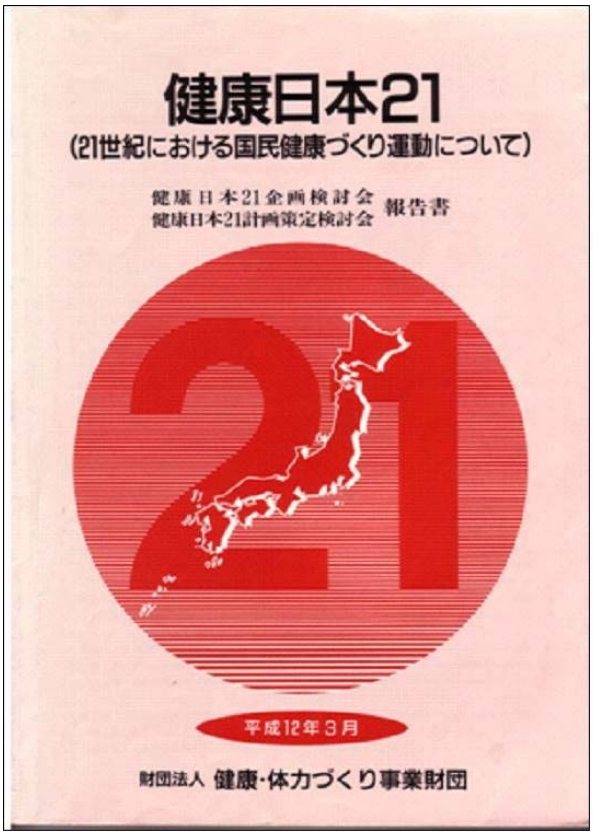
Japanese Ministry of Health and Welfare (Eds.), Healthy Japan 21 (Japanese National Health Promotion in the 21st Century). February, 2000.

English Translation of general section, prepared by Masaki Moriyama



Healthy Japan 21

General statement

February, 2000

Preface

Healthy Japan 21 consists of health measures to be used as guideposts for the new century, a new national health promotion to realize a healthy life for each individual in 21st century Japan. Its central idea is for various health-related organizations in our society to support the efforts of individuals to realize a healthy life through their own views of health. Based on this idea, and by setting concrete objectives for health-related issues (e.g., death caused by disease, prevalence of disease, lifestyle-related risk factors), by offering sufficient information and by preparing the

environments necessary for individuals to improve their lifestyle habits on the basis of self-choice, Healthy Japan 21 aims at enabling individuals to lead a full and satisfying life and making our society vital and viable.

For about 18 months, scholars and experts invited by the Ministry of Health, Labor and Welfare reviewed the achievements of health-promoting activities in Japan as well as the outcome of public health activities throughout the world and also discussed concrete measures to decrease premature deaths and disabilities to expand the period during which people spend their lives free from disease and disability, the Disease Free Life Expectancy (DFLE). Now, the committee has made its proposals for the general public and for various health-related groups.

In addition, the committee will continue its efforts to promote health for the 21st century by discussing other important issues including maternity and child health to expand DFLE and to improve the quality of life.

In this general statement, after a survey of health standards in Japan and world trends in health-promoting policies, the basic strategy for implementing Healthy Japan 21 health policy and important points for local level groups will be described.

Chapter 1 Health Standards in Japan

Section 1 Health Issues for Super-aging Japanese Society

As for the average life span, a comprehensive indicator of health conditions, Japan had the lowest figure among developed countries after the War. However, overtaking all other developed countries in a relatively short period of time, Japan has been ranked at the top since 1984. In particular, the figure for Japanese women has increasingly outdistanced the runner-up to a point considered the ultimate peak possible for human beings (Table1-1). This result can be attributed to the unified efforts of the Japanese people propped up by their high levels of education, economic development and healthcare.

One of the reasons why the life expectancy of the Japanese rapidly grew after the War was a sharp drop in acute diseases, particularly the infectious ones. On the other hand, an increase in lifestyle-related diseases including cancer and cardiovascular disease has largely changed the disease structure (Table1-2). Furthermore, disabilities accompanying aging (e.g., immobility, dementia) have also been on the rise. As most of those diseases not only take patients' lives but also lower their physical capabilities and the quality of their lives, it is an important issue for disease prevention and treatment to maintain the quality of daily lives. To prevent and treat

such lifestyle-related diseases requires individuals to improve their living habits continuously, and promote their health on their own initiative.

Accelerated by a rapid fall in the birth rate, Japan is going to be a super-aging society. One out of four people will be elderly in 2020 and one out of three in 2050. In addition, the population is expected to decrease from 2007 and drop below the 100 million benchmark in 2050.

Such an unprecedented super-aging trend must bring huge burdens of disease to our society. As we can't expect the high economic growth we have been used to, we need to decrease the social burdens of medical care and long-term care for the elderly. Therefore, aiming at a healthier society becomes a crucial goal for Japan in the 21st century.

Figure 1-1 Yearly average life expectancy among 29 OECD member countries (1960-96)

Figure 1-2 Yearly death rates by cause of death in Japan (1899-1998)

Figure 1-3 Population trends in Japan and future estimates

Section 2 Diversifying Values of Health

Today, the probability of premature death is lower than in the aftermath of the War (Table 1-4), but the probability of death before reaching 65 years of age is more than 11 percent. In addition, as mentioned above, not a small number of people become bed-ridden or suffer from dementia in the last years of their lives. Given this situation, spending a satisfying high quality life in each stage of life is an important challenge for individuals.

A recent survey shows that people have strong interest in health-related matters (Table 1-5). The richness or satisfaction felt in life varies with each individual, but it is an era when individuals make an effort to prevent premature death or disability and, by making use of surrounding resources, to lead a rich and satisfying life.

Figure 1-4 Japanese female survival curve

Figure 1-5 Lifestyle matters of concern for people in Japan

Chapter 2 World Trends in Health Promotion Measures

The idea of health promotion originally comes from the WHO Definition of Health in 1946: "Health is a state of complete physical, mental, and social well-being and not merely the absence of diseases or infirmity," and E.G. Clark and H.R. Leavell incorporated this concept into primary preventive medicine in the 1950's. At that time, "Health Promotion" meant increasing general resistance to infectious disease and promoting health education to lower disease susceptibility.

By the time the Lalonde Report (explained below) was published, Health Promotion was conceptualized as an enhancement of health, creating ideal conditions in contrast to disease. When the term was applied to the project U.S. Healthy People, it meant the improvement of individual lifestyles.

Reviewed in the 1980's, Health Promotion was advocated as the improvement of not only individual lifestyles but also environments. So, the idea of Health Promotion has varied with the times.

Section 1 The Lalonde Report / the Alma Ata Declaration

Remarkable technical innovations greatly contributed to clinical medicine after the War, and various new treatments were also developed in the 1970's. However, the methods of medical care came into question, as the burden of medical costs increased and doubts were posed about the significance of treating the whole population. Under these circumstances, a report by M. Lalonde, then Canadian Minister of Health, was released.

The Lalonde Report aimed at shifting the emphasis of public health activities from disease prevention to health promotion and restructuring the determinants of disease (i.e., the hosts and causes of disease) using long-term multiple etiologies rather than one isolated etiology. Starting with this report, the so-called new public health movement spread over Europe and the U.S. (Table 2-1).

Other reasons why this movement became a worldwide trend, along with a new understanding of the importance of disease prevention, included discoveries of disease causation through epidemiological developments and also a rise in people's commitment to civil rights and human rights movements at that time. Disease prevention activities brought about a new point of view not only for healthcare workers but also for many other people.

After the Lalonde Report and a study by T. McKeown, Halfdan Mahler, then Director-General of WHO, made the Alma Ata Declaration in 1978, in which he called

for converting the emphasis of medical care from advanced techniques to primary healthcare including disease prevention.

Section 2 Healthy People / Health for All (HFA) 2000

In 1979, using the basic ideas of the Lalonde Report, James McGinnis, a technical official of the U.S. Department of Health and Human Services, worked out a new national health policy called "Healthy People." This new policy was characterized by putting an emphasis on epidemiological or health risk factors, especially on health realization by improving individual lifestyles. Healthy People adopts a method of setting scientifically substantiated numerical targets for each age group and aiming at those targets as a national movement.

This method came into wide use all over the world in the 1980's. Especially in Europe, as part of "Health for All 2000," which was promoted in 1982, target-setting to promote health was adopted and 32 countries developed about 200 targets in 12 categories. Some countries, including Sweden, set up targets according to age groups.

Section 3 Healthy City / The Ottawa Charter

In the latter half of the 1980's, criticism arose against prevention activities based on the efforts of individuals. Pointless blaming of suffering people should be avoided, because disease cannot be prevented merely by individual efforts; preventing disease also requires improvement of social environments and development of resources. Thus, in 1986, I. Kickbusch and others advocated an environmental improvement movement mainly in Europe, using the notion of Healthy City, the whole environment of which was to be improved to contribute to health promotion.

This movement spread from Europe to the rest of the world. In the same year, an international conference on health promotion was held in Ottawa, leading to the adoption of the Ottawa Charter, which called for promoting health by improvement of not only individual lifestyles but also social environments.

Section 4 Target-oriented Health Promotion Policies

An increasing number of countries adopted a policy of enhancing their people's health by improving living environments. The United States, for example, set goals for the year 2000 and the second round of Healthy People with an additional 22 prioritized fields and 300 targets. Now they are drawing up Healthy People 2010.

The U.K. announced a new health policy, the Health of the Nation, in 1992 as part of reforms of its government-run healthcare system under the Thatcher

administration, choosing 5 diseases for primary focus and setting 26 targets. In 1998, the Labor Party started to work on a new strategy called Our Healthier Nation, but it took over basically the same methods as those of the Health of the Nation.

Also, in Canada the Province of Quebec started "Health and Well-being" in 1992, and the Province of Ontario started "Nurturing Health" in 1993.

Figure 2-1 The History of New Public Health Movement

Chapter 3 Basic Strategy

Section 1 Basic Policies

To put a health promotion policy into practice effectively, it is necessary to make the strategic plan and the executive plan separately. Then, a feedback cycle of "plan-do-see" must be established, in which the results of implementing plans are assessed and reflected in the next round of planning.

A strategic plan places its emphasis on ideas or goals for a long-term direction, so those with a sense of the whole situation make the plan. On the other hand, an executive plan has its emphasis on deciding measures or allocating resources for an effective implementation of policy, so highly practicable plans should be made by workers close to the field (Table 3-1).

In strategic plans, we generally find "vision," "concept," "purpose" and "target." "Vision" is a guideline for overlooking the whole plan and showing a direction for all participants. "Concept" is a sort of code of conduct for participants, showing the basic conception central to a plan. "Purpose" shows the concrete goals of a plan and should be shared among participants. "Target" is a numerical indicator for a plan and should also be shared among participants. Strategic planning includes status analysis, prioritization and identification of participants. Also, a resource development program necessary to promote the plan must be made. An executive plan includes practical matters such as actual procedures to be used.

For Healthy Japan 21, this report is a strategic plan for the whole nation. It is desirable for local governments and health-related groups such as insurance providers, which support health promotion activities, to make their own plans by referring to this report. Making a strategic plan on the local level is also important in order to determine appropriate participants, develop resources and guide the local community

to one direction.

For central and local governments, it is crucial to build “assessment standards” for activity results and “an information system to follow up.”

Table 3-1 Strategic Plan and Executive Plan

Plan	Purpose	Period	Factors	Designers	Necessary resources
Strategic	Decide the overall direction based on estimates	Long-term	Vision—participants Idea — How to develop resources Purpose — assessment standards Target-tracking systems Object — collecting information	Those who can grasp the whole situation	Mainly the means to plan, track and support
Executive	Implement a strategy effectively	Short-term	Purpose, targets, resources, procedures, assessment methods	Workers close to the field	Mainly the means to implement and track

1. Vision

Given that its people have the longest life expectancy in the world, Japan has become a leading country not only in economics but also in health issues. In the 21st century, however, Japan has to create a society in which elderly people enjoy a healthy life, addressing the new challenges of an unprecedented aging society. Healthy Japan 21 is a health policy designed to extend DFLE in the 21st century with a determination to be in the forefront of realizing healthy new societies.

In order to make a super-aging society vital and viable, a new health policy must be promoted by making good use of the results of health promotion activities both in Japan and abroad, and by taking future changes in disease and in society into consideration.

2. Concept

Health realization is primarily an issue for individuals to address through their

own initiative. The process of "discovering" the meaning of health, of "selecting" measures and resources for it, of "planning" a life-long health promotion and finally of "realizing" their own health is needed. On the other hand, in the environments surrounding individuals, there are health-related groups (e.g., the mass-media, businesses, NPOs, workplaces, schools, families, insurance providers, and experts), which can greatly contribute to individual health realization by offering health-related resources (e.g., infrastructure systems, information, products, and services). Society should develop those health-related resources and provide information needed for individual choices. As each health-related group has different characteristic constituents, it is important for them to cooperate with each other to help individuals realize health.

On the other hand, individuals can work with health-related groups to make them function better and also help others to realize health as fellow members of these groups.

The central idea of Healthy Japan 21 is to realize health for individuals through the cooperation of individuals and society. For the success of Healthy Japan 21, both individuals and health-related groups need to take part in the movement, fully understanding the vision, concept and purpose of Healthy Japan 21 as well as their roles.

3. Purpose

The purpose of Healthy Japan 21 is to reduce the social burdens of disease and disability, to extend the DFLE of the Japanese people, and to build a vital and viable society. As it is ultimately impossible to prevent people from dying, the emphasis in disease prevention should be put on avoiding premature death. From the view of individuals, the purpose is to lead a rich and satisfying life by preventing premature death and disability and thereby enhancing the quality of life.

To carry out the purpose of Healthy Japan 21 as a society and also from the view of an individual, it is necessary to set objectives for each stage of life and to take needed measures, because health issues vary according to age group or generation, and each stage of life consequently affects the next stage and the final result.

4. Target

Detailed in the next chapter.

Section 2 Reaching out to a Subject Population

1. Coordinating the Primary and Secondary Preventive Measures

In light of the natural history of disease, there are three stages for disease

prevention. The primary prevention for eliminating disease causes is divided into three categories on the basis of individual lifestyles, environments and medical care. First, there is Health Promotion, which is carried out by improving individual lifestyles through physical exercises and nutrition, for instance, and countermeasures to deter smoking and problem drinking. Second, we have Health Protection, which aims at reducing environmental risk factors and includes safety and health measures in workplaces and environmental healthcare. Third, Disease Prevention (i.e., reduction of disease incidence) includes the prevention of infectious and circulatory diseases and promoting maternity and child healthcare. Practically, however, as health determinants influence each other, it is difficult to draw a clear line between these three categories.

Secondary prevention, early detection and treatment of disease, can be first divided into case finding and risk finding. In the former category, efficiency and accuracy management is important in detecting a small number of abnormal cases among a large number of subjects. In the latter category, a tracking management system is important in order to reduce the risks of the detected subjects. Tertiary prevention is the stage of rehabilitation to avoid social disadvantages. Healthy Japan 21 should adopt the best combination of techniques belonging to both primary and secondary prevention with a scientifically based assessment. In recent years, "disease management" as a technique of HMO/PPS management care has been developed mainly in the United States. This technique follows one patient consistently from prevention to rehabilitation with efficient and effective management. It can be called a modern application of a technique based on a classic division into stages.

2. The High Risk Approach and the Population Approach

A disease-prevention method singling out those with a higher risk in a population with a risk factor for a health disorder and then reducing the risk is called the "High Risk Approach", while a method emphasizing reduction of risk factors for the whole population is called the "Population Approach" (Table 3-1).

In the case of hypertension, for example, by determining a population with clinical hypertension and lowering their blood pressure with intense treatments such as the use of depressor, the complication incidence for the population can be lowered. But the number of those in the borderline hypertension zone who will later suffer from serious complications including stroke actually far exceeds the number in the hypertension zone. Thus, more complications can be prevented with the Population Approach (Table 3-2).

The High Risk Approach has a clear logic and easily specifies its target subjects, but the extant of its effects is limited. On the other hand, in light of preventive effects on the whole population, the Population Approach becomes necessary, but, because it generally needs to be applied to the whole society, it is difficult to measure its effects numerically.

It is essential to implement measures with an appropriate combination of the High Risk Approach and the Population Approach.

Figure 3-1 High Risk Approach and Population Approach

Figure 3-2 Risk factors and the number of subsequent complications

3. Utilization of Social Marketing

The promotion of Healthy Japan 21 needs a kind of social marketing, that is an application of marketing techniques to promotion of social policies (e.g., information provided through the mass media, the development and supply of products and services by businesses, services and approaches by healthcare professionals) (Table 3-3). From the viewpoint of individual lifestyle improvement, it is generally said that changing individual lifestyles takes three steps: "the acceptance of knowledge," "a change in attitude" and "a change in behavior." In the order, "the mass media," "contact through small groups" and "person-to-person services," the effects are found to be increasingly effective.

Figure 3-3 The course of social marketing

Chapter 4 Establishing Targets and Assessment Standards

To promote Healthy Japan 21 effectively, information sharing by means of planning and target management and assessment are the main techniques.

Section 1 A Target Setting and Assessment Framework

For the fundamental goals for Healthy Japan 21, extending the Japanese people's DFLE and enhancing the quality of their lives, a comprehensive implementation from prioritizing health objectives to managing their realization is necessary, as in the

following framework.

1. Assess health objectives in terms of importance and prioritize them.
2. Determine the health services needed to address a particular health objective.
3. Assess comprehensively the benefit and risk bases for each health service and select the service from which the best health improvement can be obtained.
4. Set achievable targets in health improvement for the service.
5. Put the chosen service into practice and, at the same time, manage how it is implemented.
6. Finally, evaluate how well the targets are achieved and examine problems for the purpose of further improvement of management.

As this framework is instituted to address health objectives, the various participants in Healthy Japan 21 are asked to utilize it with an eye to their situations.

Section 2 Selecting Health Objectives

It is necessary to prioritize focused health objectives because of the limitations in usable resources such as personnel, materials, available time and budgets.

To improve health and the quality of life, it is important to focus on the hindrances to these goals (i.e., diseases and disabilities). There are three typical approaches to prioritizing health objectives described below. In discussing health improvement and the quality of life, the essential role of treatment or rehabilitation in health-related services should not be underestimated and it is necessary to assess the benefits and costs of healthcare and welfare comprehensively in order to find a balance.

1. The Burdens of disease

In this often-used approach, the degree of disruption to health or the quality of life and the burdens of necessary expenditures in a population directly represent the importance of health objectives and health services. Mortality, disease prevalence, low QOL, Disability Adjusted Life Years (DALY), Disease-free Life Years (DFLY), and healthcare expenditures are employed as concrete indicators of the burdens of disease.

2. The possibility of health improvement

The possibility of health improvement is also an important element. If there is zero possibility in the first place, it is meaningless to consider objectives. Assessing the bases of health service effectiveness is necessary to plan service programs and to make the final target of health improvement clear.

3. Economic efficiency

Economic efficiency should also be considered; the benefits of a health service

toward health improvement and the social resources which the service requires should both be assessed. In short, the value for money must be considered.

Based on the assessment results (e.g., the cost to extend Quality-Adjusted Life Years by one year), health services or health objectives can be prioritized. At the same time, however, equitable policies should be maintained to avoid disadvantaging anyone.

Section 3 Target Setting

The first thing to do in setting a concrete target is to assess the possibility of health improvement. Secondarily, get a handle on the status quo (e.g., the subjects, the scale and type of areas and the health conditions of each, risk factors, and health services). Finally, set targets taking into consideration all factors.

1. Assessment of Health Improvement Possibilities

First, assess the improvement possibilities for each health objective. Examine 1) the nature of an intervention, 2) the quality of evidence, 3) the predictive effect and 4) the costs vs. the effects for available health services to reach the particular health objective, and then choose the most desirable health services. A brief explanation of each area follows.

1) The nature of the intervention: To put health services in practice, list concrete services available, such as a healthcare guidance or screening.
2) The quality of evidence: To improve health through services, assess scientifically proven means of intervention using clear standards and then classify them. This kind of assessment has been already conducted in the United States and Canada (Table 4-1).

   As for evidence, when domestic information is not available, use reliable information from abroad. The lack of accurate evidence could be replaced when necessary with recommendations based on professional opinion or experience in communities.
3) The predictive effect: To estimate the health improvement of a particular service, predict how the service will reduce mortality and disease prevalence. At this time, the acceptance rate of the service should also be taken into account.
4) Cost vs. effect: Determine effective services by estimating the costs of a given service (workers, commodities, time) and comparing the result with possible effects. However, as information on effects may be limited, be aware that it will add to costs to provide new data.

Table 4-1 Interventions for the General Population (ages 25-64)
U.S. Preventive Services Task Force (2nd ed. 1996)

General Measures/ Specific Checkpoints/ Quality of evidence/ Strength of recommendation	
Checkup	Blood pressure
	Height and weight
	Total cholesterol
	Papanicolaou (Pap) test (uterine cancer)
	Fecal occult blood test (colon cancer)
	Mammogram (breast cancer)
	Problem drinking assessment
	Rubella Serology or vaccination
	Tobacco cessation
	Alcohol/drug use avoidance
Diet and Exercise	
	Limiting fat and cholesterol
	Adequate calcium intake
	Regular physical activity

Quality of evidence: I (randomized controlled trial), Ⅱ-1 (controlled trial), Ⅱ-2 (analytic epidemiology), Ⅱ-3 (time series study), Ⅲ (opinions of respected authorities)

Strength of recommendation: A (good), B (fair), C (insufficient data, other reasons)

2. Service Assessment

Second, for a particular service, assess the type, scale and current conditions of the subject population and area.

Working on the national or local level, it is necessary to identify a subject population and its corresponding area related to a given health issue, as well as its type and scale. In other words, for each health issue, determine how large the subject population is in each age group or area (as shown in Figure 4-1).

Then, assessing the current conditions of each subject population and area is necessary. This process requires particularly caution, because it closely relates to 3) predicted effects, described above.

Figure 4-1 School attendance/employment according to age

3. Target Setting

Finally, set a target from a comprehensive point of view. The effect on the overall community can be obtained by multiplying the subject populations according to age and area by the predictive value of a given health service, and then adding up those products. A feasible target can be set by comparing that effect with current values.

However, the final determination of a target requires discussions and a consensus of Healthy Japan 21 participants or the people concerned based on collective information, because there are various uncertainties or points of inadequate information. In such cases, the trends of a particular health issue must be fully taken into account.

Section 4 Assessment of Target Achievement

To know to what degree an objective of Healthy Japan 21 has been achieved, the results in relation to individuals, the subject population and the community overall as well as current conditions should be examined. For that purpose, the nature of a particular objective and the means of collecting information about it must be decided before setting a target. If there is no information collecting framework, you must start making the framework itself, too.

A kind of health information center with the function of supporting the activities of the main groups involved is necessary. It monitors the progress of plans with reference to statistical data, collects data for each community, and provides information concerning their activities (See Chapter 9).

Chapter 5 Status Analysis

Section 1 The Current Situation Concerning Premature Death and Disability

1. Premature Death

According to Life Table, a Life Stage Mortality Rate (LSMR) /65 (the probability of dying before the age of 65) has been dramatically improved from around 50% in 1948 to 15.7% for men and 7.8% for women in 1997, and this decline is expected to continue (Figure 5-1). However, the regional disparity for men is 1.5 times between the lowest

(Nagano) and the highest (Aomori) (Figure 5-2). Childhood (~15) accounts for only around 5% of LSMR/65, so deaths are concentrated mostly in the period of middle life (45~64).

Measured by Potential Years Life Lost Standardized Rate (PYLLSR), which indicates the length of life expectancy lost by premature death, cancer is ranked at the top among causes of death, followed by accident, suicide, heart disease and cerebrovascular disease (Figure 5-3).

Results for causes of death by life stage show that the leading causes are congenital/perinatal disease for those aged 0-4, accident for those 5-24, suicide and cancer as well as accident for those 25-44, and cancer for those aged 45-64 (Figure 5-4).

Figure 5-1 Trends of LSMR (0~64 years)

Figure 5-2 Prefectural distribution of LSMR (0~64 years)

Figure 5-3 PYLLSR

Figure 5-4 Causes of death by life stage

2. Disability

The number of designated disabled persons at all ages is estimated at about 5.76 million. The leading subcategory in infancy and childhood is intellectual disability, in adolescence and maturity it is mental disability, and in middle life it is physical disability. Physical disabilities after the middle years mainly are attributable to cardiovascular disease (stroke) and bone fracture/ falling. To prevent those disabilities, countermeasures for lifestyle-related diseases during younger stages is important. Other disabilities, which also seriously affect QOL, are concentrated among the most elderly (e.g., dental diseases causing dysmasesis or impaired sight). The number of elderly bed-ridden or suffering senile dementia is estimated at about 1.4 million in 2000 and 2 million in 2010. Recently, with the introduction of long-term care insurance for the elderly, Disability-Free Life Expectancy (DFLE) has been calculated on municipal levels.

3. Disease Burden with Premature Death and Disability Data Combined

In terms of the burden of disease on society overall including both premature death and disability using an abridged method recently developed, Disability-Adjusted Life Years (DALY), cancer, cardiovascular disease and mental disorders account for

about 20% respectively, followed by accident (Table 5-1).

Table 5-1 Leading diseases using DALY calculations (1993)
Cancer, depression, cerebrovascular disease, accident, ischemic heart disease, arthrosteitis, pneumonia, suicide, schizophrenia, cirrhosis hepatis, diabetes, asthma, congenital anomaly/anomorphosis, chronic rheumatism, dental disease, nephritis/renal failure, chronic obstructive pulmonary disease, dementia/Alzheimer's disease

4. Other Viewpoints

The health condition of individuals is often described using personal expressions: "spending daily life satisfactorily," "being able to work" or "enjoying one's food," which shows the fact that people matter more than diseases. Thus, it is important to recognize health in light of not only death or disability but also in terms of everyday life.

In that sense, mental health is a particularly important health issue closely relating to QOL. It has three aspects: being aware of one's emotions and being able to express feelings (emotional health), being able to consider a given situation adequately and find practical solutions to problems (intellectual health), and being able to build a constructive relation with society or others (social health).

Those important health issues should be addressed taking the possibility of improvement into consideration. As individual lifestyles and the surrounding social environments vary with age or population segment, it is necessary to clarify which diseases to prevent and which causes to deter, according to age or population variation (See Chapter 6).

Section 2 Concepts of Target-Setting

To reduce LSMR before 65 means to reduce the likelihood of individual premature death during every life stage. Given the central idea of Healthy Japan 21, it is a valuable objective. LSMR before 65 is 15.7% for men, 7.8% for women and 11.8% for both genders, and it is estimated to be 15.4%, 7.3% and 11.4% respectively for the year 2000. According to statistics in 1997, LSMR before 65 from cancer is 4.6% for both genders and accounts for 39% of LSMR before 65 overall, followed by stroke (1.6%, 9%), suicide (0.95%, 8%), and ischemic heart disease (0.67%, 7%).

Reducing disabilities of the elderly is necessary to extend DFLE at the national level. The number of those bed-ridden or demented over 65 in 2010 is estimated to be

2 million, and the leading causes of impairment are stroke and bone fracture.

Addressing the reduction of premature death and the prevention of disabilities of the elderly, a major issue is how to reduce the incidence of related diseases (Figure 5-5). Preventing stroke and bone fracture as well as tooth loss is important to reduce the disabilities of the elderly. Those diseases are usually related closely to lifestyle, so hypertension, diabetes, smoking, obesity, physical activity, etc. are the objects of concern.

Therefore, our overarching goal is to reduce premature death and disability among the elderly. Under this large goal, there are also some mid-level goals: prevention of cancer, stroke, heart disease, suicide, tooth loss, etc. In addition, we should set up smaller goals for improving lifestyles, using standard and target values in each case.

Figure 5-5 Risk factors for premature death and disability

Chapter 6 Issues for Each Life Stage

Section 1 Lifelong Health Issues

1. Premature Death

One's life can be divided into six stages: infancy (growth), childhood (learning), adolescence (embarking in life), adulthood (work), middle life (maturing) and senescence or old age (harvest) (Figure 6-1).

Individuals step forward from one stage to the next, carrying out their roles or responsibilities according to each life stage, and then reach the end of their lives. Of course, a stage is not independent from the others. One stage generates and lays the foundation for the next, and how one lives in one stage greatly influences life in the next stage.

Preventing cancer and cardiovascular diseases, which occur mostly in the stages of adulthood and middle life, requires health-oriented improvement through all life stages: establishment of healthy living habits within a family in infancy and childhood, the spread of the knowledge and skills of disease prevention in adolescence and concrete behavioral changes in adulthood.

Preventing stroke and general negative aspects of aging contributes to reducing disabilities and, in turn, to enhancing the QOL in senescence. Thus, it is important to

maintain regular physical activities and proper diet from the stage of adolescence.

In addition, lifelong dental health management, starting with preventing baby teeth from decaying in infancy, is desirable to prevent tooth loss and keep a masticating or chewing ability even in senescence.

Reproductive and maternal health are directly connected with childhood health, so measures linking the two generations are necessary.

Lifelong health promotion might even be called a customized living style for an individual. It is important for individuals to build their own life scenarios based on their own values, ways of living and perceptions of health. On the other hand, health professionals should provide them with bi-directional communication and support them with their expertise.

While each life stage is part of the process individuals pass through as they are aging, a given generation is made up of "cohorts," or those who were born in a particular period of time and share contemporary events (Figure 6-2). Each generation needs particular measures suitable for them, because a generation born in the first decade of the Showa Era for instance has different characteristics from those of baby boomers.

Figure 6-1 Health realization by individuals

Figure 6-2 Generations or cohorts relating to Healthy Japan 21

Section 2 The Six Life Stages

1. Infancy (Figure 6-3)

(1) Characteristics

Infancy is the period in which physiological functions gradually become independent. It is an important period in preparing for childhood, and in developing personality and good living habits. The death rate during this period has been dramatically improved to become one of the lowest in the world. Most deaths in this group are attributed to major morbidity or congenital anomaly occurred in the perinatal period, though accidents also account for a large portion. There are more intellectual disabilities than in other periods, and many of them result from congenital or perinatal conditions. There are relatively many patients, both outpatients and the hospitalized; respiratory tract infection ranks at the top for outpatients and asthma for hospitalized patients. The family members, parents in particular, greatly influence how the perception of health is formed.

(2) Issues

It is important to take countermeasures against accidents, an avoidable risk, and to put an emphasis on interventions through the family. Education in the family concerning health-related habits and maternal and child healthcare from the perinatal period is also essential.

2. Childhood (Figure 6-4)

(1) Characteristics

This is the period which prepares people for engagement in social activity and the period for development of psychoneurologic functions. This period doesn't show a remarkable increase in deaths and disabilities, or disease cases, but the incidence of dental caries rises considerably. Even though the actual number of deaths is relatively small, they are generally caused by accidents. The perception of health in this period is often related to cleanliness and hygiene.

(2) Issues

This period is important for establishing living habits and contact should be made through school or family. In light of the prevalence of premature death and disability, preventing accidents is a crucial issue.

3. Adolescence (Figure 6-5)

(1) Characteristics

This is a transitional period from childhood to adulthood, physically with a full growth of reproductive function. Mortality is extremely low and disabilities and diseases occur relatively seldom. As causes of death, accidents and suicides are notable. Most outpatients suffer from respiratory infectious diseases and most inpatients result from accidents or bone fractures. Health is perceived in this period from a viewpoint of beautification or fashion.

(2) Issues

Living alone or in a college environment tends to promote problematic living habits, which can develop into risky habits later in the stage of adulthood. As adolescents are likely to be offended by social interventions, concrete methods for improvement should be carefully devised. Supportive approaches should be taken mainly through school and workplace, and the mass media and businesses can also play an important role.

4. Adulthood (Figure 6-6)

(1) Characteristics

Socially, people in this stage are very active working and parenting. Their physical functions are fully developed. From this period, however, mortality begins to

increase gradually; LSMR dx25-44 is 2.2% for men and 1.2% for women. Mental disorders and physical disabilities also start increasing, and so does the number of patients, both in and out of hospital. For outpatients, there are many respiratory infectious diseases as well as dental diseases including periodontitis. For inpatients, external injuries, bone fractures and cancer become notable. Cancer ranks first among causes of death, followed by suicide and accident.

(2) Issues

Being able to work is the test of good health in this period. The time of raising a family can also offer a good opportunity to rethink health through child care practices. Supportive approaches should put an emphasis on the workplace and families and also reach out through the mass media and businesses.

5. Middle life (Figure 6-7)

(1) Characteristics

Middle life means socially a life stage for preparing for coming senescence; physical capabilities are gradually declining. This life stage accounts for the largest portion of deaths under 65; LSMR dx45-64 is 13.1% for men and 6.3% for women. In this stage, there is a rapid increase in physical disabilities. As for disease incidence, both the number of hospital admission and new outpatient cases increases; for outpatients, respiratory infectious disease and external injury top the list and cases of low back pain and ophthalmologic disease are also rising. Cancer ranks first for inpatients, followed by bone fracture and heart diseases. Perception of health in this period is closely connected with disease, and people start being more concerned about their health.

(2) Issues

Preparing for the next stage, senescence, people generally build up human relations through hobbies, discussion of health-related topics and taking care of parents. It is important to design one's own healthy life in view of potential disability and the general QOL during senescence. Baby boomers now in this stage should be planning for their old age as they reach retirement age. Supportive approaches should put an emphasis on community in addition to workplace and family, and the mass media and businesses should also bolster these means of contact.

6. Senescence

(1) Characteristics

The stage of senescence is a harvest time, the "golden years" at the end of life, but physically the progress of aging brings more health problems. People bedridden or suffering from senile dementia need nursing care. Other disabilities such as vision

and hearing impairment and masticatory dysfunction also lower QOL. As for disease incidence, an extremely large number of patients can be observed; there are many outpatient cases of hypertension, low back pain and cataracts and many inpatient cases of stroke, heart disease, cancer and cataracts. Focusing on averting death and disability, the perception of health in this stage tends to be negative.

(2) Issues

Professionals in community healthcare and welfare mainly work on supportive actions. It is important for people during this stage of life to make efforts to maintain a good QOL even with a certain degree of disease or disability. For that purpose, interacting with society and taking part in social contact is essential. It can be said that how one lives affects physical health.

Section 3 Focusing on Particular Life Stages

As mentioned in the previous section, approaches to promoting health have to be taken according to the health issues and the health perceptions of each life stage, but in light of effects and efficiency it is important to focus on specific periods when people are more concerned about health or more easily influenced.

Infants or children receive a basic perception of health and form their own ideas and living habits under the protection of their families. School and family life largely influence them. When they enter early and middle adolescence, they are influenced less by family but more by school education. In addition, their friends and the mass media also become influential. In this rebellious stage, they are vulnerable to bad habits and not a few of them fall into a problematic life style. To address this problem, making contact through their friends can be effective.

In early or middle adulthood, people build a home and raise their children. This period offers a good opportunity to rethink what health means to them through their children's health, and human relations built in this period become important resources for the next stage. From middle life onward, people review their health preparing for their old age or through the experience of taking care of their parents. The mass media and close human relationships can have an effect on them.

In Healthy Japan 21, in light of obtaining sustainable effectivity in a long-term perspective, the stages of infancy and childhood are the most important. With its influence on the following stages, adolescence also means a lot. On the other hand, given that Healthy Japan 21 will be implemented from 2000 to 2010, those who were born in the first decade of the Showa Era and baby boomers are considered important target groups (Figure 6-2). It should be noticed that the focus in supporting these generations is shifting from the workplace to the community.

Figure 6-2 Generations or cohorts relating to Healthy Japan 21

Chapter 7 Environmental Improvement and the Role of Those Influencing Change

Target setting itself is not the purpose of planning and promoting the project Healthy Japan 21. The purpose is to inspire Japanese citizens to realign their attitudes and behaviors by setting various targets, which indicate standards to achieve, through wide-ranging discussions. Health realization is basically an issue in which individuals should take the initiative according to their various health perceptions. Along with those individual efforts, it is essential to create an environment to support individual behavior modification for the whole society.

Not only individuals are responsible for their behavior modification and the consequent health conditions. To enhance health standards, environments surrounding individuals must be improved. This idea parallels the concept of health promotion advocated by WHO in the 1986 Ottawa Charter and widely deployed in European countries and the United States, as previously mentioned.

To promote environmental improvement for Healthy Japan 21, it is necessary to clearly identify influential effectors of change and specify the role of each. They should complement each other, making the best use of their respective characteristics, work together, and support all citizens effectively.

Section 1 The Mass Media

The mass media can spread much information swiftly and continuously to a large portion of the general public, young and old, from urban areas to the countryside. However, once information is distributed, it can hardly be corrected. The mass media can directly impact all generations and all age groups. In particular, the electronic media has a strong influence on the younger generation.

The mass media can be divided into three categories: electronic media such as TV and radio broadcasting, print media such as newspapers, magazines and books and new media such as the rapidly spreading Internet and CDs. Some media, health magazines, for instance, specialize in healthcare topics, and other media such as TV and newspapers treat health as only a part of their contents.

Information is a resource the mass media can offer. As people often obtain

health information through the mass media, there is a social responsibility to convey health information on a scientific basis. In addition, media are closely connected with business activities, because they generally depend on advertising revenue.

Section 2 Businesses

Businesses can contribute to individual health through a diversified and creative market, which provides people with sufficient information and options. As various business activities are related to every phase of people's lives, positive business developments contributing to the general health are highly desirable.

In Japan, there are 6.7 million companies providing products or services (as of 1996). They are categorized by scale (large companies as well as small and medium companies) or by type of industry (health industry, non-health industries).

In the health industry, there are about 640,000 business institutions relating to environmental health, 10,000 pharmaceutical or medical equipment companies, 7,000 medical care companies including test contractors, and 2000 companies relating to health promotion such as sports facilities, etc. By providing products or services, companies influence consumers' health. For example, pharmaceuticals and medical equipment directly relate to consumers' health, while services for relaxation, physical exercise, and stress relief are also provided by businesses. Even though not categorized as a health industry, the food industry, for instance, and many other companies have some bearing on health.

Because of changes in individual needs, fewer family members and a faster-paced lifestyle, what used to be offered by the family is now available elsewhere. For example, eating prepared food sold at supermarkets and eating out are getting more and more popular. The selective behavior of individuals and awareness of the food industry have a strong influence on individual nutrition improvement.

Therefore, businesses can contribute to consumers' well-being by offering health-promoting products or services. They can also convey an image of a healthy life style to many people through their sales promotions.

Businesses should take positive actions to provide relevant information such as nutritional labeling for food and hazard warnings for cigarette so that consumers can select healthy lifestyle habits through their own initiative.

In addition, businesses are responsible for the health of their employees and have an important role in health management at worksites.

Section 3 Nonprofit Organizations

Recently, organizations which, unlike businesses or the mass media, don't pursuit profits have increased rapidly. These nonprofit organizations (NPOs) can provide accessible information or resources on a grass-roots basis, but they are prone to have difficulty in expanding their activities. The ardent involvement of each participant is a key advantage of NPOs, but their liabilities are linked to the limitations of individuals, too. Relatively close and continuous contact through NPOs bolstered by the efforts of participants can be influential with the following groups.

Adolescents are influenced through relations with the same age group or hobby group, and young adults are influenced through relations for sharing a common interest such as child-rearing or hobbies. Topics in these circles are not always connected with health in the beginning, but they can eventually include health issues. In the stage of middle life, people have various human relationships within their communities, such as taking care of parents, enjoying hobbies and working, and it is important especially for this part of the population to think about health together.

There are various kinds of NPOs. According to the National Council of Social Welfare, there are about 80,000 volunteer groups with as many as 5 million volunteer workers. They have a wide range of activities: healthcare and welfare, social education, community planning, environmental protection, promotion of arts and culture, disaster relief, international cooperation, etc. Among them, healthcare accounts for a large proportion.

Information offered by NPOs is close to the daily lives of people and useful in comparison with that offered by the mass media. NPOs also directly provide people with health-related services and commodities.

Participants in such NPO activities can relate to others in many ways. In the overall picture of Healthy Japan 21, NPOs are expected to provide people with relevant, detailed and accurate information and services which other health-related organizations cannot.

Section 4 Workplaces, Schools, Communities and Homes

Workplaces, schools, communities and homes are the places where people lead their lives, and they are important in making close and continual mutual contact in small groups possible. These places have their own common objectives with relatively fixed members, facilitating continual and effective provision and exchange of information. However, they have one drawback as well: they are liable to lack proactive participation by members.

Schools are where people spend most of their childhood, and naturally health

education at schools carries a lot of weight. Workplaces are where people spend their time as workers from adolescence to the middle life period, and so this place plays an important role not only from the viewpoint of maintaining health while working but also in terms of keeping fit after retirement. Communities are the places people live. These places exert influence on people throughout their lives, and have a great impact on those in infancy and senescence, the self-employed, and homemakers, in particular. As with communities, homes affect people's health throughout a lifetime and this is a crucial site where people in infancy and childhood acquire their lifelong lifestyles.

Section 5 Insurance Providers

Medical insurance can be roughly divided into two types: regional-based and occupational-based. There are approximately 1800 occupational-based health insurance associations organized by single companies or by several co-operating companies of the same trade, and most of the small and medium-sized businesses are subscribers of government-managed health insurance. In addition, there are a large variety of occupational-based insurance providers, including mutual aid associations, while regional-based health insurance centers on municipalities. In addition, there are other insurance associations set up by specific types of occupational groups, and there are over 5000 insurance providers of the both types all told.

Insurance providers make payments for medical expenses to medical institutions on behalf of the insured, and provide health and welfare services necessary for health improvement of the insured and their dependents. Insurance providers affect healthcare professionals' actions, through which they can help improve the health of each individual in the nation.

Along with coping with the risks of an outbreak of disease, insurance providers have so far focused their efforts on disease prevention measures from a viewpoint of providing appropriate medical benefits. However, too much stress has apparently been placed on health checkups or medical examinations, and new activities for health improvement in response to the needs of an era of lifestyle-related disease should be enhanced in future. Specifically speaking, based on the principles of insurance, healthcare endeavors centering on primary prevention as well as relations with medical institutions should be strengthened by aiming at preservation and improvement of health of the insured in order to decrease health risks, as well.

Section 6 Healthcare Professionals

Many healthcare professionals (e.g., doctors, dentists, pharmacists, public health

nurses, nurses, dieticians, and dental hygienists) are working at varied sites (e.g., medical facilities, pharmacies, and administrative organizations) in the fields of medical care and public health. The number of these professionals amounts to approximately 2.8 million.

Healthcare professionals can provide technical skills and information on health issues. Hospitals, clinics, family doctors and dentists which mainly focus on disease prevention and treatment in particular, are expected to assume an increasingly important role not only for treatment but also for disease prevention. As for the missions of pharmacies and pharmacists, consultations about proper usage of medicines and proper healthcare, and provision of useful health-related tips are essential.

Many of these healthcare professionals are state certified and bear a major responsibility for the quality of services they provide. It is especially vital for them to develop their pertinent knowledge and skills for healthcare guidance concerning lifestyle-related diseases.

Section 7 Administrative Organizations

Administrative organizations are classified into three categories: the central Japanese Government, local prefectural governments, and municipal governments. As for the central government, the Ministry of Health, Labor and Welfare as well as the Ministry of Education, Culture, Sports, Science and Technology are the relevant ministries, while in local governments, various public health departments and bureaus are more or less concerned with health issues.

Administrative organizations are legally authorized to give orders or guidance to health-related groups, including regulations or punishment. In addition, compiling policies, guidelines, and proposals based on scientific evidence through councils composed of well-informed people in the relevant fields, they can utilize this information in their own policies, and offer proposals and guidelines to the public at large including private sector healthcare providers as well. There is a downside to these efforts, however: due to its authoritative nature, an administration inevitably becomes one-sided, coercive, and disinclined to encourage individual participation. Providing information and services is also a major role for administrative organizations to play, and promoting studies and research is vital as well.

A detailed account of administrative roles can be found in the next chapter.

Chapter 8 Roles of Administrative Organizations and Local Programs

Section 1 Roles of Central and Local Governments

Central, prefectural and municipal governments each assume different roles in the Healthy Japan 21 project, but each of them needs to map out, implement, and evaluate separate programs. In addition, in drawing up and implementing programs, they ought to combine their efforts when possible and work in tandem with municipal projects for maternal and child healthcare as well as healthcare efforts for the elderly, healthcare projects carried out by insurance providers, and health promotion activities at schools and workplaces. They must also ensure that health objectives are achieved effectively and systematically.

The detailed roles of the nation, the prefectures and municipalities, and points of concern about programs formulated by local governments are as follows:

1. National Roles

The national government is a nerve center for working out overall strategies for Healthy Japan 21. First of all, basic policies should be clarified, and then they should be presented to the public and to health-related groups.

Furthermore, the national government is required to coordinate the efforts of health-related groups and provide guidance to steer the process for smooth health promotion activities, and to reach out to the people through the media and other avenues.

In addition, the national government should establish a data system to provide an accurate picture of national health indexes, a system through which it can conduct data collection and analysis, measure actual progress, and share the results with the public and health-related groups. Furthermore, it should conduct interim and final evaluations about validity of the program, and update the program based on these evaluations.

2. Prefectural Roles

Prefectures are the core bodies for mapping out specific programs for promoting Healthy Japan 21 and supporting health-related groups, including municipalities, for better health. With these goals in mind, prefectures should take into consideration the focus and direction indicated by the national government, study and analyze a variety of health concerns in each prefecture, decide on various health-related groups to take responsibility for health improvement, and call on the public to participate in the Healthy Japan 21 project. Prefectures ought to join hands with these groups in

planning (e.g., prioritizing regional health issues and target-setting).

Incidentally, programs should be mapped out by each prefecture and secondary medical care bloc. In formulating a program in each secondary medical care bloc, public health centers should assume a leadership role in obtaining and analyzing health data.

Furthermore, prefectural governments must reach out to residents through the media and other avenues for smooth health promotion activities.

Prefectures should set up a data system to overview health indexes, evaluate how far the goals have been achieved, and inform residents of the results.

3. Municipal Roles

Based on the fact that municipalities have largely fulfilled their roles as service providers in maternal and child healthcare projects as well as in healthcare efforts for the elderly, they are also expected to take the initiative in program formulation and implementation for Healthy Japan 21, which is intended for the population as a whole. At this time, they should pay heed to consistency with the programs for each secondary medical care bloc planned by the prefectures. In formulating programs, they should join efforts with public health centers covering the municipality concerned.

Since ordinance-designated cities and special wards, unlike other municipalities, have public health centers in their own right, those health centers should assume a leadership role in working out programs. They need to work in close cooperation with prefectures in collecting and analyzing information as well.

In implementing the programs, they should make full use of the municipal health centers, provide health-related information, and help each individual promote good health, cooperating all the while with health promotion centers, medical facilities and pharmacies.

Section 2 Points of Concern in Formulating Local Programs

1. Focused Policy in Municipalities

In order for health policy to be considered an administrative top priority and to ensure better health by instituting the Healthy Japan 21 local programs, prefectures and municipalities should each address their own program on equal terms with their other fundamental programs and overall projects.

2. Principles to Be Incorporated in Local Programs

(1) The principle of “Citizens First”

One of the key principles in local programs is to consider local citizens first and foremost, which means citizens occupy the core position for a health-improvement

drive in communities. This principle holds true not only for communities but also for schools and workplaces.

(2) Developing individual citizens' abilities

Another key principle is to develop each citizen's abilities. For this purpose, as opposed to a traditional professional-led health-improvement drive, more stress should be put on the primary role of individuals in their own self-care development.

(3) A better social environment

Good health can't be obtained by individual effort alone, so improvement of the social environment and development of resources are vital. There is a need to provide a better environment helping individuals become aware of their health status and helping them improve their health through their own initiative.

(4) Public participation

It is important for citizens to participate in decision-making (i.e., every process of this initiative from formulation to implementation to assessment of local programs). On the other hand, it is vital for citizens to be aware of their own responsibility and to go into action without depending too heavily on public administrations for their health improvement. All parties concerned including citizens must share in the overall process, selecting the most effective undertakings possible based on scientific data and clarifying regional special conditions of health and health-related resources.

3. Participation of All Interested Parties in Program Formulation

Formulation of a program in and of itself is not an objective. In such a case, the program would be liable to become perfunctory. In order to map out an effective program, involvement of all parties and agencies concerned from the formulation stage is required, and it is important to make each party's responsibility clear through an examination process.

4. Planning Goal-Oriented Programs

In working out a program, after fully agreeing on and confirming the goals to be aimed at, all parties concerned need to set concrete target values for attaining the goals. Objectives should be appropriately set as target values, and measures to achieve the goals should be spelled out in concrete terms such as checkup rates and the number of home-visit services, for example.

5. Setting Health Improvement Challenges

(1) Clarifying present health levels

Health improvement challenges in the community can be illustrated as a disparity between the current health level and the level to be achieved in the future. However, unless present health levels are analyzed clearly, it will be difficult to make

the health improvement challenges clear. In order to clarify these health improvement challenges, utilizing appropriate information systems and understanding relevant regional traits are essential.

(2) Clarifying the health disparities between neighboring communities

Clarifying the health disparities between neighboring communities is essential for setting health improvement challenges and target values. In addition, it is also useful for causation analysis and selection of needed improvement measures as well. Not only comparison of present values, but also comparative chronological change should be taken into consideration.

(3) Clarifying health improvement challenges according to life stage

The analysis mentioned above should also be reviewed according to generation and age group, and selection of goals and approaches tailored to the needs of each life stage is necessary.

Take cigarette smoking for instance. It is important to view the actual picture of smoker distribution not only among adults but among children, and to work out highly effective smoking cessation measures, working in closer cooperation with schools and boards of education.

(4) Clarifying priorities

Since social resources such as personnel, goods, time, and money are limited, it is necessary to prioritize. In ranking, it is necessary to take every factor into consideration, including the scale of the problem, possibilities for improvement, efficiency concerns, and citizen's needs.

6. Developing Health Resources in the Community

In order to make everyone's lifestyle healthier, it is necessary to vitalize various health resources (e.g., voluntary group activities, social networking activities, facilities for providing meals in the community, the food service industry (such as restaurants) and sports facilities). It is also important for a range of parties concerned to participate in mapping out health improvement programs in terms of developing health resources as well.

Section 3 Points of Concern in Implementing Local Programs

1. Disclosing and Sharing Information

It is clearly advisable that people be kept up-to-date with the progress of environmental improvements and projects. For more effective implementation of the local program, it is vital for the government administration, local citizens and health-related groups to share information on measures and methods with each other.

2. Providing Information and Supporting Individual Choice

Individual values and lifestyles are now more diverse than ever before, and people have by far a more profound knowledge of health than earlier. Under such emerging circumstances, what is required of professionals at health education sessions is to provide the most up-to-date information about the pros and cons of health choices, to provide information for behavioral improvement if the person in question wishes it, and to support each individual's decision-making, as for instance in making decisions about how to maintain a healthy weight or whether to quit smoking or reduce smoking. Instead of imposing or even demanding a course of action desirable from the viewpoint of a professional, the best approach is to pertinently provide the person with necessary information for personal decision-making through discussions which take into consideration where the person stands and any differences in values. Since there can be no uniform options which benefit everyone, professionals should not simply make absolute judgements on whatever options individual might make. Not until a wide variety of options are assured can the individual bear responsibility for the choice he or she eventually makes.

3. Utilization of Private Heath Service Facilities

Naturally, public agencies take the lead in implementing local programs. However, since private sector healthcare-related organizations provide many services in urban areas, it is also possible to make full use of such private facilities for effective and efficient service supply. In such cases, in order to ensure quality service, there is a need to supervise the private health service system and offer needed training to those concerned.

Section 4 Points of Concern in Assessing Local Programs

Final evaluation of the effectiveness of health improvement programs can be ascertained when the health of the people has actually improved or the system has worked well for actual improvements in people's health. The evaluation should be made not only by service-providers but also by consumers and, indeed, all citizens.

After interim assessments, remedial measures should be formulated based on the evaluation results. It is vital to establish an integrated system of information collection, planning, evaluation, and improvement.

In order to promote any program effectively, it is essential to create a clear program formulation schedule by fiscal year, one including program formulation, interim assessment, and re-formulation of the program. As for local programs, schedules for promoting practical program formulation should be specified after a

national-level strategic program has been formulated. It is important to plan in advance necessary campaigns and a variety of events such as presentations of experience by citizen groups.

Chapter 9 Establishment of a Health Information System

Information is indispensable in the formulation, implementation and evaluation of the Healthy Japan 21 agenda. In mapping out a program, up-to-date information is necessary at every stage from understanding challenges to deciding priorities, to setting goals. Likewise, in implementing and evaluating the program, information on the state of progress is critical. It is necessary to ensure that information on the program's state of progress is easily accessible to health-related groups involved in endeavors as part of the program. In addition, due to the program's nature, it is also necessary to provide every individual in the nation with information on prevention methods and other key material.

In order to effectively obtain quality information based on scientific evidence, it is essential to establish a strategic information system for Healthy Japan 21.

Section 1 Roles in Obtaining and Providing Information

1. National Roles

The national government has been compiling nationwide statistical data periodically and systematically and providing local governments and the populace with the information. The national government bears an ongoing responsibility to obtain information in order to keep up with the overall progress of Healthy Japan 21 and assess it. For this purpose, a finger must be kept on the pulse of the current level of the target diseases and risk factors for the program, and to collect information both for the interim evaluation scheduled for 2005 and the summary evaluation to be conducted in 2010.

Furthermore, official statistics collected in the past as well as surveys yet to be conducted ought to be classified according to morbidity and mortality, quality of life, perspectives on health, risk factors on health, and current lifestyle status. In addition, these data should be put in an order so that they will be available for promoting the Healthy Japan 21 project, and they ought to be provided in a format that allows local governments to compare data with others and analyze results.

Unreliable or even health-hazardous information is sometimes reported by the media. So, the national government should provide correct information based on scientific evidence, and use various channels to disseminate it.

The national government should also collect and provide information on a wide range of health service providers so that people can choose pertinent health services easily.

2. Roles of Local Governments

Since many national surveys are sample surveys, information on communities under the control of local governments has in fact been compiled by the central government. Consequently, local governments have been inclined not to accumulate much information. In promoting Healthy Japan 21 in the future, local governments should accumulate information on the relevant community from national surveys, and also on their own initiative collect and accumulate original information suited to regional conditions. In addition, in order for local governments to decide on and implement policies themselves, they need to set up a strategic information system, including information sources utilizing the Internet and other channels of communication.

Furthermore, local governments should also collect and provide information on a wide range of health service providers so that people can pick out pertinent health services easily.

3. Individuals

Information on the health of each individual basically belongs to that individual. Therefore, each individual should handle such information on his or her own responsibility, and move forward toward better health, making full use of the information. In selecting resources for better heath, each individual naturally needs to obtain relevant information. For this purpose, information media suitable for each particular generation or age group should be available.

4. Health-Related Groups

Health-related groups should accumulate and study information on their own, enabling them to join hands with other groups and support individuals more effectively.

Section2 Currently Available Information and Information Desirable in the Future

1. Information on Mortality Statistics

Information on death rates can be obtained primarily through demographic statistics. Demographic statistics can be categorized not only nationwide but also by

prefecture, secondary medical care bloc, public health center, and even by municipality.

However, the reality is that in the past demographic data have not been accumulated by local governments in a way that allows further statistical processing by local governments, and consequently the data have not been utilized fully.

The national government should calculate potential years of life lost (PYLL) and the probability of death before reaching a particular age (e.g., LSMR/65), and provide local governments with the results.

2. Information on Circumstances of Disease Occurrence

Information on the circumstances of disease occurrence for Healthy Japan 21 has not been obtained at the national level at this stage, and only data related to cancer and stroke have been put on record in several prefectures and communities.

A system enabling an overview of nationwide disease occurrence conditions (such as morbidity) should be established in relation to Healthy Japan 21, and this goes for local governments as well.

3. Information on Disease and Disability Rates

From disease data at the national level, the number of patients who are currently on medication can be calculated using the total patient numbers based on the "Patient Survey." However, a detailed picture of those who are not taking medication cannot be obtained just through the "Patient Survey." Consequently, the "National Nutrition Survey," the "Circulatory Diseases Basic Survey" and the "Diabetes Survey" are also being conducted. In addition, to determine dental health status, the "Dental Diseases Survey" has been carried out every 6 years.

Prefectures have not obtained these patient numbers, and it is necessary for them to become able to do so in the future. As for disability numbers, it is possible to acquire data at the national level based on the "People's Basic Lifestyle Survey" by combining the "Patient Survey," the "Survey of Health Facilities for the Elderly," and the "Survey of Social Welfare Facilities." Also it is possible for municipalities to determine disability numbers to a certain extent from data based on the "Handbook for the Physically Challenged."

4. Information on Health-Related Behavior (Lifestyle Choices)

Information on health-related behavior (e.g., alcohol consumption, cigarette smoking, and physical activity) has been obtained at the national level by the "National Nutrition Survey." Some prefectures have carried out follow-up surveys to the "National Nutrition Survey," or even done their own surveys, but this is not the case in all prefectures. Hardly any secondary medical care blocs and municipalities have obtained such data yet. Not only prefectures but also secondary medical care

blocs and municipalities should be able to obtain data about health-related lifestyle choices in the future.

5. Information on Public Knowledge of Disease and Prevention Methods

Neither the national government nor local governments understand well whether people are well informed about diseases and appropriate prevention methods, or whether people accurately know their own health status (e.g., BMI or body mass index, blood pressure, blood-sugar level and cholesterol level). The national government, local governments, and insurance providers, who are all responsible for providing information, must comprehend the above-mentioned circumstances as well in order to supply information efficiently.

6. Information on Access to Healthcare Services

Information on how people use healthcare services may be obtained from the "People's Basic Lifestyle Survey" or the "Health and Welfare Trends Survey", but these surveys have not been conducted regularly. Although the degree of access to services offered by service providers such as health promotion services has been measured by the "Health and Welfare-Related Service Demand Survey," the rate of access to services offered by medical facilities and government agencies has not been determined yet. In reality, information on healthcare services used by people has hardly been obtained even at the national level.

As for the rate of access to healthcare services, surveys from the viewpoint of the general population should be conducted by national, prefectural and municipal governments.

7. Information on the Provision of Healthcare Services

The rate of provision of healthcare services by local governments has been determined in the "Public Health Administration Operating Report," which gives totals by prefectures, the "Public Health Center Management Report," which gives totals by public health centers, and the "Public Healthcare Project for the Elderly Report," which gives totals by municipalities. Among these reports, the "Public Health Center Management Report" was renamed to the "Regional Health Project Report" to mark the full-fledged enforcement of the Regional Health Law, by which means results for municipalities have become measurable. Additionally, in fiscal 1999 the "Public Healthcare Project for the Elderly Report" was incorporated into the "Regional Health Project Report."

8. Surveys Conducted by the Private Sector

Other than national government surveys, many useful surveys have been carried out, including the "National Time Utilization Study" by the NHK Broadcasting Culture

Research Institute and the “National Statistical Survey on Cigarette Smoking” by the Japan Tobacco Inc., just to name two.

Section 3 Effective Usage of Information

Along with determining the provision rate of healthcare services by local governments and insurance providers, the national government should also continue collecting information on a myriad of health improvement programs and their implementation which are carried out by local governments and insurance providers. This is greatly significant not only in terms of supervising planning and implementation, but also in terms of re-distribution of collected information to other governments or implementers in need.

(Translated by Masaki Moriyama, Fukuoka University School of Medicine)

健康日本21、英訳、英語翻訳