listed” yielded a lower negative utility value for the consultation group (-0.38) than the non-consultation group. The consultation group was inclined to favor cost transparency.
- Presentation of risk information: “Notification includes risk of onset or treatment cost simulation if condition goes ignored” yielded a utility value of 0.243 for the consultation group and 0.162 for the non-consultation group. While both groups preferred being presented with specific information regarding future risk, the preference was stronger among the consultation group.



Fig.14 Utility Values of Each Level By Consultation Uptake

3-3

Care-seeking behavior and subjective symptom severity

Analysis Sample Composition (Sample Size and Percentage)

Subjective Symptoms	All groups, n(%)	Non-consultation group, n(%)	Consultation group, n(%)
Severe symptoms	34(7.9%)	8(3.7%)	26(12.0%)
Some symptoms	134(31.0%)	64(29.6%)	70(32.4%)
No symptoms	264(61.1%)	144(66.7%)	120(55.6%)

Relative Importance of Each Attribute

- “Person recommending reexamination” was more important for respondents with no subjective symptoms (30.3%) than for respondents with severe or mild subjective symptoms.
- “Healthcare institution location method” (21.3%) and “time of reexamination” (19.0%) were more important for members of the non-consultation group who experienced severe subjective symptoms than for other respondents, while “presentation of estimated cost” (14.8%) was relatively less important. The findings suggest that compared to other groups, members of the non-consultation group who experienced severe subjective symptoms may encounter physical and environmental obstacles that discourage them from seeking consultations, such as the procedures involved in finding a healthcare institution or the times consultations are available.
- The importance of “presentation of estimated cost” was relatively high for respondents who had some or no symptoms (approx. 19% to 20%), suggesting that this is a major criterion for their decision to seek a consultation.

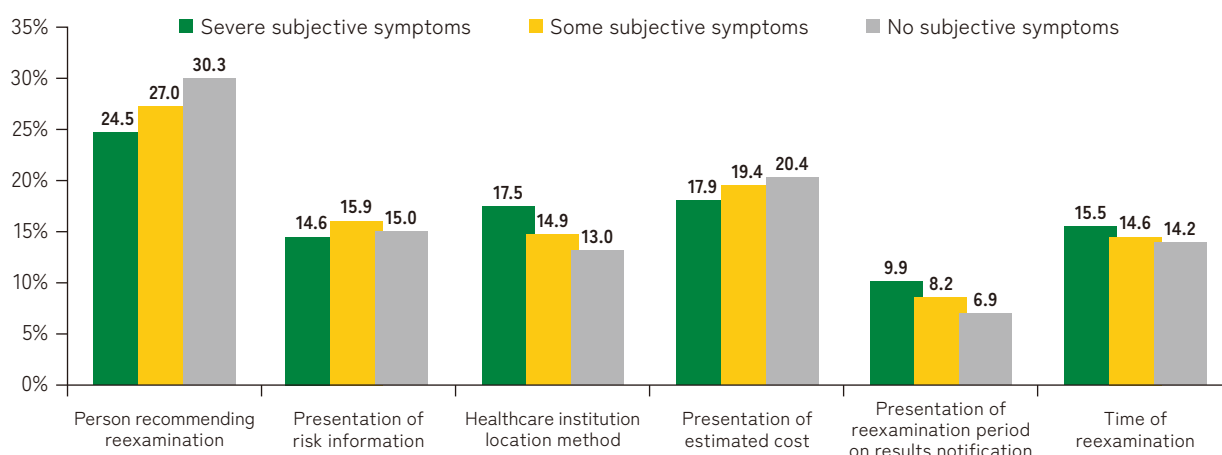


Fig.15 Relative Importance of Each Attribute By Subjective Symptom Severity

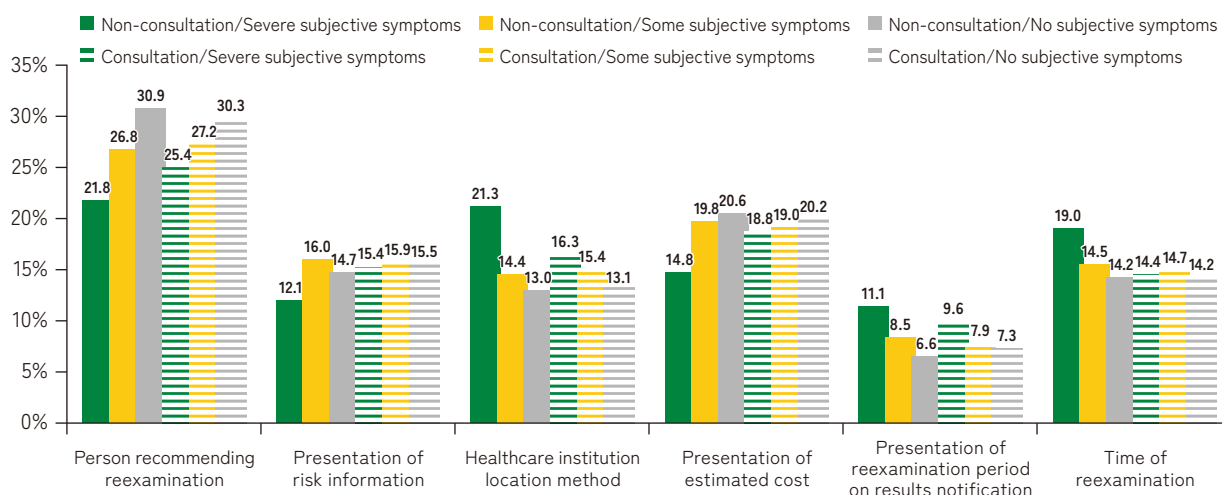


Fig.16 Relative Importance of Each Attribute By Subjective Symptom Severity and Care-Seeking Behavior

Utility Values of Each Level

- Among respondents with no subjective symptoms, “Results notification only” yielded a significantly higher positive utility value for the non-consultation group than for consultation group members. Compared to other groups, non-consultation group members with no subjective symptoms tend to prefer a more relaxed approach (“results notification only”) over direct interventions such as in-person or over the phone.
- “Notification only presents risk in numbers and grades from A to E,” “no cost information listed,” and “outside of working hours” were negative factors for many segments to a varying degree.
- Consultation group members with severe subjective symptoms exhibited a distinct pattern compared to other segments. While the difference was slight, “reexamination recommended in-person or over the phone by nurse or public health nurse” and “reexamination recommended in-person or over the phone by physician” yielded higher utility values than “results notification only.”



Fig.17 Utility Values of Each Level by Subjective Symptom Severity

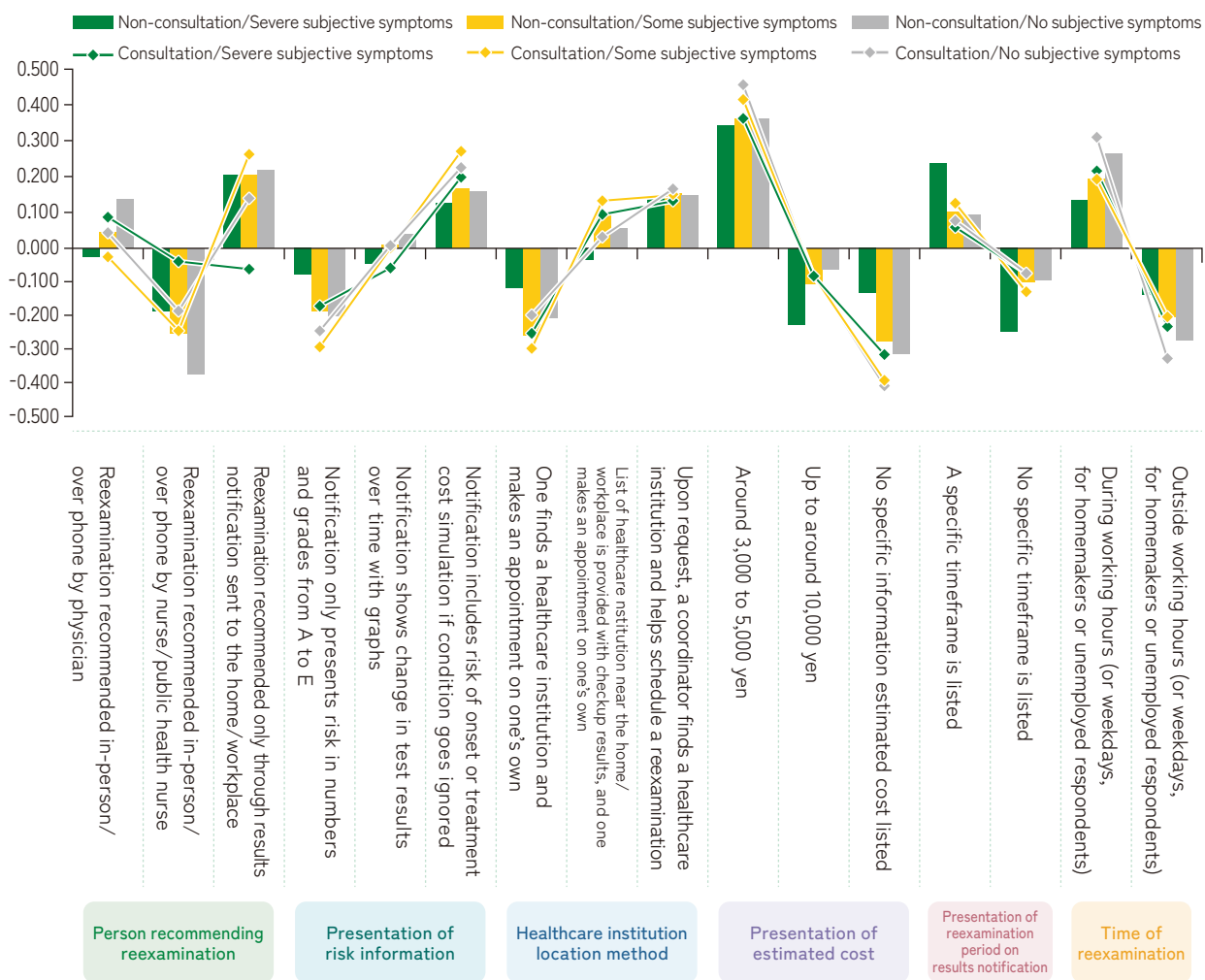


Fig.18 Utility Values of Each Level by Subjective Symptom Severity and Care-Seeking Behavior

3-4 Care-seeking behavior and insurance coverage type

Insurance Coverage Type	All groups, n(%)	Non-consultation, n(%)	Consultation, n(%)
All	432(100.0%)	216(100.0%)	216(100.0%)
Employee health insurance (self)	265(61.3%)	135(62.5%)	130(60.2%)
Employee health insurance (as dependent)	78(18.1%)	33(15.3%)	45(20.8%)
NHI	68(15.7%)	34(15.7%)	34(15.7%)
Other/unclear	21(4.9%)	14(6.5%)	7(3.2%)

Note: Percentages listed in the non-consultation and consultation group columns represent the proportions within each group (n=216).

Relative Importance of Each Attribute

- Compared to respondents covered by NHI, “source of recommendation” was more important among respondents with employee health insurance (self) coverage (approx. 28% to 30%).
- “Time of reexamination (during working hours, etc.)” was more important for respondents with employee health insurance (self) than it was for those with NHI.
- Respondents covered by NHI tended to assign greater importance to “healthcare institution location method” and “presentation of estimated cost” compared to the respondents with employee health insurance (self).
- Among respondents who emphasized sources of reexamination recommendations in the non-consultation group, 30.2% were covered by employee health insurance (self) and 29.0% were covered by NHI. These percentages are higher than they are for members of the consultation group with the same types of coverage. Among the non-consultation group, “source of recommendation” may be a factor that encourages care-seeking behavior for both those covered by employee health insurance (self) and those covered by NHI.

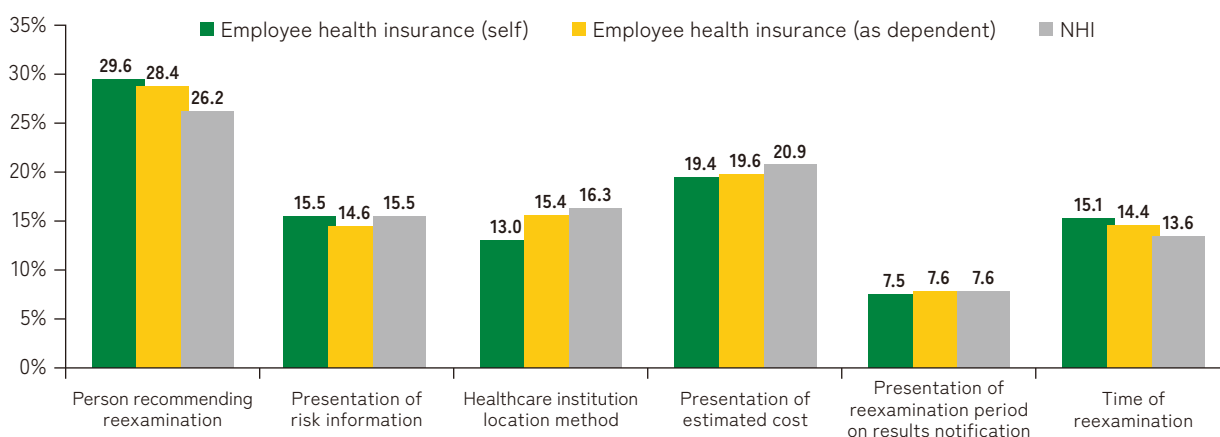


Fig.19 Relative Importance of Each Attribute by Insurance Coverage Type

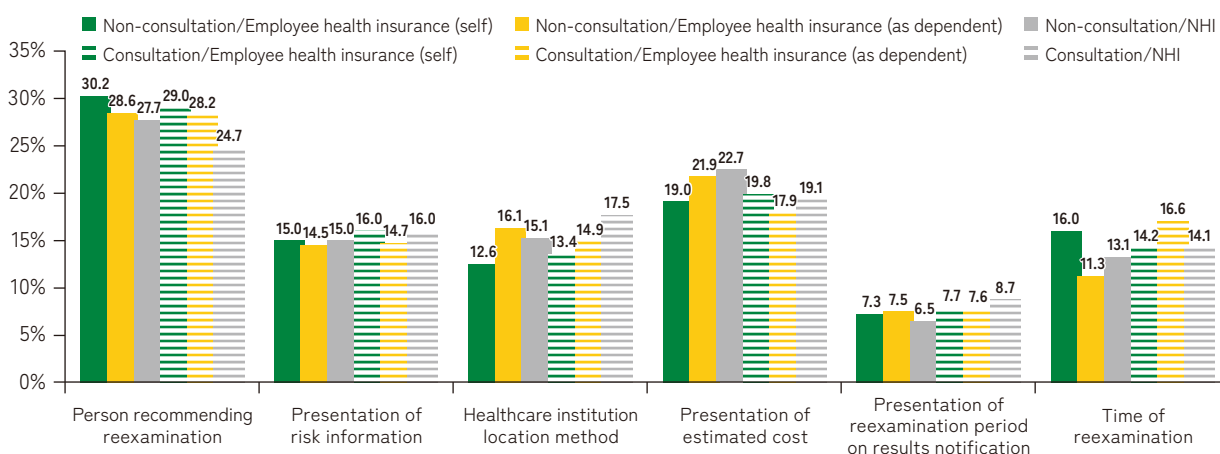


Fig.20 Relative Importance of Each Attribute by Insurance Coverage Type and Care-Seeking Behavior

Utility Values of Each Level

● “One finds a healthcare institution and makes an appointment on one’s own” yielded negative utility values for those with employee health insurance (as dependent) or NHI coverage that was almost twice as low as it was for those with employee health insurance (self) coverage (-0.169).

● Regarding the source of reexamination recommendations, “reexamination recommended in-person or over the phone by physician” yielded a much higher utility value for those with employee health insurance (as dependent) than it did for other segments.

● Regarding the source of reexamination recommendations, “recommendation provided only through notification sent to the home or workplace” yielded a positive utility value for non-consultation group members with NHI coverage, suggesting that this is a factor they emphasize. Conversely, non-consultation group members with employee health insurance (as dependent) were inclined to emphasize in-person recommendations from a physician.

● As for the presentation of risk-related information, “notification includes risk of onset or treatment cost simulation if condition goes ignored” yielded higher utility value for non-consultation group members with employee health insurance (self) coverage compared to other non-consultation group members. This utility value was lower than it was for the consultation group.

● Regarding time of reexamination, “during working hours” yielded a slightly higher utility value for members of the non-consultation group with employee health insurance (self) coverage than members of the consultation group with the same insurance coverage.

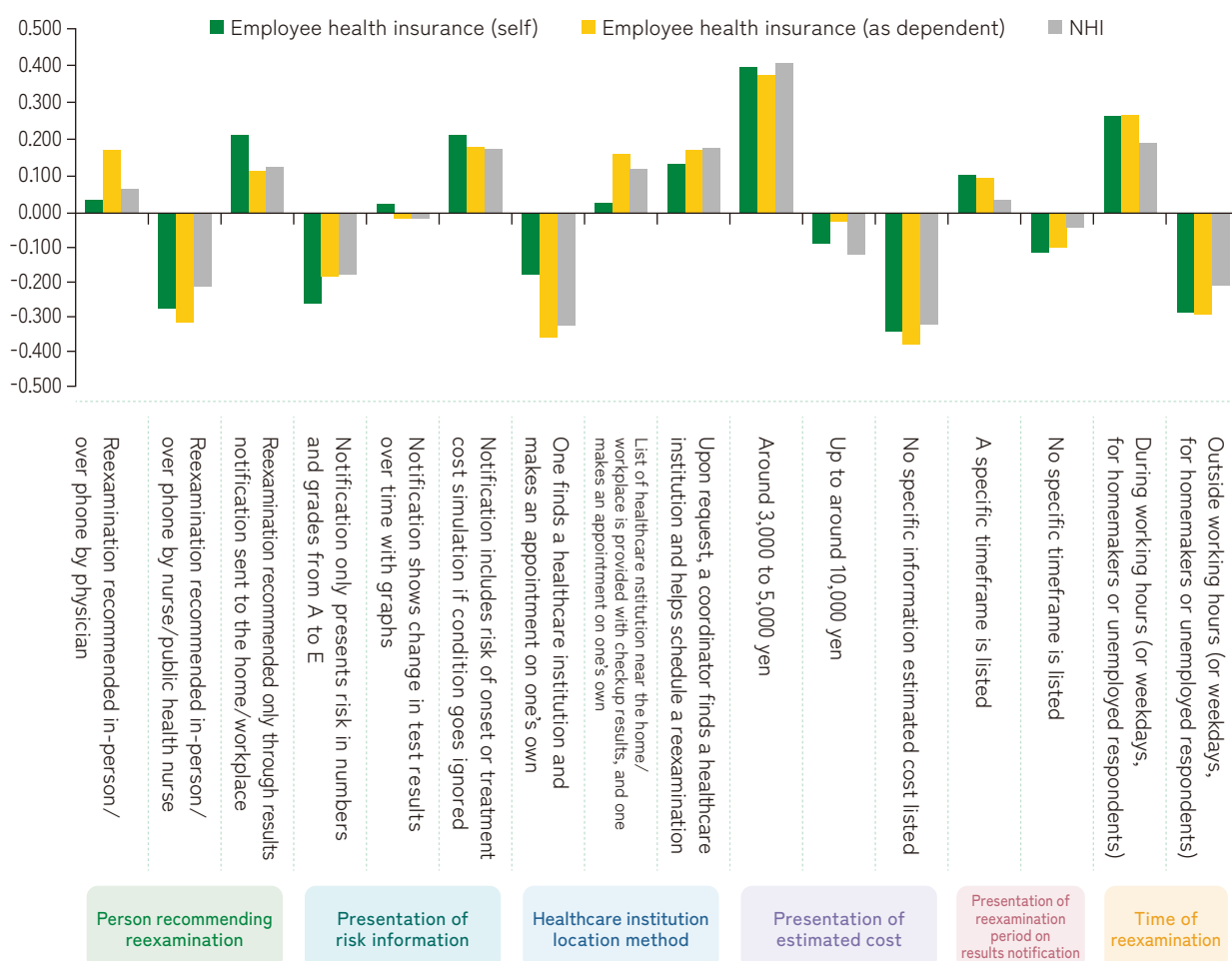


Fig.21 Utility Values of Each Level By Insurance Coverage Type



Fig.22 Utility Values of Each Level By Care-Seeking Behavior and Insurance Coverage Type

3-5 Care-seeking behavior and size of place of residence

Analysis Sample Composition (Sample Size and Percentage)

Size of Place of Residence	All groups, n(%)	Non-consultation, n(%)	Consultation, n(%)
Total	432(100.0%)	216(100.0%)	216(100.0%)
Large city	163(37.7%)	83(19.2%)	80(18.5%)
Medium city	171(39.6%)	82(19.0%)	89(20.6%)
Small city	98(22.7%)	51(11.8%)	47(10.9%)

Relative Importance of Each Attribute

*Please note with “size of place of residence,” we have divided all of Japan into the following three categories.

- Large city: Tokyo’s 23 wards and cities designated by government ordinance
- Medium City: Cities with populations of 100,000 people or more
- Small city: Cities, towns, and rural districts with populations of fewer than 100,000 people

● For all city types, “source of recommendation” accounted for around 30%, suggesting that it may be a major key for care-seeking behavior regardless of place of residence.

● At 16.4%, “time for reexamination” was more important for non-consultation group members in large cities than non-consultation group members in medium or small cities. Conversely, among the non-consultation group, “presentation of estimated cost” was more important for those in medium or small cities than those in large cities.

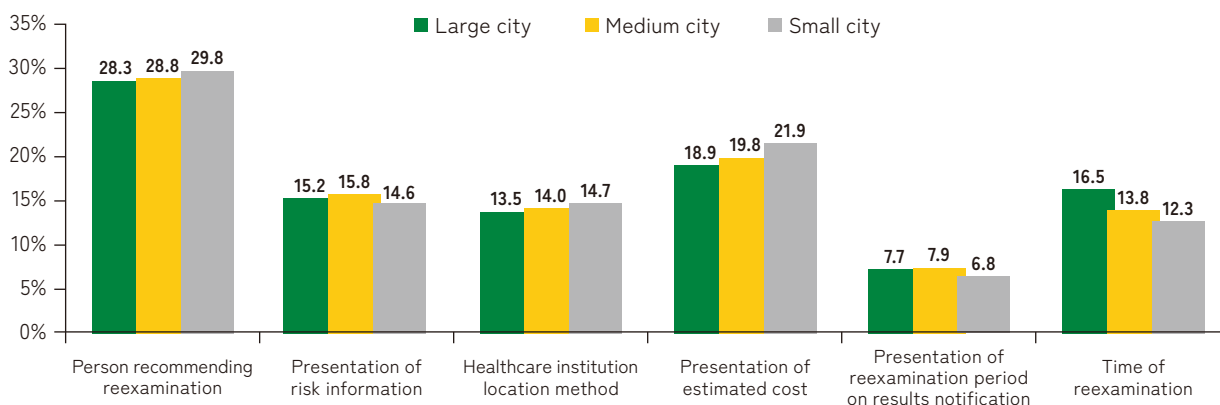


Fig.23 Relative Importance of Each Attribute by Size of Place of residence

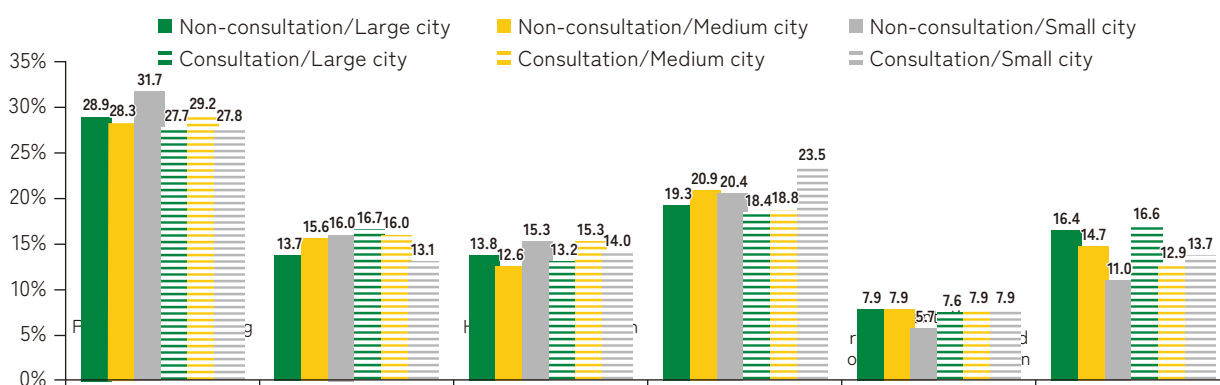


Fig.24 Relative Importance of Each Attribute by Care-Seeking Behavior and Size of Place of residence

Utility Values of Each Level

- Among respondents in large cities, the non-consultation group placed more emphasis on “notification includes risk of onset or treatment cost simulation if condition goes ignored” than the consultation group.
- Comparing respondents in small cities, the non-consultation group placed more emphasis on “reexamination recommended in-person or over the phone by physician” than the consultation group, suggesting that the source of a recommendation may be a significant factor.



Fig.25 Utility Values of Each Level by Size of Place of residence

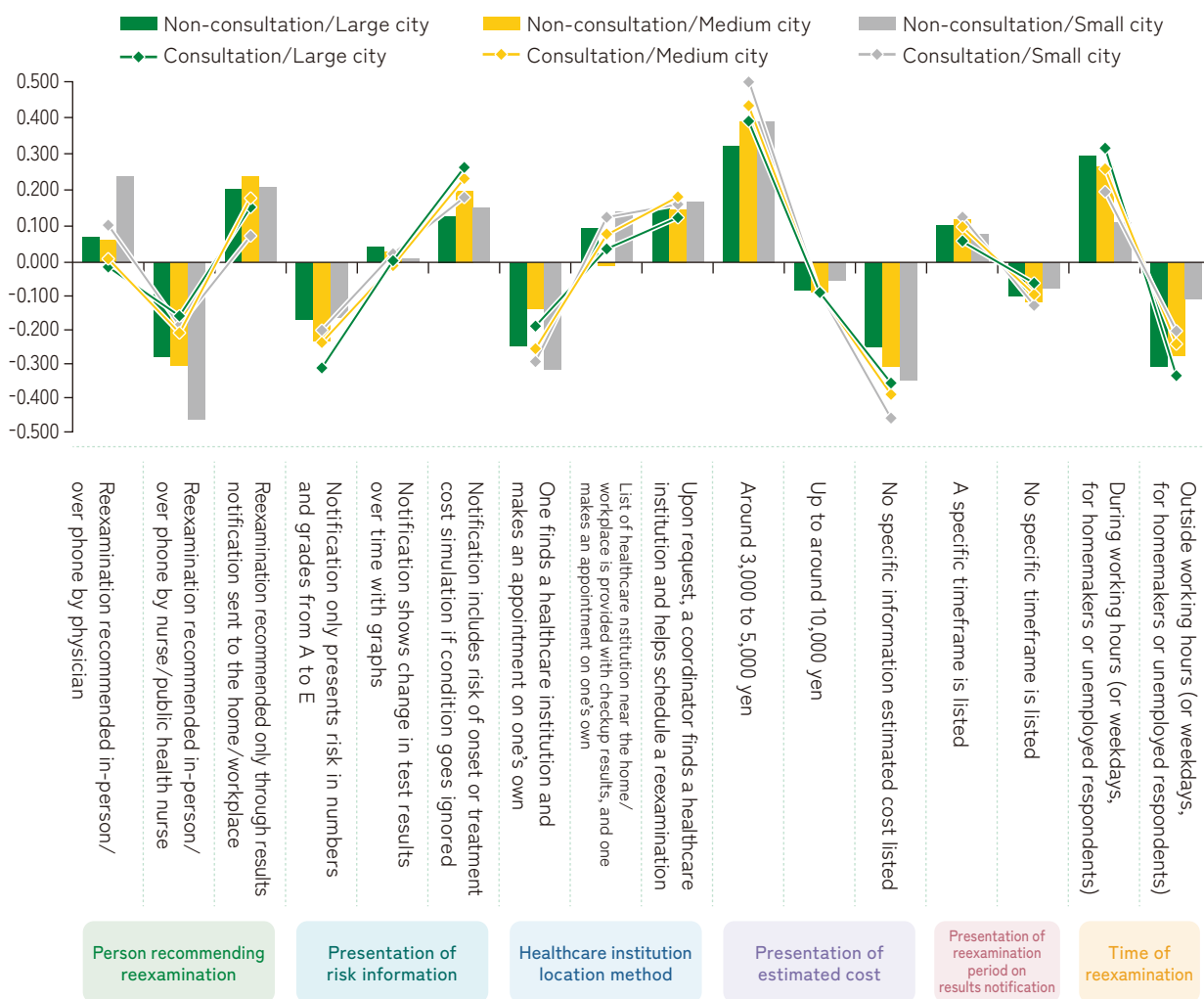


Fig.26 Utility Values for Each Level by Care-Seeking Behavior and Size of Place of residence

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