

Japan's obesity panic:

health and risk management in contemporary Japan

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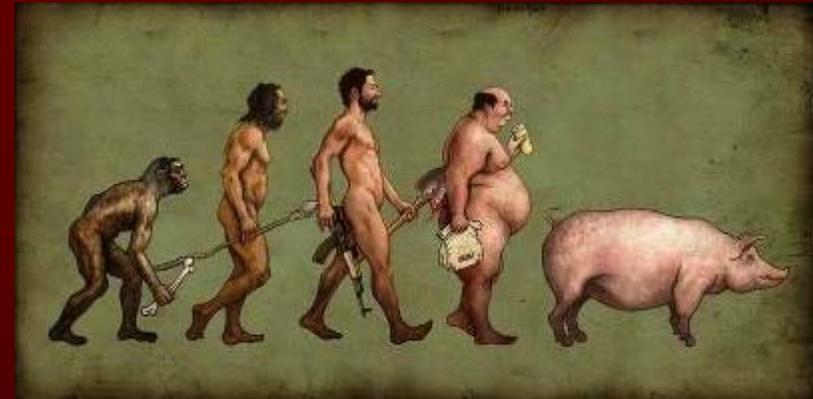
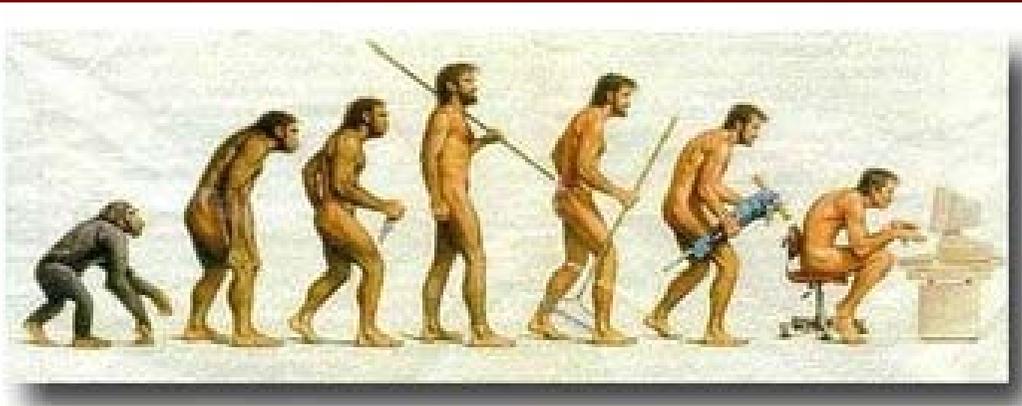
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● The body

- central role in debates on managing life risks
- health work
 - balanced diet
 - fitness activities
 - proper sleep
 - medical check-ups
- medium of communication
 - biological states of health and illness
 - moral qualities of appropriateness and inappropriateness
- body messages are man-made, culturally shaped
 - interwoven in complex web of social and cultural relations
 - e.g. arts, consumption, education, communal life ...
 - interface between self and society



- Era of saturation (*hōshoku no jidai*)
 - excessive food supply
 - 24 hour convenience stores
 - Westernization of diet; increased protein intake
- Era of deficiency in physical activities (*undō fusoku no jidai*)
 - sedentary lifestyles
 - transport and communication technologies



- **obesity** or **adiposis** = excess body fat affecting health
- obesity-related **illnesses**:
 - cardiovascular diseases
 - diet-related chronic diseases, type 2 diabetes, hypertension, stroke, cancer
- “**globesity**”: excessive overweight is threat of pandemic proportions (WHO)
- Japan: low rate of obese (3.1%) and overweight (23.4%) adults
- **obesity crisis**: media reports and government politics
- Special Health Check-up (2008), nicknamed as ***metabo kenshin***
- **metabolic syndrome**: cluster of heart disease risk factors



- 1. study background: obesity concerns
- 2. Beck, Giddens, and Foucault on risk
- 3. anthropometric history of health politics
- 4. *datsu metabo*: obesity and the battle against lifestyle-related diseases
- 5. critical interventions against obesity politics
- 6. media impact, industrial responses and other consequences
- 7. conclusions:
 - health and the risk society of Japan
 - health politics and neoliberalism



● Ulrich Beck, *Risk Society*

- alternative way of theorizing modernity: focus on the production of “social bads”
 - e.g. climate change
 - terrorism
 - environmental pollution
 - depletion of natural resources
- second modernity
 - reflexive process: progress is the course for problems
- hazards are factual, risks are constructed, man-made:
 - human inventiveness, political will:
 - e.g. tuberculosis; New Influenza
- risks are increasingly global in nature
 - → everyone is in danger



● Anthony Giddens, *Reflexive Modernity*

- growth of knowledge generates loss of certainty (customs, tradition, superstition) and demands reflexivity:
 - to make choices
 - to be aware of the consequences of acting
- individualisation:
 - the late-modern subject is forced to make decisions on its own
- increasing reliance on experts
 - authority is increasingly questioned
- responsibility is privatized
 - burdens are often socialized
 - polity response: neoliberalism



● Michel Foucault, *gouvernementality*

- knowledge is contingent on power
 - central concept emerging from modernity
 - risk strategies are subjected to negotiations of truth
 - disciplinary power
 - risk discourses for maintaining the social order
- risk and neoliberal rule
 - government “at a distance”
 - individuals translate rationalities of political rule into microtechnologies of self-conduct
 - responsibility is transferred to the individual
- risk discourses
 - on the surface committed to scientism and rationality
 - but tainted by moral underpinnings



● health risks

- health is a social construct, not a biological fact
 - what is health?
 - how is health maintained, gained or recovered?
 - different layers of knowledge demand different treatments (eg, body harm caused by a spell or bacterial infection?)
- knowledge gains about health and the body
 - specialization of the medical trade
 - knowledge continues to be fragmented, rudimentary; contested
- public health and individual health
 - for the welfare state health risks are public risks
- maintaining health increasingly becomes the task of each and any individual



- Vitality Survey (*Katsuryoku Chōsa*), 1888
 - first survey to monitor the effects of physical training guidelines
 - introduced in 1888 at government-administered schools
- Body Survey (*Shintai Kensa*), 1900
 - mandatory for all schools
 - annual body measurement of school children and students
 - up to the present
- School Health Survey (*Kenkō Shindan*), 1958
 - annual health check-up for pupils, teachers, staff
 - census model
 - body weight, height, proportions, state of nutrition



- Survey of Physical Fitness and Athletic Ability (*Tairyoku Undō Nōryoku Chōsa*), 1964

- for 5th and 6th graders at elementary school level
- after 1967, sample extended to include junior high school and adults up to 29 years
- 1967, introduction of fitness test for adults aged 30 to 60 years
- since 1980, also tests of younger elementary school children

- others

- draft examination (1873-1945)
- National Health and Nutrition Survey (*Kokumin Kenkō Eiyō Chōsa*), 1952
- labour health surveys; occasionally since 1912, mandatory 1972
- regular health screenings of senior citizens introduced in 1970s
- Basic Health Check (*Kihon Kenkō Shinsa*, 1980s) and Special Health Check (*Tokutei Kenshin*, 2007)
- *ningen dokku*: combination of standard medical tests at the occasion of one single hospital visit



- population size
 - from 50 million to 126 million
- life expectancy
 - from less than 52 years to more than 82
- infant mortality
 - from 160/1,000 births to 2.3/1,000
- body size
 - growth in height: from 155 to 172 (m), from 145 to 159 (f)
 - particularly strong growth rates in second half of 20th century: dietary changes
 - sitting height: from 168/89 to 171/91 (Japanese aged 18 in 1930 and 2000)
 - body proportions: Asian body type morphing into European body type
 - changes in weight over the 20th century:
 - female from 47.1 kg to 50.4 (1950) and 51.7 (2006)
 - male from 52.3 kg to 55.0 (1950) and 67.4 (2006)
- international comparison of BMI (kg/m²)
 - Japanese men (23.7) and women (21.8) well below the WHO's cut-off point of 25 defining overweight and 30 defining obesity



Success story? Probably not as

- 1, risk of chronic disease increases progressively from a BMI of 21 (according to WHO)
- 2, BMI is not very reliable and more of a benchmark for quick assessment
- 3, other measures like the waist-hip-ratio are giving less positive values to the Japanese, particularly to men
- significant increase in lifestyle related diseases (*seijinbyō*, *seikatsu shukanbyō*)
 - risk of developing diabetes, high blood pressure, colon cancer, and of dying prematurely
 - age-related symptoms of physical decay (e.g. ischemic heart disease, hyperlipidemia, hypertension, diabetes, obesity, osteoporosis, postmenopausal syndrome)
 - “cardiovascular time bomb”

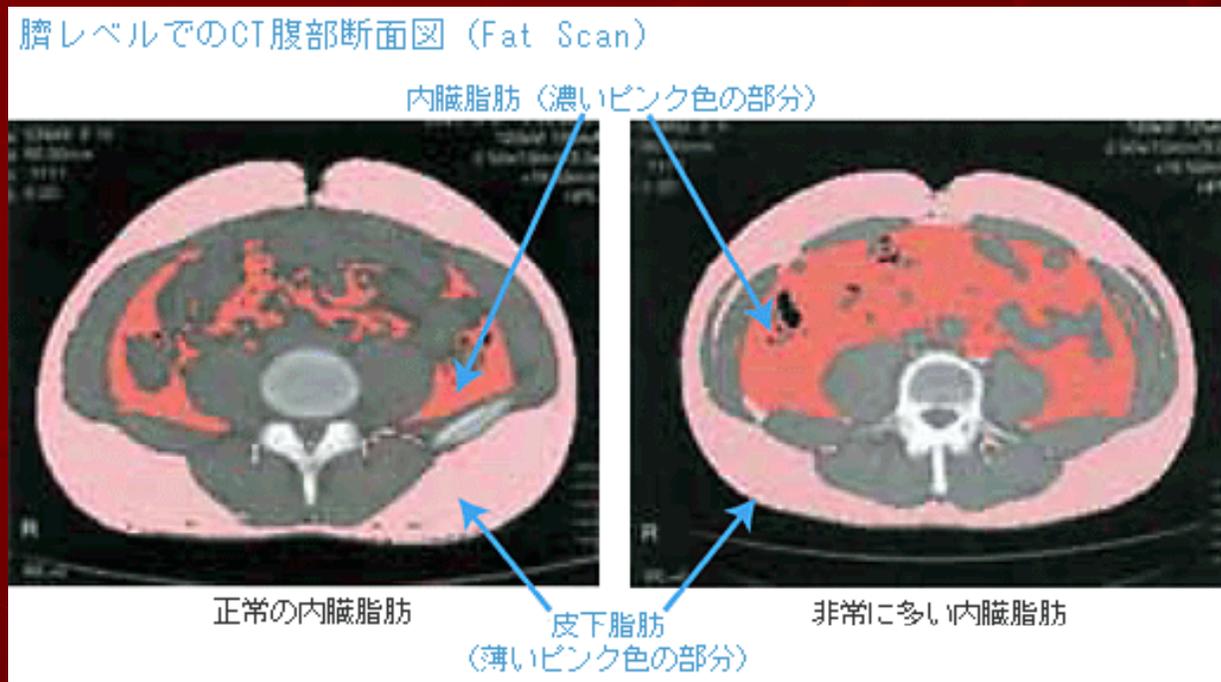


Healthy Japan 21 (*Kenkō Nihon 21*)

- all-ecompassing view on health
 - points of concern for all age groups; relating health to questions of fitness, lifestyle choices, life satisfaction, community life and ethics
- objectives differ for age groups; specific programs
- policies define specific target numbers (accountability)
 - 70 specific goal items in nine focus areas
 - lifestyle related: (1) nutrition and diet, (2) physical activity and exercise, (3) rest and mental health, (4) tobacco, (5) alcohol, (6) dental health,
 - disease-related: (7) diabetes, (8) cardiovascular diseases, and (9) cancer
 - *tokutei kenkō shinsa* (metabo check-up)
- midterm evaluation
 - obesity trend continued but at a slower pace
 - alarming numbers for men aged 20-69



- *metabo* = metabolic syndrome—combination of factors that heighten the risk of developing vascular diseases, diabetes, hypertension, cancer et al.



Left: regular distribution of fat tissue
Right: abnormal amount of abdominal fat



- since 2008/4: „mandatory“ annual health and body checkups for „risk groups“
 - anyone living (and working) in Japan aged 40 up to 75
 - member of (national, company) health insurance scheme



A representative from the Japanese Society of Internal Medicine accepts the award of „Word of the Year“ in 2006.



● **fat anomaly** (waist circumference of m>85 and women>90 PLUS two or more out of the following

- Diabetes (≥ 110 mg/dL)
- Hypertony ($\geq 130/85$ mmHg)
- Hyperlipidemia (elevated triglycerides/ ≥ 150 mg/dL or reduced HDL cholesterol/ < 40 mg/dL)



- step 1: body measurement (height, weight, waistline, BMI)
 - ≥ 85 cm/m and 90 cm/f \rightarrow A group (no or low risk group)
 - waist circumference ok but BMI of 25 and more \rightarrow B group (moderate or high risk group)



- step 2: physical checkup for invisible health risks

- blood glucose analysis

- 100mg/dl, or HbA1c of 5.2%, or persons under medical treatment

- adiposity („body fat“) measurement

- 150mg/dl, or HDL cholesterol of < 40mg/dl, or persons under medical treatment

- blood pressure

- >130/85, or persons under medical treatment

- questionnaire

- smoking career
- lifestyle habits, etc.



- step 3: counseling

- motivating (*dōki-zuke*): A group + smoking career, or B group + 1 or 2 additional risk factors
 - group or individual counseling, once only
 - guidelines for a healthier lifestyle
- positive action (*sekkyokuteki shien*): A group + 2 or more risk factors; B group + 3 or more risk factors
 - consecutive meetings (individual, group, email) for at least three months
 - concrete action to improve health and to monitor progress (however, people aged 65 and more of high risk group are excluded from this programme)
- information only: A group and B group

- reassessment after six months



Special Health Check-up (*tokutei kenkō shinsa*)

- semi-mandatory : carrot-and-stick system
 - no census style though similar reach is desired
 - obligatory exercise for insurers
 - incentive: flexible contribution to health care fund for the old-aged (75 years and older) from 2012 on
 - benchmarks
 - percentage of insurants participating
 - percentage of counseling successfully completed
 - impact on the reduction of metabolic syndrome
- target group of 57 million Japanese aged 40-65
 - in first year of operation, insurers reached between 28% and 60% of their insurants



- Opposition against the metabo check-up
 - financial burden: need of additional staff, nurses etc.
 - dropping of established check-up routines (cancer)
 - standards too strict
 - 98% of men and 92 percent of women to be considered in poor health (Prof. Oguchi, Tokai University Medical School)
- political debate on health promotion
 - government ignored international standards and studies providing counter-evidence
 - financial scenarios are unlikely and unrealistic
 - fabricating a disease and intimidating the population
 - *kanja-gari*: hunt for patients benefits commercial interests;
 - outsourcing and privatization of health care
 - biased experts in service of government

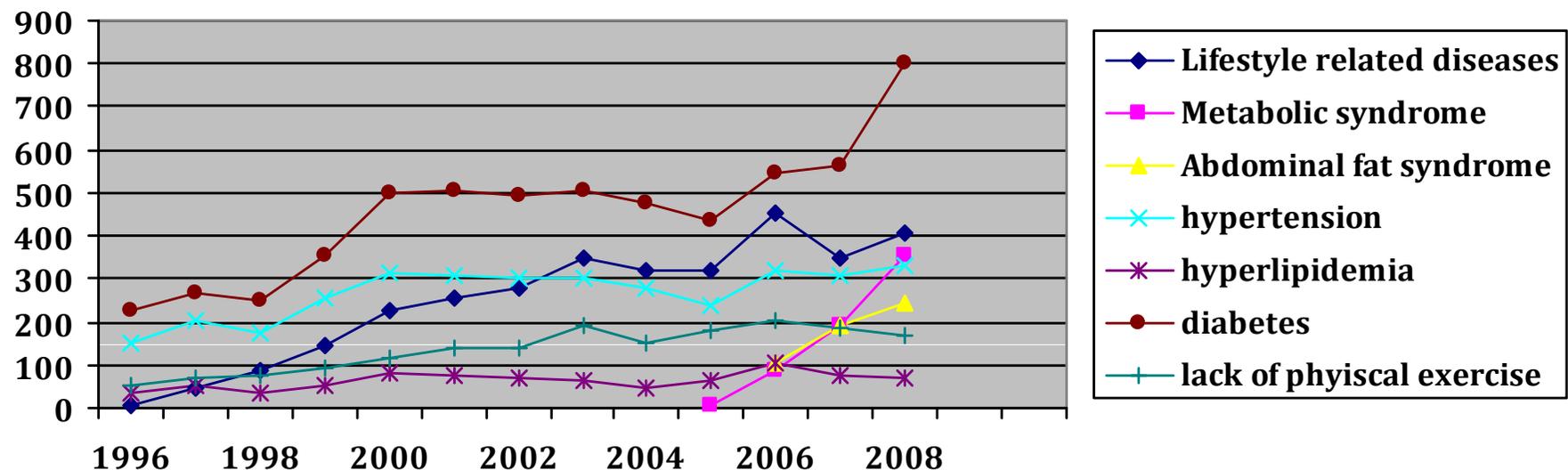


- IDF global consensus
 - acknowledges differences between ethnies
 - for Asians: waistline male >90cm, female 80
- Consortium of 8 Medical Associations Japan
 - male >85, female 90cm
 - based on evidence from computer scans
- counterevidence
 - studies failed to show association between metabolic syndrome and obesity, between obesity and mortality risks
 - particular view of the genealogy of medical knowledge
 - what we used to know → what we know by now → what we will know in the future
 - by product of *sankangaku* (= triangle of industry bureaucracy, medical science)



media phenomenon

- *metabo*: buzzword of the year in 2006
- nominated for 2007: *shintai kensa*
- rising number of newspaper articles, other media reporting
- metaphorical usage
- growing concern with health and body shape
- new business opportunities: healthy food; Nintendo





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metabo business

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metabo business

Health politics and the risk society of Japan

- Japan is as any other late-modern society prone to the fabrication of risks.
- In Japan, health and the body are subject to power struggles between academic factions, political groups and their allies and clients.
- Japan opted for a shift from **high risk-approach**, focusing on people who fell seriously ill, to a **population approach** based on the epidemiological probability of contracting a disease.
- → Epidemiology in the service of risk governance does not just indicate risks but produces them.

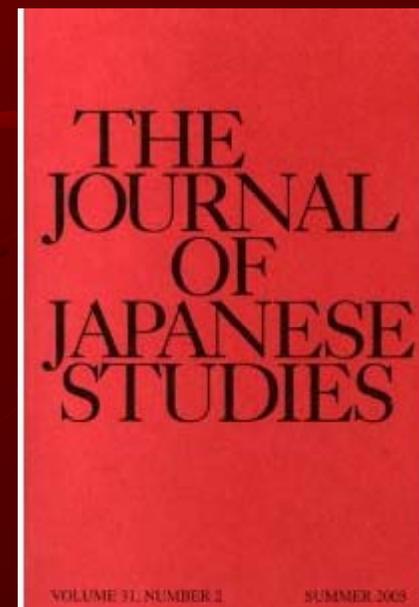


Health politics and the neoliberal project

- health and welfare politics are risky endeavours
 - political decisions
 - expert selection
 - process of updating professional knowledge
- “surveillance medicine”
 - body is comprised as a **compound of predictive risk factors** related to individual behavior
 - metabo: **infinite chain of risks** conflating symptoms, signs and diseases
- making of a “**bio-political correctness**”
- neoliberal politics under disguise of welfare corporatism
 - burdens are shifted from central government to local communities and the individual but mediated by corporate agents



Policing health and the body:
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and the Japanese obesity crisis”,
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