Executive summary

In some ways, Japan's public health challenges are distinct from those faced by other OECD countries. The rate of obesity is the lowest in the OECD, alcohol consumption is well below the OECD average, and the rate of smoking is slightly below the OECD average, even if this average masks a significant gender gap in smoking rates, with Japanese men smoking well above the male OECD average. Indeed, Japan's life expectancy – 84.1 years in 2016 – is the longest in the OECD, and almost four years longer than the OECD average of 80.8 years. In other respects, though, the health challenges that Japan is facing are familiar to other OECD countries, for example a rising burden of chronic diseases. Other challenges will be felt even more acutely in Japan, in particular the rapidly aging population; in 2050 nearly 40% of the Japanese population will be over 65, and 15% will be over 80. Promoting healthy, disease-free aging must be a central priority for Japan, and attention must also be paid to the potential for rising rates of risky health behaviour, for example rising alcohol consumption, and even rising rates of obesity.

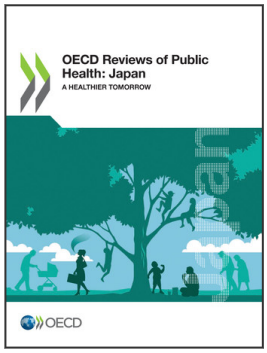
Japan's primary prevention strategy, Health Japan 21 (HJ21) – is a comprehensive programme aimed at improving healthy lifestyles, from increasing fruit and vegetable consumption and exercise, to reducing smoking and alcohol consumption, to improving mental wellbeing and reducing stress. This broad strategy casts the net very wide – for example the strategy includes 53 targets – and local levels of government are expected to tailor their implementation of HJ21 based on local population priorities. In some instances, this has resulted in a variety of innovative, multi-sectoral community-based interventions that bring together different local stakeholders. In other instances, though, HJ21's broad approach risks a dispersion of energy and resources; furthermore, it is not clear that all local governments are equally effective at implementing the types of health promotion and prevention policies that would be required to meet the HJ21 targets. Japan should consider selecting a smaller number of priority areas, and the central government could consider ways to offer more support to local levels of government, for example promoting select interventions that have been proven to be high-impact and good-value. In addition, there is scope for Japan to introduce or strengthen population-level policies alongside HJ21, in particular stronger tobacco policy, as well as new regulation on food labelling, and stronger regulation of the marketing of alcohol products.

When it comes to secondary prevention Japan has also taken a very broad approach; Japan has arguably the most extensive range of health check-ups and screenings of all OECD countries. These include check-ups for infants and children, an annual check for full-time employees, an annual stress test, a specific check focused on chronic diseases, and a series of other screenings which are encouraged but not compulsory, for instance periodic tests of osteoporosis, periodontal disease, or hepatitis B and C. It is not clear that all tests are adding value to the system either in reducing disease, or reducing health costs, and the risk of duplicative tests, waste, over-diagnosis and even unnecessary exposure to harm (e.g. through x-ray radiation) should not be ignored. Conversely, cancer screening – for which there is significant international-evidence of its effectiveness in

reducing cancer mortality – is relatively under-developed, without a nationally standardised approach. There is considerable scope for Japan to re-examine the range of health check-ups that are in place, evaluating all health check-ups and cancer screening together, and likely streamlining the range of tests offered. The focus should then shift to ensuring complete coverage of a smaller range of tests among people with high risks.

Japan faces some relatively significant public health risks, notably a significant exposure to natural hazards such as earthquakes, floods, typhoons, and tsunamis. In some instances, these risks have intersected – for example the frail elderly have been particularly affected by some natural hazards. This significant exposure to hazards has led Japan to make preparedness of public health emergencies a key priority, both internationally and domestically, and a strong set of policies are in place. That said, there is scope for further strengthening, in particular through promoting further co-ordination between stakeholders, for example through inter-agency information sharing, and joint exercises and drills.

Indeed, across all areas there is scope to improve co-ordination and collaboration between stakeholders, and to make the system more data-driven. Japan has a highly decentralised public health system, with the high-level policy direction set by the central government, and implemented at local levels. While respecting the primordial local autonomy established in the Japanese governance system, there may still be scope to offer more support and guidance to less highly performing municipalities, as well as to promote exchange of best practices between local authorities. A more data-driven system could support co-ordination as well as the implementation of other public health goals. For example, a stronger data system – at least part of which should be made easily accessible to the Japanese public – could help benchmarking of local authorities delivering HJ21, the implementation of a more systematic national cancer screening, and even the timeliness and effectiveness of responses during public health emergencies.



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