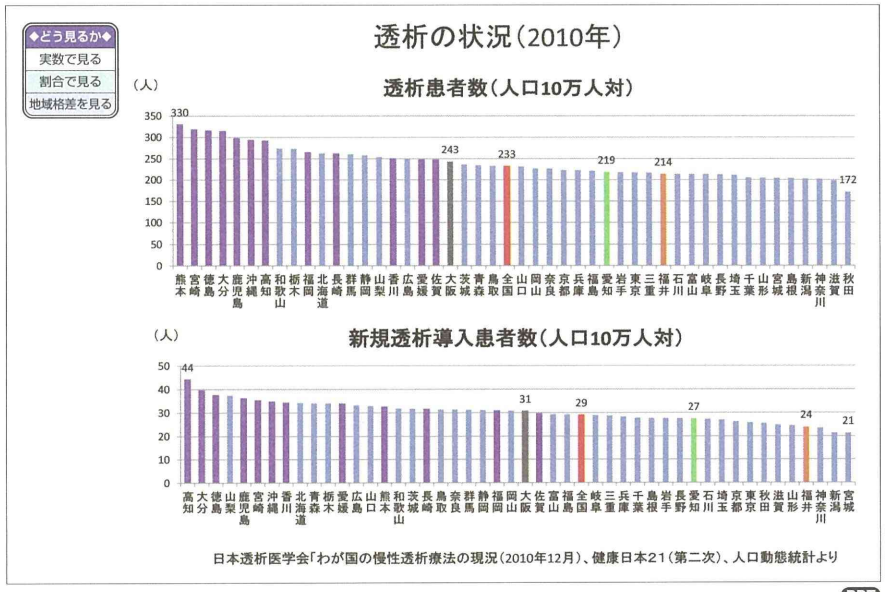
見える化⑤ 人工透析の状況



PPT

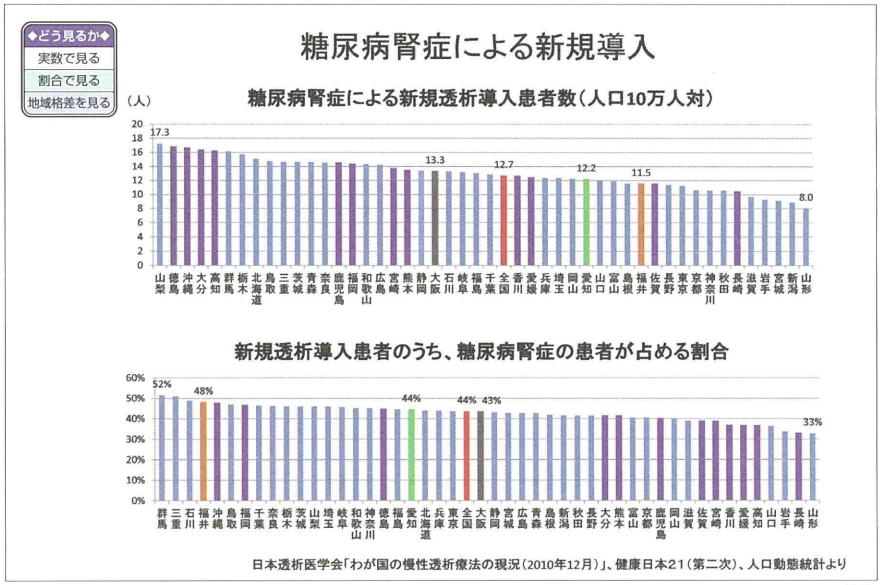
糖尿病腎症における治療の一つである人工透析（血液透析療法）に関するデータは、糖尿病の重症化予防対策を考える上で重要です。まずは原因を限定せず、すべての人工透析の患者数と新規導入数について、都道府県ごとにそれぞれグラフ化しました。

◆データを見てわかること

○10万人対透析患者数、新規導入数には、地域差が大きいです。
【透析患者数】
多 い 県 ①熊本 ②宮崎 ③徳島
少ない県 ①秋田 ②滋賀 ③神奈川
【新規導入数】
多 い 県 ①高知 ②大分 ③徳島
少ない県 ①宮城 ②新潟 ③神奈川
○透析患者数は九州地区、四国地区（棒グラフの紫色で示した）に多く、東北地区、北陸地区で少ない傾向がみられます。
○平成22年に新規に透析導入に至った人は、四国、九州地区で高い傾向がみられます。
○透析導入の原因疾病は、①糖尿病腎症（44.2%）、②慢性糸球体腎炎（20.4%）、③腎硬化症（11.7%）等で、この3つの疾患により全透析の3/4以上を占めます。腎硬化症は、主に高血圧を原因として発症する腎臓病で、徐々に増加しています。

健康日本21目標値

糖尿病合併症（糖尿病腎症による年間新規透析導入患者数）の減少
16,247人（平成22年）
▼
15,000人（平成34年度）



PPT

次に挙げたのは、糖尿病（腎症）による人工透析導入に関するデータです。
糖尿病による導入が多い地域では、糖尿病対策（健診・保健指導の実施率向上、受診勧奨徹底、治療中断防止キャンペーンなど）が必要です。血糖ならびに血圧のコントロールが不良の場合、特に腎不全に至りやすいため、糖尿病の管理だけでなく、血圧の管理も重要です。

◆データを見てわかること

○糖尿病が原因で透析に至る割合についても、都道府県格差がみられます。
【糖尿病による新規導入】
多 い 県 ①山梨 ②徳島 ③沖縄
少ない県 ①山形 ②新潟 ③宮城
【糖尿病腎症による透析の割合】
多 い 県 ①群馬 ②三重 ③石川
少ない県 ①山形 ②長崎 ③岩手

九州・四国地域は、全体の透析患者数、新規透析導入患者数は多いですが、沖縄県、福岡県、徳島県を除き、透析導入に占める糖尿病腎症の割合は比較的低く、ほかの理由での透析導入が多い可能性が考えられます。

参考 知っておきたい 透析導入、その後

慢性腎不全による人工透析：1人月額医療費約40万円（年間約500万）、年間医療費総額約1.4兆円（2009年）「第13回透析医療費実態調査報告（日本透析医学会）」より

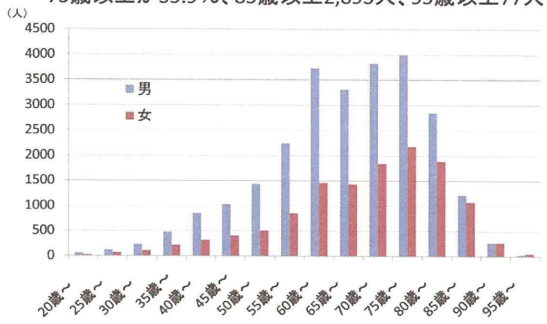
透析期間は、5年以上10年未満は 25.3%、10年以上15年未満は 12.7%、15年以上20年未満は 6.6%、20年以上は 7.6%で、5年以上の長期透析患者は全体の 52.2%であり、漸増傾向が認められています。
25年以上の長期透析患者は 11,802人で前年度より 569人増加しています。（日本透析医学会、「わが国の慢性透析療法の現況、2011年末の慢性透析患者に関する基礎集計」より）

透析の新規導入は、高齢者に多いことから、高齢化による影響も考えられます。
腎不全のどの段階で透析導入しているのか、何歳まで透析導入の適応としているのかといった要素のほか、透析施設数などによる影響も考えられます。また、透析導入時の患者の年齢は、年々高齢化しています。

透析導入患者の性・年齢分布 PPT

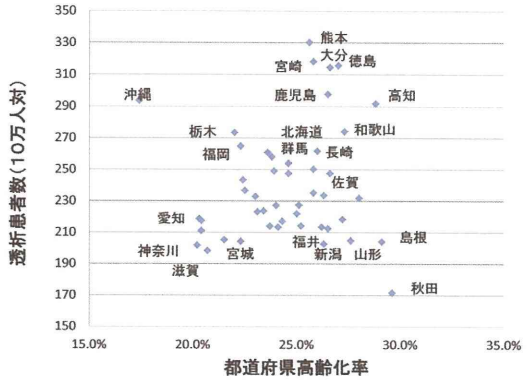
（38,392人）

透析導入のピークは75～79歳階級　男性は女性の2倍、75歳以上が35.9%、85歳以上2,893人、95歳以上77人



（日本透析医学会「わが国の慢性透析療法の現況（2011年12月）」より）

高齢化率と透析患者数の関連



日本透析医学会「わが国の慢性透析療法の現況（2010年12月）、健康日本21（第二次）、人口動態統計より

PPT

これは都道府県の高齢化率を横軸に、人口10万人対透析患者数を縦軸にとって作成した散布図です。
高齢化率が高いほど透析患者が多いのでは、という予測に反して、両者の相関はみられず、きわめてばらつきの大きい状況であることがわかりました。
透析の多い地域では、その原因を医療、予防、サービス提供体制など、さまざまな観点で分析していく必要があります。

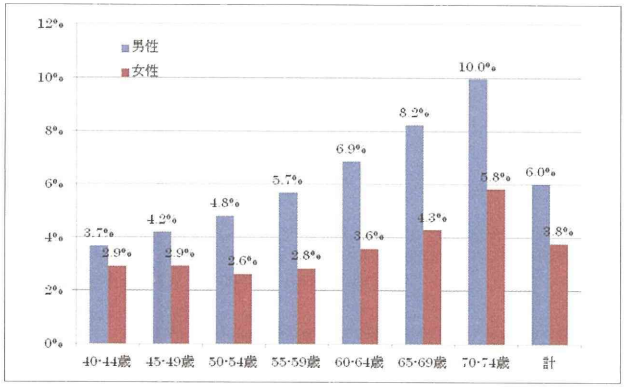
80

ひとこと・ヒント

腎不全を予防するために

特定健診では尿蛋白検査が必須項目であり、（＋）以上の場合にはすぐに医療機関受診を勧めます。クレアチニンを測定している場合には、尿蛋白が陰性でもeGFRが50mL/min/1.73m²未満の場合、医療機関受診を勧めます。医療機関では、腎臓障害のステージにあわせて、糖尿病や高血圧の管理、減塩や低たんぱく食、運動制限を行い、腎機能の悪化を防ぎます。詳細は「CKD診療ガイド」を参照してください。日本腎臓学会ホームページ（http://www.jsn.or.jp/）から閲覧、ダウンロードできます。
特定健診データ分析からみた性・年齢階級別有所見率（＋以上）は以下の通りです。

特定健診における尿蛋白陽性率（平成22年度　愛知県882,425人のデータ分析結果より）



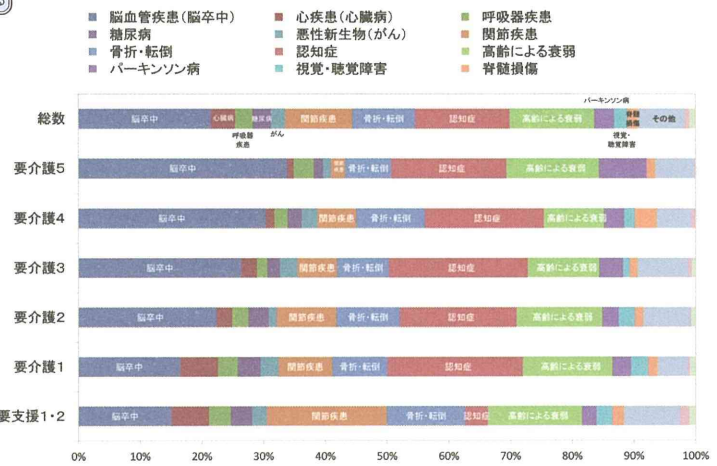
参考　透析の見合わせについての学会提言

○日本透析医学会は、2012年度（平成24年度）に『「慢性血液透析療法の非導入／継続中止（見合わせ）」に関する血液透析療法ガイドラインワーキンググループからの提言（案）2012』を発表しました。
○この提言案では、透析導入にあたり、①十分な情報提供と自己決定の援助　②自己決定の尊重・事前指示書の作成　③同意書の取得が必要、としています。
○一定の状況を満たす終末期患者では、透析療法の導入または継続を見合わせることを提案しています。すなわち、①医療チームがあらゆる対策を講じても透析が医療技術的に危険か困難で、実施することが生命予後へ悪影響を及ぼす　②意思決定能力のある患者が透析を拒否している　③意思決定能力がない患者の家族が透析を拒否している場合、などにおいて、一定の検討プロセスを経て見合わせ、効果的な緩和ケアを提供することを提案しています。
○詳細は、日本透析医学会ホームページ（http://www.jsdt.or.jp/）を参照してください。

見える化⑥要介護の状況

◆どう見るか◆
割合で見る
地域格差を見る

介護が必要となった主な原因の構成割合（要介護度別）



出典：平成22年国民生活基礎調査

PPT

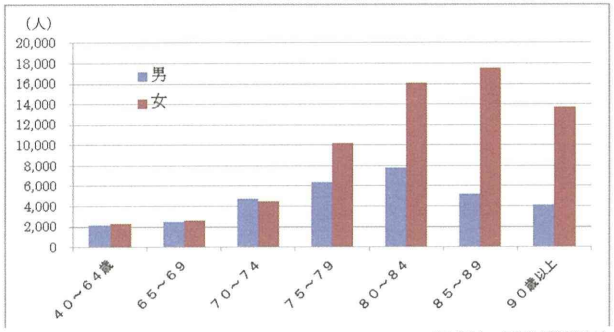
生活習慣病は、要介護状況と関連があります。そこで介護に関するデータから、要介護状況について調べます。

◆データを見てわかること

介護を要する原因として、①脳血管疾患（脳卒中）、②認知症、③高齢による衰弱、④関節疾患、⑤骨折・転倒の順ですが、要介護3以上の重度では脳血管疾患（脳卒中）、認知症、高齢による衰弱が多いのに対し、軽度では関節疾患が多い傾向がみられます。

介護を要する人の性・年齢階級別内訳を示すグラフ（下図）から前期高齢者では男性がやや多く、後期高齢者では女性が多いことがわかります。全体では、介護を要する人の67％は女性です。

介護を要する人の性・年齢階級別内訳（介護を要する人口10万人対）

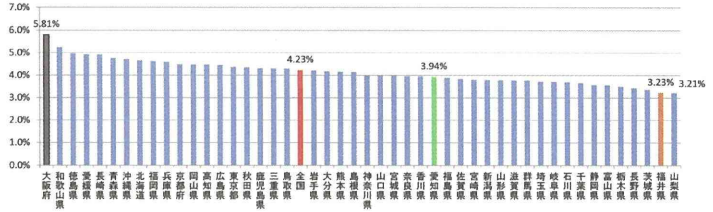


（平成22年　国民生活基礎調査）

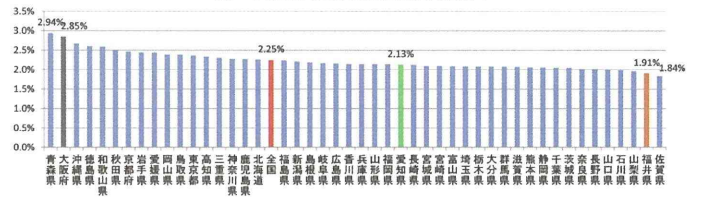
◆どう見るか◆
割合で見る
地域格差を見る

都道府県別　要介護認定率（65歳～74歳）（平成22年度）

65～74歳の要介護認定率（要支援1～要介護5）



65～74歳の要介護2以上の認定率



（平成22年度介護保険事業状況報告　年報）

PPT

65～74歳の介護状況です。健康寿命の算定には「要介護2以上にならない」ことを定義としているものもあることから、要介護2以上の認定率について、都道府県格差をグラフ化しました。

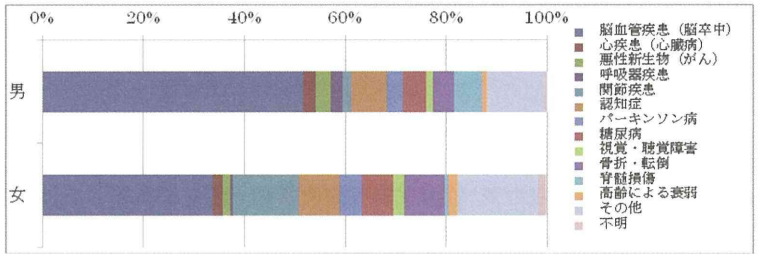
◆データを見てわかること

○前期高齢者（65～74歳）での要介護認定は、大阪府、和歌山県、徳島県などで高いです。
○要介護2以上の認定率で見ると、青森県、大阪府、沖縄県の順となっています。

75歳未満で要介護認定を受けた人の原因をみると（下のグラフ参照）、男女とも脳血管疾患（脳卒中）が最も多く、男性では50％を超えています。脳血管疾患（脳卒中）は高血圧、糖尿病などの生活習慣病や喫煙、食塩摂取過多、多量飲酒等が主要な原因ともなっていることから生活習慣病対策が重要です。

女性では関節疾患の割合も高くなっており、ロコモティブシンドローム予防対策の重要性を示しています。

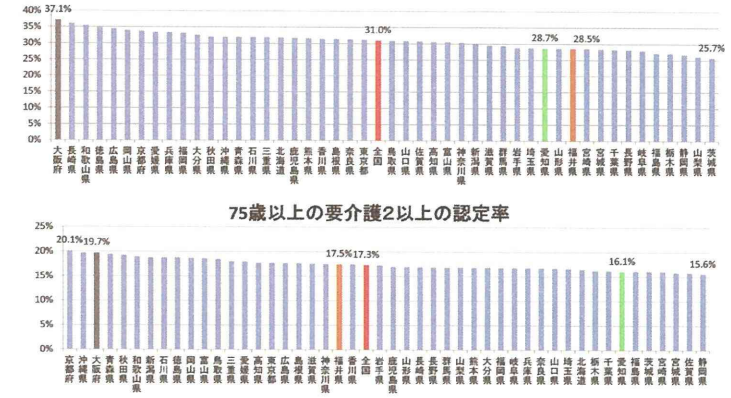
介護が必要となった主な原因（65 ～ 74歳）



（平成22年　国民生活基礎調査）

◆どう見るか◆
割合で見る
地域格差を見る

都道府県別　要介護認定率（75歳以上）（平成22年度）



（平成22年度介護保険事業状況報告　年報）

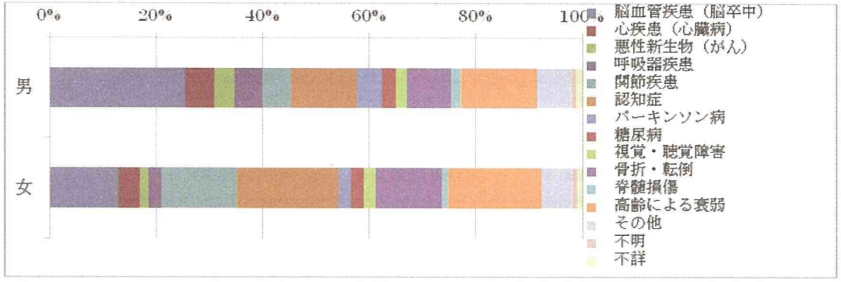
PPT

75歳以上の介護状況（2010年度）についてもグラフ化しました。

◆データを見てわかること

75歳以上に限定してみると
○要介護認定率が高いのは大阪府、長崎県、和歌山県の順となっています。
○要介護2以上では京都府、沖縄県、大阪府の順となっています。
○大阪府は前期高齢者、後期高齢者とも要介護認定率が高く、「2以上」の割合も多いことが課題と考えられます。
要介護認定を受けやすい社会基盤となっているのか、高齢者の生活機能が実際に低下しているのか、検証が必要ではないかと考えられます。
○福井県は前期高齢者の要介護認定率は低いですが、75歳以上の割合では中位となっています。
75歳以上人口に占める85歳以上人口の割合が高い（P.10）こともその要因として考えられます。

介護が必要となった主な原因（75歳以上）

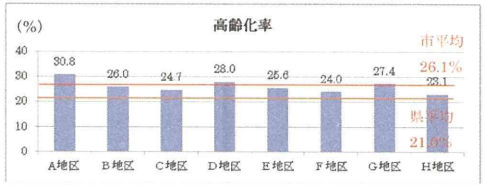


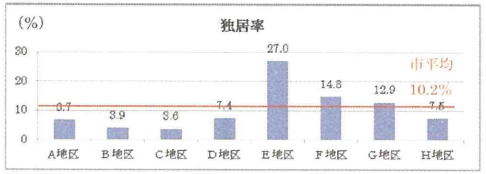
（平成22年　国民生活基礎調査）

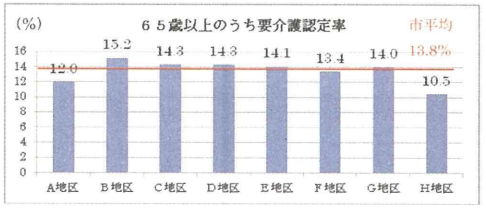
STEP UP

地域の介護保険データ等を活用した分析例（愛知県蒲郡市の取り組み）

蒲郡市は人口8万2,000人、高齢化率25.3%で、県下では高齢化が進んだ地域です。近年の高齢化の進展による社会保障費の増大や、県全体と比較して透析患者数、糖尿病等の受療率、メタボ該当率が高いことから、健康日本21の策定をよい機会として、健康づくり対策を見直すことになり、庁内で部局横断的にデータを持ち寄り、地域の健康課題を考えることになりました。高齢化率、独居率、要介護認定率の地区別分析や、国保医療費、特定健診データで県平均よりも多い病気などを抽出、対策につなげていきます。

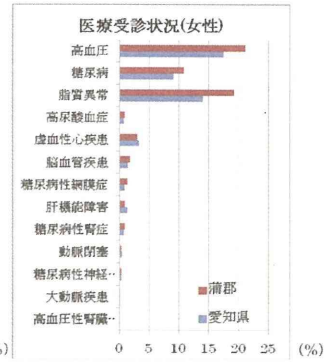






○A地区は漁業を主体とする地区で、高齢化率は市内で最も高いが、独居率は比較的低い。そのためか要介護認定率も低い。
○B地区では高齢者の施設が増えてきている。その結果、独居率は低いが、要介護認定率が高くなっているのではないか。
○E地区は町の中心部で、独居率が高い。要介護1までの軽度な認定を受けている人が多い（少しの援助で独居生活が可能な地域ともいえる）。
○H地区は新興住宅地があるので高齢化率は市内では低い。

市全体では特定健診結果でメタボ率が高いこと、高血圧、糖尿病等の受療率も高いこと、健診受診率に地域差があるなどの課題があり、食生活や運動習慣への働きかけが必要。
（市の勉強会 2013.02.07 より）



3章　既存データを活用した市町村支援の事例

市町村の健康づくり施策推進の支援をすることも、都道府県にとって重要な役割の一つです。本章では、既存データを用いた効果的な市町村支援の事例について紹介します。

事例1　福井県

健康指標のデータベース化により、市町ごとの健康課題を明確化し、生活習慣病の発症・重症化予防の対策につなげる。

●福井県がデータに基づく健康課題の分析を実施

都道府県は、国が全国的な目標を定めた健康日本21（第二次）を勘案し、地域の実情を踏まえて地域住民にわかりやすい目標を設定して都道府県健康増進計画に盛り込むとともに、必要に応じて市町村ごとの分析を行い、市町村健康増進計画の策定の支援を行うこととしています。

福井県は、東京大学高齢社会総合研究機構との共同研究事業であるジェロントロジー（総合長寿学）の研究成果を応用し、特定健診データと医療費レセプトデータを個人ベースで接合したデータベースを構築しました。

平成24年度から「わがまち健康づくり推進プロジェクト」（地域健康度診断システム）を開始し、市町ごとに健康度分析を行い、健康課題の分析と健康づくり対策の立案・評価を実施しています。

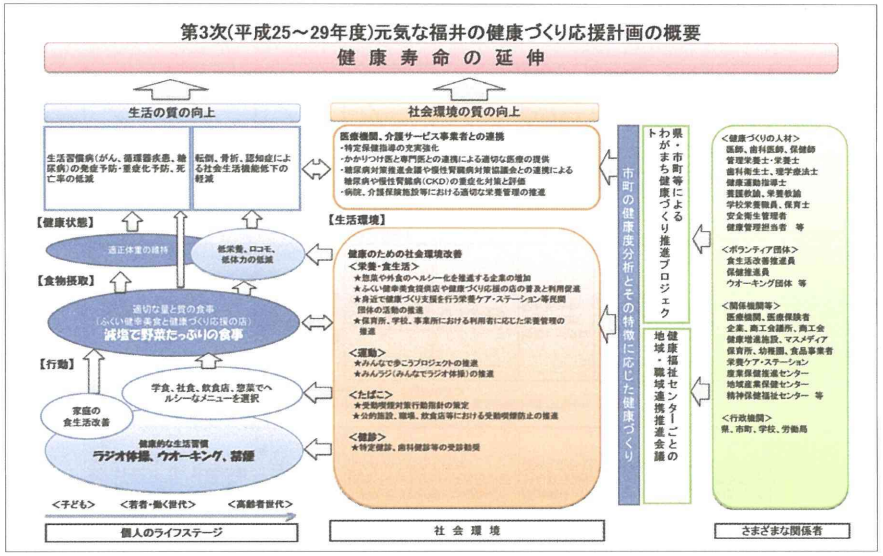
●分析結果に基づく健康づくり対策

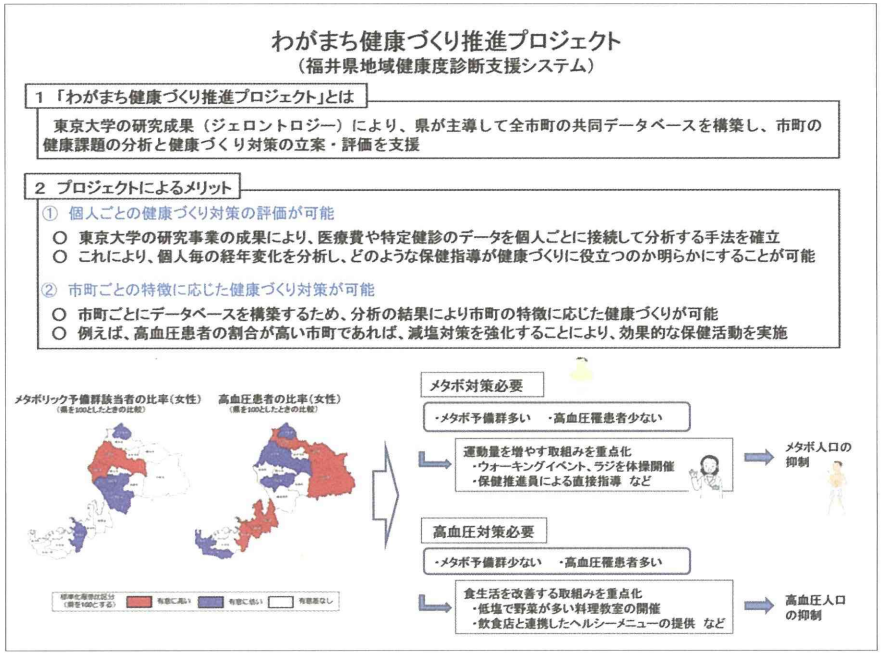
データベースは、2008～2010年の３年間に市町の国民健康保険が実施する特定健診を受診した約6.5万人を対象に、個人毎に接続した特定健診の結果（28項目）と医療費レセプトデータで構成されています。

福井県高浜町では、このデータベースの分析結果に町のデータやグループインタビューの結果等をあわせて地区診断を行い、健康づくりの方向性を絞り「野菜の摂取量を増やす」ことを重点対策としました。これらのデータを町内の各団体や関係機関と共有し重点対策の重要性を理解することにより、協働による町の健康づくりへと発展させています。

また、福井県美浜町では、データから見える町の健康課題（高血圧が多い）を住民と行政が共有することで、住民が生活習慣病予防の必要性を理解し、食生活を中心とした生活習慣の改善に取り組む運動が始まっています。

県は毎年、市町を対象にデータベースの分析および評価方法について研修を実施し、市町が地域の特徴に応じた健康づくり対策が実施できるよう支援していきます。また、データベースでは医療費レセプトデータが接続されていることから、長期的な健康づくり対策がどのように反映されたのか評価も行っていく予定です。





事例 2

大阪府

市町村国保の医療費と特定健診等データを分析、健康課題を明らかにして改善策の提案・実践までをトータルに支援する

●行動変容推進事業

大阪府は、循環器病の調査・研究機関である大阪がん循環器病予防センターと共に、府内の市町村国民健康保険に関する医療費や特定健診データを分析して、府内市町村（国保）の健康・医療に係る課題を明確化し、課題に対する取り組みを提案するとともに実践を支援していく「行動変容推進事業（2010~2013年度）」を行っています。

各市町村が「医療費が高い」「受診率が低い」「ハイリスク者が多い」などの現状を正しく認識し、改善策を計画・実行・評価というPDCAサイクルを実施することに加え、被保険者、保険者、関係者などの問題意識を高め行動変容につなげることで、予防の推進、受診率向上、医療費の適正化を図ることを目的とした取り組みです。

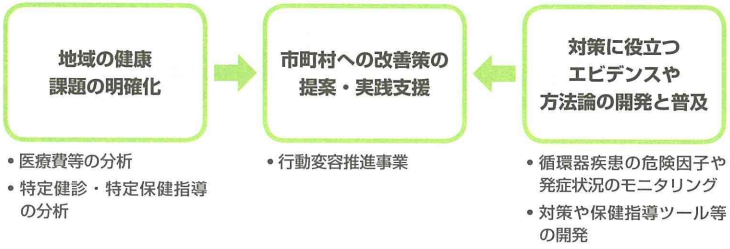
●医療費と特定健診データ分析から始まる行動変容推進事業の取り組み経過

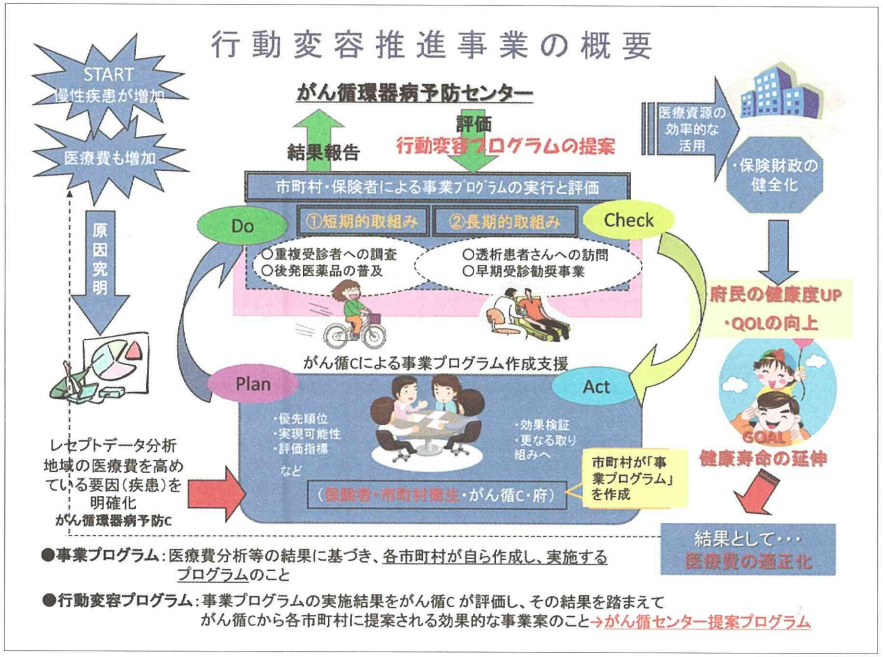
2010~2011年度については、モデル事業として、泉佐野市等9市町で先行実施しました。医療費分析の結果、各保健所圏域、あるいは各市町村において、調剤医療費や柔整の医療費が高いといった医療種別の傾向や、腎不全や脳卒中の医療費が高いといった疾患別の特徴などが明らかとなり、それらの課題解決のための実態調査や背景調査を実施しました。その結果を、大阪がん循環器病予防センターと共に評価し、新たな取り組みへと繋げました。

翌2012年度は、本事業の対象を府内の全市町村に拡大し、全市町村別の医療費と特定健診データを分析し、その読み取り方についての研修と共に各市町村に結果を返しました。そして課題の明確化や課題解決に必要な取り組みを保健所と共に検討できるよう、保健所へも管内市町村のデータを提供しました。

各市町村は課題解決に必要な取り組みを実施・評価し、その結果をがん循環器病予防センターが確認して、最終的に専門的知見を踏まえた取り組みの提案をすることとなっています。

2013年度は、引き続き課題解決のためのフォローアップをはじめ、事業の評価結果を踏まえた汎用性の高いプログラムの開発を進めていく予定です。





H22年度からの行動変容推進事業経過　　※行動変容プログラムは「プログラム」と略す

月	22年		23年			24年			25年（案）
日	9-12月	1-3月	9-11月	12-1月	2-3月	4-7月	8-11月	12-3月	通年
泉佐野HC（6市町） 寝屋川HC（1市）	データ分析の結果を踏まえ、プログラムの提案と各市町村での実施方法の検討	市町村でのプログラム（長期・短期）の実施	研修等により、実施したプログラムを他市町村へ紹介（事業の普及）	各市町でプログラムを実施した結果明らかとなった課題解決のための取り組みを検討		課題解決のための取り組みを実施・評価。大阪がん循環器病予防センターの過去の知見等を踏まえ政策提言を含めた助言・評価			・評価結果を踏まえ、汎用性の高いプログラムを開発 ・報告書の作成 ・フォローアップ研修
【以下、2市の選定理由】 1. 実施のなかった圏域に拡大 2. 医療費分析に意欲的で、衛生部門で生活習慣病予防への取り組みが積極的に実施されている 3. 南高安地区での効果の確認と市内の他地域への効果の波及									
箕面市（池田HC） 八尾市（八尾HC）			データ分析の結果を踏まえ、プログラムの提案と各市での実施方法の検討	市町村でのプログラム（長期・短期）の実施	実施したプログラムの結果を評価	実施したプログラムの結果を他市町村へ報告	プログラムを実施した結果明らかとなった課題解決のための取り組みを実施		
【府内全域へ拡大理由】 1. 当初からの3年計画で全市町村への拡大を目指す 2. 25年度の各保険者における特定健診等実施計画の評価に役立てる 3. 同じフォーマットで府下の全市町村の分析を実施することで正しく比較ができる									
モデル実施以外の29市町村（残り5市町）						全市町村分のデータ分析の結果を提示。モデル市の報告や府の循環器予防施策に係る研修会を開催。	各市町村で分析結果を読み取り、必要な事業を計画してもらうための研修をがん循環器病予防センター主催で府内4か所でブロック別に開催。	各市町村で事業を計画、実施、評価大阪がん循環器病予防センターよりプログラムの提案	

事例 3

愛知県

健康づくり技術を活用した派遣型の支援によって、市町村の健康づくり技術の向上及び市町村間の健康格差の縮小を図る。

●あいち健康プラザの技術を活用した市町村健康づくり技術支援事業

愛知県は、「あいち健康の森健康科学総合センター（通称：あいち健康プラザ）」を健康づくりの中核施設と位置付け、①運動施設の運営による一人ひとりに合った健康づくりプログラムの研究開発や提案、②研究成果や情報を活用した行政・企業・健康保険組合・民間施設への指導者の養成、交流支援などの取り組みを行っています。

平成24年度から、「あいち健康プラザ」で培われた健康づくり技術等を活用し、市町村に対して健康づくり施策に関する全面的な相談や技術支援を行い、県民の健康づくりの環境整備を図っています（P.59参照）。

●市町村の求めに応じたタイプ別の技術支援

市町村健康づくり技術支援事業は、「あいち健康プラザ」より医師・運動指導員・管理栄養士等の多職種チームを市町村へ派遣し、市町村の健康づくり事業や健診データ分析・評価、市町村健康増進計画の見直し、健康関連施設の有効活用等に関して助言を行います。

事前に、市町村より種別に応じた「希望調書」の提出及び実施団体の選定を行います。事業開始にあたっては現状調査・ヒアリング等により支援プランの検討を行い、検討結果に基づき、派遣された多職種チームが市町村職員と一緒に実践活動を行います。

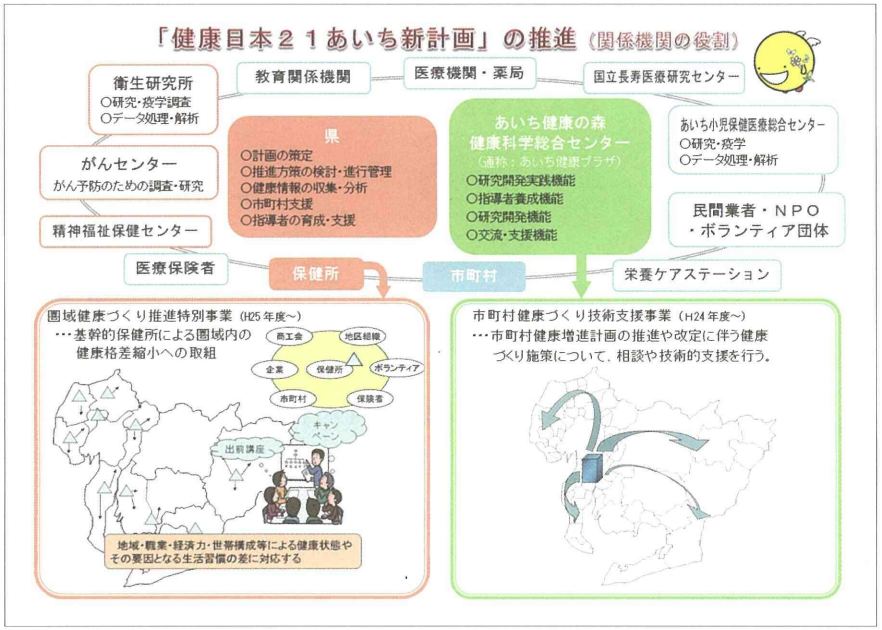
平成24年度は、選定の結果、県内54市町村のうち8市町村（「希望調書」の提出は15市町村）、種別B：2団体、種別C：6団体に対して支援を行っています。

次年度からは、新たな健康づくり計画がスタートすることから、新体制（P.59参照）によって構造的に取り組みます。

平成24年度の主な支援内容

種別B
- 健康づくり推進員を養成するための効果的な活用方法の検討
- 効果的な保健指導プログラムの検討

種別C
- 市町村健康増進計画の評価策定にあたってのデータ収集、分析方法への助言
- 部局横断的な健康づくり施策の取り組み支援
  （市町村幹部職員及び他課を含めた勉強会、講演会の実施）
- 糖尿病予防対策事業の評価方法の支援



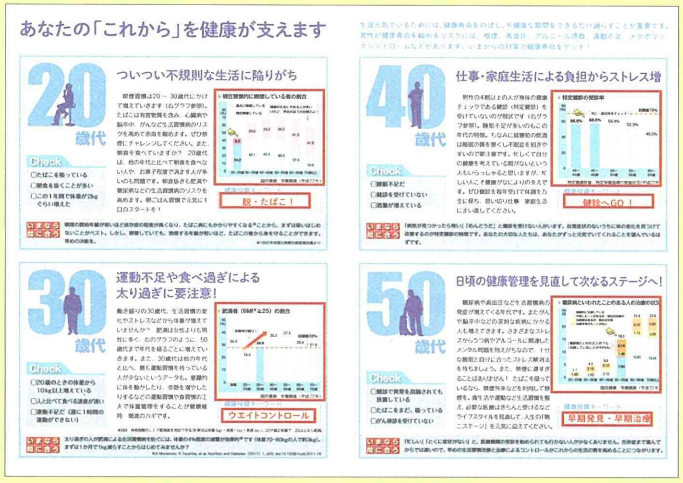
4章　既存データを活用したツール

健康日本21（第二次）を推進するためには、住民一人ひとりの心に届くメッセージが必要です。本研究班ではおおよそ20～50歳代の男性及び女性に向けたリーフレット（A4サイズ・4ページ）を作成しました。

基本データは、付属のDVDに収録されています。このまま使用することができますが、既存データ（グラフ）の部分等を、オリジナルデータに差し替えてカスタマイズして使用いただくこともできます。ぜひ、ご活用の上、配付対象者からの反響等お知らせください。

(1)健康づくり啓発リーフレット（男性版）

□の部分は地方自治体独自のデータに入れ替えることができます。



(2)健康づくり啓発リーフレット（女性版）

□の部分は地方自治体独自のデータに入れ替えることができます。

資料編

※内容はすべて付属DVDに収録。

以下は、表題のみの掲載です。内容については付属 DVD をご覧ください。

●健康日本21（第二次）参考資料関係スライド集

●健康日本21（第二次）参考資料関係スライド集（英語版）

●厚生労働科学研究費補助金 循環器疾患・糖尿病等生活習慣病対策総合研究事業の研究班による市民啓発ツール

健康日本21（第二次）推進の一環として、自治体等における生活習慣病対策の取り組みを支援するため、これまでに様々な研究班が研究成果として作成した啓発ツール（電子媒体）を収録しました（以下は一覧表）。厚生労働省 健康局 がん対策・健康増進課から平成23～24年度の研究代表者にご協力を依頼し、任意で提供いただいた電子媒体をとりまとめています。市民講座や健康教室、各種健診・検診会場での配布等にご活用ください。ただし、著作権は各研究班にありますので、この内容のお問い合わせは研究代表者（または各電子媒体に明記のある連絡先）にお願いします。なお、無断で営利目的の冊子等へ転載することは禁じられています。

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厚生労働科学研究費補助金 循環器疾患・糖尿病等生活習慣病対策総合研究事業の研究班による市民啓発ツール一覧表

番号	研究代表者（所属）	研究課題名	啓発ツールの内容 キーワード 等
1	三浦 克之（滋賀医科大学）	2010年国民健康・栄養調査対象者の追跡開始（NIPPON DATA2010）とNIPPON DATA80／90の追跡継続に関する研究	NIPPON DATA リスク評価チャート 循環器疾患危険因子、長寿、ADL
2	磯 博康（大阪大学）	離島・農村地域における効果的な生活習慣病対策の運用と展開に関する研究（H21～23）	糖尿病、脳卒中等危険度予測シート、受診勧奨、脳卒中予防対策と医療費
3	岡村 智教（慶應義塾大学）	大規模コホート共同研究の発展による危険因子管理の優先順位の把握と個人リスク評価に関するエビデンスの構築	喫煙、血圧、コレステロールと死亡率、冠動脈疾患死亡等
4	大井田 隆（日本大学）	未成年の喫煙・飲酒状況に関する実態調査研究	中高生の喫煙及び飲酒行動の実態と関連要因
5	大和 浩（産業医科大学）	わが国の今後の喫煙対策と受動喫煙対策の方向性とその推進に関する研究	職場内禁煙マニュアル
6	徳留 信寛（国立健康・栄養研究所）	日本人の食事摂取基準の改定と活用に資する総合的研究	食事摂取基準を知る、使う、伝える（専門家向け）
7	門脇 孝（東京大学）	特定健診・保健指導におけるメタボリックシンドロームの診断・管理のエビデンス創出に関する横断・縦断研究	心血管疾患発症を効果的に予防するためのウエスト周囲長等の最適基準値の検討
8	津下 一代（あいち健康の森 健康科学総合センター）	生活習慣病予防活動・疾病管理による健康指標に及ぼす影響と医療費適正化効果に関する研究	保健指導のエッセンス 運動指導の安全対策
9	北川 道弘（国立成育医療研究センター）	女性における生活習慣病戦略の確立－妊娠中のイベントにより生活習慣病ハイリスク群をいかに効果的に選定し予防するか	妊娠中の高血糖、高血圧の人に対する産後配布用リーフレット
10	宮本 恵宏（国立循環器病研究センター）	慢性期ハイリスク者、脳卒中および心疾患患者に適切な早期受診を促すための地域啓発研究	糖尿病予防啓発ポスター、AED 関連ホームページの紹介等
11	豊田 一則（国立循環器病研究センター）	急性期脳卒中への内科複合治療の確立に関する研究	脳卒中の予防、治療に関する講演（PDF）
12	野々木 宏（国立循環器病研究センター）	急性心筋梗塞に対する病院前救護や遠隔医療等を含めた超急性期診療体制の構築に関する研究	心臓発作啓発リーフレット 心肺蘇生法
13	峰松 一夫（国立循環器病研究センター）	一過性脳虚血発作（TIA）の診断基準の再検討、ならびにわが国の医療環境に則した適切な診断・治療システムの確立に関する研究	TIA に関する講演資料
14	飯原 弘二（国立循環器病研究センター）	包括的脳卒中センターの整備に向けた脳卒中の救急医療に関する研究	脳卒中医療の救急体制（実態調査）（専門家向け）
15	吉永 正夫（国立病院機構 鹿児島医療センター）	未成年者、特に幼児、小・中学生の糖尿病等の生活習慣病予防のための総合検診のあり方に関する研究	小児のメタボリックシンドローム
16	田村 功一（横浜市立大学）	肥満を伴う高血圧症に対する防風通聖散の併用投与による、24時間自由行動下血圧及び糖脂質代謝・酸化ストレスの改善効果についての研究	肥満を伴う高血圧症（専門家向け）
17	陳 和夫（京都大学）	肥満残存高血圧合併睡眠時無呼吸患者に対する防風通聖散及び大柴胡湯の治療効果の比較と病態生理の解明	睡眠呼吸障害（専門家向け）

（敬称略、順不同）

A Basic Direction for Comprehensive Implementation of National Health Promotion

This direction, under aging population with falling birth rate and transition of disease structure of our nation in the 21st century, through improvement of lifestyle and social environment, aiming all of citizens from infant to elderly to have hope and meaning for living under supporting each other, aiming to achieve a vibrant society with healthy and spiritually rich lives according to life stages (i.e. each stage of human life such as infancy, childhood, adolescence, adulthood, older ages and so on), and then aiming social security system to become sustainable, declares basic matters for comprehensive implementation of national health promotion, and promote "The second term of National Health Promotion Movement in the twenty first century (Health Japan 21 (the second term))" (National Movement) from 2013 fiscal year to 2022 fiscal year.

1. Basic goals for implementation of National Health Promotion

A) Extension of healthy life expectancy and decrease in health disparities

Addressing issues associated with the rapid increase of the aging population and change of diseases structure, through prevention of life-style related diseases, and improvement and maintenance of healthy body functions, we will extend healthy life expectancy (length of life that an individual is fully functional for daily activities).

Furthermore, through development of social environment which supports health life at every life stage, we decrease health disparities (gap in health status created by socioeconomic status within a community).

B) Primary and secondary prevention of life-style related diseases (prevention of NCD*)

This goal is intended to prevent various cancers, cardiovascular diseases, diabetes and chronic obstructive pulmonary disease (COPD). The emphasis is on lifestyle behaviors, such as eating healthy diet and getting habitual exercise, as well as primary and secondary prevention of NCD.

* Cancer, cardiovascular disease, diabetes, and COPD are categorized as lifestyle-related chronic diseases. These diseases are coded as non-communicable diseases (NCD) internationally, and are particularly responsive to lifestyle modification strategies.

C) Improvement and maintenance of function for social abilities

This policy was developed to address issues that contribute to the maintenance of function at every life stage from infants to elderly people. It is also important to address mental health issues at workplace.

D) Establishment of a social environment where health of individuals is protected and supported

As health of the individual is affected by social environment of family, schools, the community, and workplaces, it is important to endeavor to develop environment which support and protect health of individuals as overall society. Therefore, we establish a supportive environment not only provided by the government, but also by corporations and non-profit organizations.

Furthermore, by promoting mutual benefit and social ties, both in the community and occupational setting, this policy is intended to help organize a supportive and inclusive environment where the health of everyone is advanced.

E) Nutrition and healthy diet, physical activity and exercise, proper rest, alcohol drinking, tobacco smoking, and oral health.

To accomplish the four targets above, it is important to improve nutrition and healthy diet, physical activity and exercise, proper rest, alcohol drinking, tobacco smoking, and oral health as basic factors related to health promotion of citizens. For the effective establishment of health promotion programs, it is crucial to segment the target populations based on socioeconomic status, life stage, and gender differences and incorporate distinctive characteristics, needs, and health issues.

In addition, we specially conduct measures to improve life styles among high-risk population of life-style related diseases or adolescences and middle-aged adults who will be elderly during period when proportion of elderly population becomes largest in accordance with the context, and also reinforce health promotion among citizens through communities and workplaces, based on effect of social environment on health of citizens.

2. Targets for health promotion among citizens

A) Targets setting and evaluation

National government provides an infrastructure that increases awareness of health promotion among Japanese professionals in related fields. In addition, conducting continuous research and analysis of health measures and providing the results to the public enhances the field of health promotion in the country and therefore contributes to optimizing health status at the individual level.

In order to encourage Japanese to take part in health promotion activities, health professionals with a wide range of specialties should collaborate to develop evidence-based targets that last up to approximately 10 years. These targets should be based on the experts' knowledge, experience, and shared values regarding current situations and problems.

Consecutive analysis and follow-up research should be conducted, especially for major targets, so that health disparities and differences in lifestyle that may be present among regions can be accurately identified. Furthermore, conducting mid-term evaluations after five years and final evaluations after 10 years of execution of the policies is essential to determine the effectiveness of specific activities for each target.

B) Concepts on target setting

In order to optimize extension of healthy life expectancy and decrease in health disparities, this policy encourages the primary and secondary prevention of life-style related diseases, the development

of healthier lifestyles, and a better social environment.

① **Extension of healthy life expectancy and decrease in health disparities**

Extension of healthy life expectancy and decrease in health disparities are the final targets that this policy intends to achieve by improving lifestyles and organizing the social environment. The specific targets are shown in appendix table 1, based on indicator of length of life that an individual is fully functional for daily activities. In addition, the execution of comprehensive health promotion plans and cooperation among a wide range of fields, such as medical care and nursing care, are needed to achieve these targets.

② **Primary and secondary prevention of life-style related diseases (prevention of NCD*)**

For extension of healthy life expectancy of citizens, it is important to conduct measures to diabetes whose number of patients is increasing and which leads to serious complications, and COPD, whose umber of death is predicted to be increasing in the near future, as well as measures to cancer and cardiovascular disease as major causes of death in our nation.

For cancer, the target is increment in participation rate of cancer screening especially for promotion of early detection as well as reduction of age-adjusted mortality rate, in viewpoint of comprehensive promotion of prevention, diagnosis treatment and others.

For cardiovascular disease, the target is improvement of hypertension and reduction of dyslipidemia, which are risk factors of incidence of cerebrovascular disease and ischemic heart disease, and reduction of mortality due to these diseases.

For diabetes, the target is adequate control of blood glucose levels, reduction of patients to suspend the treatment and reduction of complications to prevent becoming severe, as well as halt of people with it by prevention of incidence. .

For COPD, the target is raising awareness of COPD, because early detection is important, and because we can prevent by smoking cessation as tobacco smoking is the strongest risk factor,

The specific targets we mentioned above are shown in appendix table. To achieve these targets, national government conducts promotion of behavior change such as healthy diet, adequate exercise, smoking cessation and others and establishment of a social environment as well as promotes partnership among health care providers and conducts specific health checkups and specific health guidance.

③ **Improvement and maintenance of health status in regard to maintaining social functions**

With the low birth rate and rapid increase of the aged population, it is important for the Japanese to maintain their health status, which enables them to maintain social functioning as long as possible.

Maintaining mental health is as important as physical health. Mental health is an important component of quality of life. In other words, by supporting a society where people's healthy state of mind is protected, this policy aims to reduce the suicide rate and prevalence of serious depressive conditions, improve the occupational environment, and decrease children's mental and physical conditions.

Moreover, this policy stresses the importance of promoting the health of pregnant women and children, who are the future of citizens. Thus, this policy aims to increase the number of children who maintain a healthy lifestyle and proper weight throughout their lives.

In addition, for the purpose of delaying the deterioration of body functions associated with aging, focusing on health promotion among the elderly is also crucial because it is directly related to a decrease in nursing-care service users and the prevention of deterioration of cognitive function and locomotive syndrome. In turn, helping the elderly maintain nutrition intake and physical activity increases the likelihood that they will actively take part in society as they age.

The specific targets we mentioned above are shown in appendix table 3. National government conducts improvement of measures to mental health, measures to health promotion for pregnant women and children, and measures to prevention and support in nursing care.

④ **Establishment of a social environment where the health status of the individual is protected and supported**

It is important to include individuals, private corporations, non-profit organizations, and non-governmental organizations to establish a social environment where the health status of the individual is not only protected but also supported. The specific targets are shown in appendix table 4. This policy aims to empower communities, increase the number of individuals who participate in activity for health promotion, encourage corporations to proactively disseminate health-related information, and increase access to local facilities where individuals can obtain health information or counseling. The specific targets are shown in appendix table 4. As a result, this holistic effort enables people to identify health disparity issues that may occur locally and to induce more local governments to make efforts to solve health-related issues.

⑤ **Improvement of lifestyles and social environment related to nutrition and healthy diet, physical activity and exercise, proper rest, alcohol drinking, tobacco smoking and oral health**

The targets of, nutrition and healthy diet, physical activity and exercise, proper rest, alcohol drinking, tobacco smoking, and oral health are shown in appendix Table 5, based on following viewpoints.

1. Nutrition and healthy diet

Nutrition and healthy diet play a crucial role in the prevention of NCDs, improvement and maintenance of health to preserve social function and the improvement of quality of life. Thus, targets for nutrition and healthy diet include a wide range of issues including focusing on the next generation and elderly, adherence to proper weight and appropriate diet at every life stage, and development of a supportive social environment, such as promotion of a low-salt diet and specific food service facilities (food service facilities providing meals continuously to a large number of specific people; the same applies hereinafter).

In order to achieve these targets, the government is developing guidelines and standards on nutrition and healthy diet, encouraging related organizations to increase awareness of healthy diets,

promoting *shoku-iku* (term used for "dietary education or food education"), educating professionals, and organizing collaboration among private corporations and non-profit organizations.

2. Physical activity and exercise

Physical activity and exercise play a crucial role in the prevention and control of NCDs and improvement of the quality of life. Thus, targets for physical activity and exercise include a wide range of issues, including special focus on the next generation and elderly, development of physically active habits, increase in the level of physical activity, and development of a supportive social environment where individuals can easily engage in physical activity and exercise.

In order to achieve these targets, references and guidelines of exercise for health promotion are revised and improved, and the government is engaged in organizing collaboration among private corporations and non-profit organizations.

3. Proper rest

Proper rest is an essential factor for a good quality of life. It is very important to get adequate sleep on a daily basis for optimal mental and physical functioning. Targets are primarily set to promote adequate sleep and to decrease the ratio of employees who work 60 hours or more per week. In order to achieve these targets, the government is engaged in improving guidelines on proper rest in relation to health promotion.

4. Alcohol drinking

Consumption of alcohol greater than recommended limits not only raises the risk of medical conditions such as certain life-style related diseases and depression, but it also has adverse effects on society, such as underage drinking and trauma associated with drunk driving. Targets are set to decrease the number of individuals who consume alcoholic beverages above the recommended level and to prevent children and pregnant women from drinking alcoholic beverages.

In order to achieve these targets, the government is engaged in raising awareness especially among children with accurate information regarding the alcohol drinking.

5. Tobacco smoking

Because tobacco smoking is the strongest yet preventable factor for NCD such as cancer, cardiovascular disease, diabetes and COPD as well as increment of infants with low birth weight, and because passive smoking also causes numerous diseases, it is important to prevent health issues caused by tobacco smoking. Targets are set to decrease the prevalence of smoking among adults and minors and passive smoking.

To achieve these targets, the national government is engaged in measures to prevent passive smoking, support of smoking cessation for smokers who want to quit smoking, measures to prevent start smoking among minors, education related to health effect of tobacco and smoking cessation, raising awareness and others.

6. Oral health

Oral health is crucial for proper food intake and articulation; therefore it contributes to good quality of life. Targets are set to prevent periodontal disease, dental caries, and tooth loss, and to maintain oral function so that long-lasting oral health is promoted.

In order to achieve these targets, the government is engaged in distributing information on oral health and devoting more efforts to programs like the "8020 campaign" (keep 20 or more teeth at the age of 80).

3. Basic Concepts for Prefecture- and Community-Based Health Promotion Plans

A) Setting targets and evaluation for health promotion plans

For the establishment of prefecture- and community-based health promotion plans, local governments need to decide which issues to work on and set targets to solve those issues based on information from various sources, including population statistics, medical and nursing care, data of specific health checkups, and existing social resources in the community. It is also necessary to periodically evaluate and revise the health promotion plan.

Prefecture-based health promotion plans are usually based on national targets. However, they should also focus on local issues so that targets are community oriented and are easily understood.

In addition, local governments should make efforts to examine health status and health disparities that may exist among population groups in the community.

B) Applications on development of health promotion plans

It is important to take the following items into consideration while developing health promotion plans:

① Prefectures play a central role in coordinating activities with organizations and individuals so that health promotion plans are implemented efficiently and effectively. Key participants may include health promotion program leaders, medical facilities, school nurses, occupational health directors, health-related corporations and their directors, and nonprofit organizations. Prefectures should take advantage of local associations that are composed of liaisons with such organizations and individuals so that each organization is assigned specific tasks based on its capabilities. This strategy would be more likely to result in better execution of the health promotion plans.

② At the prefecture level, the health promotion plan should exist in consonance with the following: medical plan that is defined in paragraph 1 in article 30-4 of the medical law (law item 80, 1948); prefectural medical cost adjustment plan that is defined in paragraph 1 in article 9 of the law for providing medical care for elderly (item 80, 1982); Prefectural Insured Long-Term Care Service Plan that is defined in paragraph 1 in article 118 of Long-Term Care Insurance Act-(Act No.123, 1997); prefectural cancer prevention plan that is defined in item 1 in article 11 of the Cancer Control Basic Act (paragraph 98, 2006) and other health promotion plans and associated plans; and Basic Matters Related to the Promotion of Dental and Oral Health that are defined in paragraph 1 in article 12 of the Law of Promotion of Dental and Oral Health (item 95, 2011).

In the prefectural health promotion plans, moreover, components addressing the efforts of prefectures to assist with the development of local-level health promotion plans and to conduct analysis on identifying and improving local health disparity issues should be included.

③ Public health centers should play a role in improving community health, providing professional and technical services, collecting and analyzing local health information to solve health disparity issues, and providing information to the residents and other related organizations, and assisting in the process of developing a local health promotion plan as needed.

④ For the development of health promotion plans in municipalities, local governments should work with the prefecture and public health centers to efficiently distribute tasks. As a medical insurer, municipalities should aim to establish integrated health programs such as a health promotion plan that includes specified health checkups that are defined in paragraph 1 in article 19 of the law for providing medical care for elderly. Simultaneously, municipalities should incorporate health promotion plans into other local health plans and Municipal Insured Long-Term Care Service Plan, which are defined in paragraph 1 in article 117 of Long-Term Care Insurance Act. Furthermore, municipalities should be aware that health promotion plans that are established based on article 19-2 and 17 of the Health Promotion Act (item 103, 2002) should be labeled as health promotion plans of them.

⑤ Prefectures, as well as municipalities, should periodically conduct evaluations and make modifications of health promotion plans according to national targets, while continuously being devoted to improving the health status of residents. In addition, programs provided by the prefectures or municipalities as well as the medical insurer in districts of prefectures and city, town and village, people related to school health , people related to occupational health, and private corporations should undergo evaluation in order to identify ongoing issues and ways to achieve targets and make constructive modifications for better outcomes.

⑥ Prefectures and municipalities should make certain that the voices of the residents are reflected in the development of targets and evaluation processes for better outcomes.

4. Basic Concepts for National Health and Nutrition Survey and Other Health-Promotion -Related Surveys and Researches

A) Utilization of surveys for health promotion measurement

National Health and Nutrition Survey should be conducted effectively so that relevant targets are evaluated for the purpose of improving the health status of the citizens of Japan. In addition, research to investigate the social environment associated with the improvement of lifestyle is also encouraged.

The national government, local governments, and independent policy corporations should conduct analysis and evaluations on health promotion plans according to a wide range of resources including the following: National Health and Nutrition Survey; Comprehensive Survey of Living Conditions; health examinations; health guidance; report from local cancer registry activities; various statistics on diseases and illnesses; and medical insurance claims. In doing so, confidentiality of participants should be primarily and strictly protected, and regulations including the law on protection of personal information (Act No. 57 of 2003), protection of personal information owned by administrative agencies (Act No. 58 of 2003), protection of personal information owned by independent policy corporations (item 59, 2003), protection of personal information owned by local governments, which is defined in paragraph 11 in article 11, and statistics law (item 53, 2007) should be followed. Also, it is important to conduct evidence-based health promotion measurements by utilizing results from such resources. Information collected from these surveys should be published.

National and local governments should be committed to utilizing Information and Communication Technology (ICT) because ICT enables individuals to obtain their own health information to enable pursuit of personal health as well as to collect and analyze nationwide health-related data for preventing life-style related diseases.

B) Encouragement of health promotion research

The nation, local governments, and independent policy corporations are engaged in conducting research associated with essential factors for health promotion, such as the social environment and lifestyle related diseases, and publishing accurate and adequate amount of information based on the research. Moreover, new research outcomes should be reflected in the revision of policies and also contribute to more effective implementation of health promotion programs.

5. Basic concepts for liaison and cooperation among individuals who work in health promotion

In order to provide high-quality health care services more effectively and continuously, various health screenings including specific health checkups and specific health guidance, cancer screening, and health checkups based on Industrial Safety and Health Act should be enforced. Moreover, when health-related programs are offered, relevant organizations should collaborate by forming a liaison or utilizing an existing one so that problems that may occur when people are relocated, switch jobs, or retire are more appropriately solved.

For example, it is more likely that screenings will be carried out efficiently and effectively if organizations that provide them circulate health information among themselves. Moreover, providing a number of screenings in one location would be more convenient for participants and would increase the participation rate. Developing a campaign to raise the participation rate for screenings, with the cooperation of organizers, would also be effective.

In addition to the facts with regard to liaison and cooperation that were mentioned above, the Health Promotion Act, paragraph 1 in article 9, describes the guidelines for health promotion program providers on conducting health screenings.

6. Basic concepts for improving health literacy on nutrition, physical activity, proper rest, alcohol drinking, tobacco smoking, and oral health

A) Basic concept

Because health promotion requires behavioral change along with awareness, it is necessary to assist citizens with health promotion activities and to provide adequate and appropriate information. In doing so, health information should be scientifically proven, easily understood, applicable to daily lifestyle, effective, and efficient. Moreover, health information should be provided to raise awareness that each component of the society such as households, preschools, schools, workplaces, and community play an important role in health promotion.

In terms of providing information regarding lifestyle, it is important to integrate numerous hannels including ICT, mass media, voluntary organizations, business sector, schools, medical insurers, and health counselors in order to reach the target population effectively.

B) National Health Promotion Month

For the purpose of promoting a national movement, National Health Promotion month takes place in September. National and local governments, corporations, and non-profit organizations hold different types of events and promotions primarily to raise awareness of health, but also to help further enhance the health status of individuals.

Furthermore, National Nutrition month is also held in September to produce a synergistic effect for the two movements.

Both National Health Promotion and Nutrition months encourage local communities to identify local health-related issues and to hold health campaigns that strive to include less interested residents. In addition to communities, national and local governments, corporations, and non-profit organizations also collaborate on a nationwide event to promote more focused and effective implementation.

7. Other Facts Regarding Health Promotion

A) Establishment of an effective structure to solve community health issues

Health centers of cities, towns, and villages should play a central role in formulating core health promotion liaisons, which may include medical insurers, medical institutions, pharmacies, community support centers, educational institutions, mass media, corporations, and voluntary organizations, in order to establish comprehensive action plans to accomplish relevant health targets based on each organization's health promotion plan. This would strengthen coordination among organizations, which would foster more productive and effective implementation of health promotion programs.

B) Encouragement of programs and liaisons constructively derived from various organizations

Corporations that support the concept of health promoting activities, such as good nutrition, physical activity, and proper rest, in their services and/or products, and non-governmental organizations and non-profit organizations that are devoted to working on health should continuously strive to contribute to the health of individuals, and should publicize appropriate information regarding their services and products. National and local governments should consider recognizing organizations that can show positive outcomes in the area of health promotion. Specifically, advocating for excellence by helping with public relations activities and offering incentives would increase the number of corporations who contribute to a healthy social environment. Furthermore, if corporations that provide health-related services partner with other organizations such as those that provide health screenings or diagnostic testing, more efficient and effective services could be provided. Combining such programs creates a health promotion market where high quality services are provided based on individual needs.

Health promotion includes a wide range of health-related issues. There are measures that are specifically mentioned by the Ministry of Health, Labor, and Welfare, which include *shoku-iku* (dietary and food education), maternal and prenatal health, mental health, nursing care prevention, occupational health, and health promotion programs provided by health guidance instructors and medical insurers. However, there are other essential measures such as school health, development of sidewalks and walking trails, exposure to the natural environment, participation in life-long sports by utilizing local resources such as comprehensive community sports clubs, and improvement of the health industry. All these measures are essential to health promotion and the relevant political fields and institutions should be devoted to improving such measures.

C) Professionals involved in health promotion

In local governments, physicians, dentists, pharmacists, nurses, public health nurses, midwives, registered dietitians, dietitians, and dental hygienists should be assigned to counsel and educate individuals on lifestyle issues like nutrition, physical activity, proper rest, mental health, alcohol drinking, tobacco smoking, and oral health, based on their profession.

National and local governments should also aim to increase the number and quality of public health nurses and registered dietitians, who implement health promotion plans, to assist the development of liaisons between physical health instructors and sports medicine doctors, to develop health-related voluntary organizations that are committed to working on lifestyle issues such as healthy diet, physical activity, and tobacco use, as well as to create a supportive structure for the development of self-help groups.

To accomplish this, the national government should develop a comprehensive plan, educate health professionals on how to work collaboratively across disciplines field, and provide seminars on professional development. Prefectures, cities, towns, and villages should be required to partner with associations of physicians, dentists, pharmacists, nurses, and dietitians in order to provide up-to-date science-based seminars not only for staff members of local governments, but also for local health professionals who are involved in the implementation of health promotion plans.

Community and school health staff should also collaborate to promote the health of individuals.

Appendix

Table 1

Targets for achieving extension of healthy life expectancy and decrease in health disparities

Indicators	Current data	Target
1. Extension of healthy life expectancy (average period of time spent without restrictions in daily activities)	Male 70.42 years Female 73.62 years (2010)	Increase healthy life expectancy more than the increase of life expectancy (2022)
2. Decrease in health disparities (differences among prefectures in average period of time spent without restrictions in daily activities)	Male 2.79 years Female 2.95 years (2010)	Decrease in differences among prefectures (2022)

Note: To accomplish (1) above, not only the "average period of time spent without restrictions," but "average period of time individuals consider themselves as healthy" should also be taken account.

Furthermore, to accomplish (2), each prefecture should aim to extend their healthy life expectancy with the longest healthy life expectancy among all prefectures being the target.

Table 2

Targets for the prevention of the development and worsening of major life-style related diseases

(1) Cancer

Indicators	Current data	Target
1. Decrease in age-adjusted mortality rate of cancer under age 75 (per 100,000)	84.3 (2010)	73.9 (2015)
2. Increase in participation rate of cancer screenings	Gastric cancer Male 34.3% Female 26.3% Lung cancer Male 24.9% Female 21.2% Colorectal cancer Male 27.4% Female 22.6% Cervical cancer Female 32.0% Breast cancer Female 31.4% (2010)	50% (40% for gastric, lung, and colorectal cancer) (2016)

Note: These rates represent individuals who are between 40 and 69 years old (cervical cancer is between 20 and 69 years old).

(2) Cardiovascular Disease

Indicators	Current data	Target
1. Decrease in adjusted mortality rate of cerebrovascular disease (CVD) and ischemic heart disease (IHD) (per 100,000)	CVD Male 49.5 Female 26.9 IHD Male 36.9 Female 15.3 (2010)	CVD Male 41.6 Female 24.7 IHD Male 31.8 Female 13.7 (2022)
2. Improvement of hypertension (decrease in systolic blood pressure)	Male 138 mmHg Female 133 mmHg (2010)	Male 134 mmHg Female 129 mmHg (2022)
3. Decrease in percentage of adults with dislypidemia	Those with total cholesterol over 240 mg/dl Male 13.8% Female 22.0% Those with LDL cholesterol over 160 mg/dl Male 8.3% Female 11.7% (2010)	Those with total cholesterol over 240mg/dl Male 10% Female 17% Those with LDL cholesterol over 160 mg/dl Male 6.2% Female 8.8% (2022)
4. Decrease definite and at-risk people with metabolic syndrome	14,000,000 (2008)	25% less than 2008 (2015)
5. Increase in participation rates of specific health checkups and specific health guidance	Specific health checkups 41.3% Specific health guidance 12.3% (2009)	Will be set based on the second term of medical cost adjustment plan starting in 2013 (2017)

(3) Diabetes

Indicators	Current data	Target
1. Decrease in complications (number of patients newly introduced dialysis due to diabetic nephropathy)	16,247 (2010)	15,000 (2022)
2. Increase in percentage of patients who continue treatment	63.7% (2010)	75% (2022)
3. Decrease in percentage of individuals with elevated blood glucose levels (HbA1c(NGSP)≧8.4%)	1.2% (2009)	1.0% (2022)
4. Prevent the increase in diabetic patients	8,900,000 (2007)	1,000,000 (2022)
5. Decrease in metabolic syndrome patients and those at risk	14,000,000 (2008)	25% less than 2008 (2015)
6. Increase in participation rates of specific health checkups and health guidance	Specific health checkups 41.3% Specific health guidance 12.3% (2009)	Will be set based on the second period of medical cost adjustment plan starting in 2013 (2017)

(4) COPD

Indicators	Current data	Target
1. Raise awareness of COPD	25% (2011)	80% (2022)

Table 3

Targets for maintenance and improvement in necessary functions to live social life

(1) Mental health

Indicators	Current data	Target
1. Decrease in suicide rate (per 100,000)	23.4 (2010)	Will be set based on modified suicide prevention plan
2. Decrease in percentage of individuals who suffer from mood disorders or anxiety disorders	10.4% (2010)	9.4% (2022)
3. Increase in percentage of occupational settings where interventions for mental health are available	33.6% (2007)	100% (2020)
4. Increase in percentage of pediatricians and child psychiatrists per 100,000 children	Pediatricians: 94.4 (2010) Child psychiatrists: 10.6 (2009)	To increase (2014)

(2) Children's health

Indicators	Current data	Target
1. Increase in percentage of children who maintain healthy lifestyle (nutrition, healthy diet, physical activity)		
A. Increase in percentage of children who eat three meals a day	5th grade 89.4% (2010)	To reach 100% (2022)
B. Increase in percentage of children who exercise regularly	(Ref) Three times a week or more 5th grade (2010) Male 61.5% Female 35.9%	To increase (2022)
2. Increase in percentage of children with proper weight		
A. Decrease in percentage of low birth weight infants	9.6% (2010)	To decrease (2014)
C. Decrease in percentage of children who tend to be obese	5th graders who are overweight or obese (2011) Male 4.60% Female 3.39%	To decrease (2014)

(3) Health of elderly

Indicators	Current data	Target
1. Restraint of the increase in Long-Term Care insurance service users	4,520,000 (2012)	6,570,000 (2025)
2. Increase in identification rate of high-risk elderly with low cognitive function	0.9% (2009)	10% (2022)
3. Increase in percentage of individuals who know about locomotive syndrome	(Ref.) 17.3% (2012)	80% (2022)
4. Restraint of the increase in undernourished elderly	17.4% (2010)	22% (2022)
5. Decrease number of elderly with back or foot pain (per 1,000)	Male 218 Female 291 (2010)	Male 200 Female 260 (2022)
6. Participation in society (employed or in community activities)	(Reference) Those who are involved in any form of community activities Male 64.0% Female 55.1% (2008)	80% (2022)

Note: the target for 1. is set based on the results from the Outline basic and integrated Reform Plan for Social Welfare and Tax

Table 4

Targets for establishing a social environment where health is supported and protected

Indicators	Current data	Target
1. Strengthen community ties	(Ref.) "There is a strong bond between myself and community." 45.7% (2007)	65% (2022)
2. Increase in percentage of individuals who are involved in health promotion activities	(Ref.) Health or medical service volunteer 3.0% (2008)	25% (2022)
3. Increase in number of corporations that deal with health promotion and educational activities	420 (2012)	3,000 (2022)
4.Increase in number of organizations that offer accessible opportunities for health promotion support or counseling	(Reference) Reported by the organizations 7,134 (2012)	15,000 (2022)
5. Increase in number of local governments that make efforts to solve health disparity issues (number of prefectures that identify problems and have intervention programs for those in need)	11 (2012)	47 (2022)

Table 5

Targets for improvement of social environment and lifestyle factors such as nutrition, healthy diet, physical activity, exercise, proper rest, alcohol drinking, tobacco smoking, and oral health

(1) Nutrition and healthy diet

Indicators	Current data	Target
1. Increase in percentage of individuals with proper weight (Decreased percentage of obese individuals [BMI 25 and more] and underweight individuals [BMI less than 18.5])	Obese males in their 20's to 60's 31.2% Obese females in their 40's to 60's 22.2%	Obese males in their 20's to 60's 28% Obese females in their 40's to 60's 19%

	Underweight females 20-29 years old 29.0% (2010)	Underweight females 20-29 years old 20% (2022)
2. Increase in percentage of individuals who consume appropriate quality and quantity of food		
A. Increase in percentage of individuals who eat balanced diet with staple food, main dish and side dish more than twice a day	68.1% (2011)	80% (2022)
B. Decrease in salt intake	10.6 g (2010)	8 g (2022)
C. Increase in consumption of vegetables and fruits	Mean daily intake of vegetables 282g Individuals who consume less than 100 g of fruits per day 61.4% (2010)	Mean daily intake of vegetables 350g Individuals who consume less than 100 g of fruits per day 30% (2022)
3. Increase in dining with family regularly (decrease in percentage of children who eat alone)	Breakfast School child Elementary 15.3% School student Junior high 33.7% Dinner School child Elementary 2.2% School student Junior high 6.0% (2010)	To decrease (2022)
4. Increase in number of corporations in food industry that supply food product low in salt and fat	Food corporations: 14 corporations Restaurants 17,284 locations (2012)	Food corporations: 100 corporations Restaurants: 30,000 locations (2022)
5. Increase in percentage of specific food service facilities that plan, cook, and evaluate and improve nutritional content of the menu based on the needs of the clients	(Ref.) Facilities with registered dietitians or dietitians 70.5% (2010)	80% (2022)

(2) Physical activity and exercise

Indicators	Current data	Target
1. Increase in daily number of steps	20-64 years old Male 7,841 steps Female 6,883 steps Over 65 years old Male 5,628 steps Female 4,584 steps (2010)	20-64 years old Male 9,000 steps Female 8,500 steps Over 65 years old Male 7,000 steps Female 6,000 steps (2022)
2. Increase in percentage of individuals who regularly exercise	20-64 years old Male 26.3% Female 22.9%	20-64 years old Male 36% Female 33%
	Over 65 years old Male 47.6% Female 37.6% (2010)	Over 65 years old Male 58% Female 48% (2022)
3. Increase in number of local governments that offer community development and organizations to promote physical activity	17 prefectures (2012)	47 prefectures (2022)

(3) Proper rest

Indicators	Current data	Target
1. Decrease in percentage of individuals who do not get adequate rest	18.4% (2009)	15% (2022)
2. Decrease in percentage of employees who work 60 hours or more per week	9.3% (2011)	5.0% (2020)

(4) Alcohol drinking

Indicators	Current data	Target
1. Decrease in percentage of individuals who consume alcohol over recommended limits (male > 40 g, female > 20 g per day)	Male 15.3% Female 7.5% (2010)	Male 13% Female 6.4% (2022)
2. Eradication of underage drinking	Third grade of junior high school Male 10.5% Female 11.7% Third grade of high school Male 21.7% Female 19.9% (2010)	0% (2022)
3. Eradication of alcohol consumption among pregnant women	8.7% (2010)	0% (2014)

(5) Tobacco smoking

Indicators	Current data	Target
1. Decrease in percentage of adult smoking rate (quit smoking among smokers who want to quit smoking)	19.5% (2010)	12% (2022)
2. Eradication of smoking among minors	First grade of junior high school Male 1.6% Female 0.9% Third grade of high school Male 8.6% Female 3.8% (2010)	0% (2022)
3. Eradication of smoking among pregnant women	5.0% (2010)	0% (2014)

4. Decrease in percentage of facilities where exposure to secondhand smoke is present	Governmental institutions 16.9% Health institutions 13.3% (2008) Workplace 64% (2011) Household 10.7% Restaurants 50.1% (2010)	Governmental institutions 0% Health institutions 0% (2022) Workplace--no secondhand smoke (2020) Household 3% Restaurants 15% (2022)

(6) Oral health

Indicators	Current data	Target
1. Maintenance and improvement of oral function (increase in percentage of individuals over the age 60 with good mastication)	73.4% (2009)	80% (2022)
2. Prevention of tooth loss		
A. Increase in percentage of 80-year-old individuals with over 20 teeth remaining	25% (2005)	50% (2022)
B. Increase in percentage of 60-year-old individuals with over 24 teeth remaining	60.2% (2005)	70% (2022)
C. Increase in percentage of 40-year-old individuals with all teeth remaining	54.1% (2005)	75% (2022)
3. Decrease in percentage of individuals with periodontal disease		
A. Decrease in percentage of individuals in 20s with gingivitis	31.7% (2009)	25% (2022)
B. Decrease in percentage of individuals in 40s with periodontitis	37.3% (2005)	25% (2022)
C. Decrease in percentage of individuals in 60s with periodontitis	54.7% (2005)	45% (2022)
4. Increase in number of children without dental caries		
A. Increase in number of prefectures where over 80% of 3-year-old children have no dental caries	6 prefectures (2009)	23 prefectures (2022)
B. Increase in number of prefectures where 12-year-old children have less than 1 cavity	7 prefectures (2011)	28 prefectures (2022)
5. Increase in percentage of individuals who participated in dental check-up in the past 1 year	34.1% (2009)	65% (2022)

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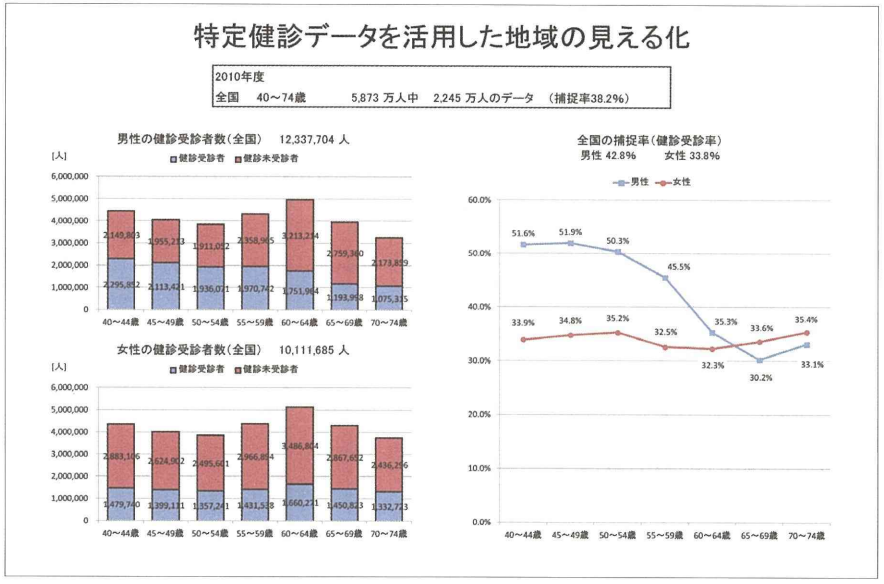
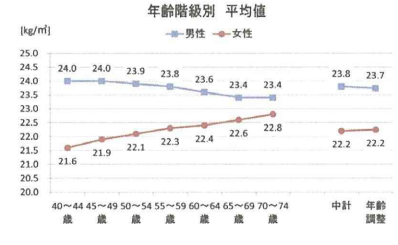
特定健診データ（全国版） PPT

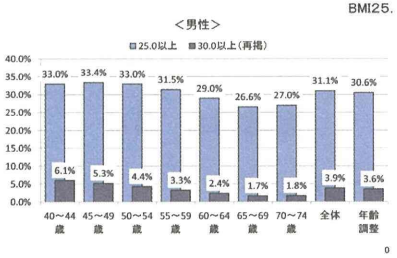
地域の状況を的確に知るためには、全国や他地域との比較、過去からの推移の検討が必要です。本研究班では、特定健診データ（厚生労働省「特定健康診査・特定保健指導の実施結果に関するデータ」http://www.mhlw.go.jp/bunya/shakaihosho/iryuouseido01/info02a-2.html）をもとに、簡単に都道府県別グラフを作成できるソフト（付属DVDに収録）を開発しました。

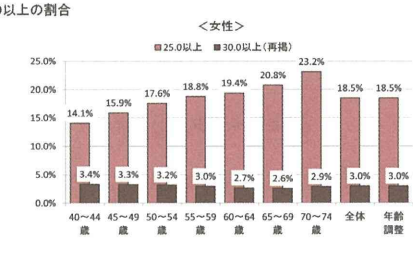
各検査値について、有効回答数、年齢階級別平均値、有所見率を"見える化"しています。
年齢調整有所見率についてマップ表示も可能です。
以下（P.81～95）は、全国データのグラフ一覧です。ラベル表示には全国の値が表示されていますので、比較対照の際にご活用ください。



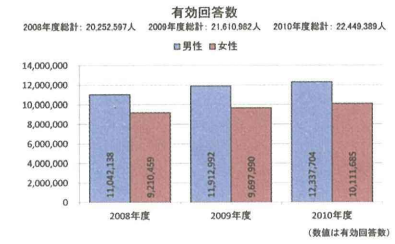
全国のBMI（肥満）の状況（2010年度）



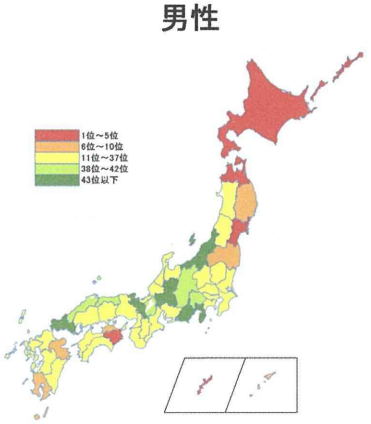


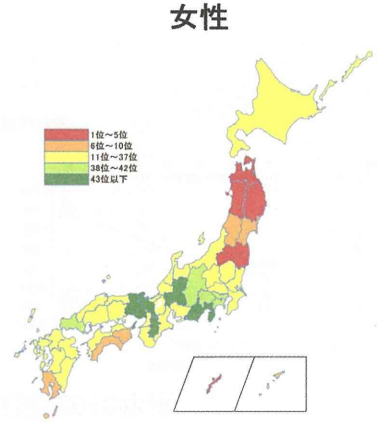


全国のBMI（肥満）の状況（年次推移）

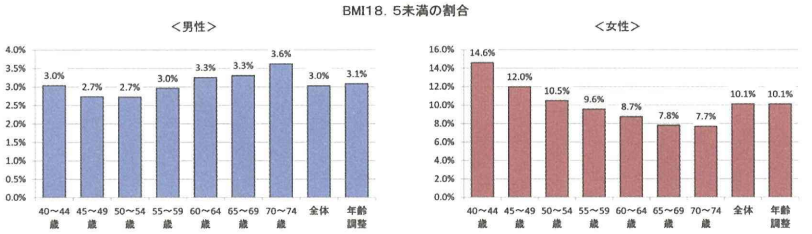


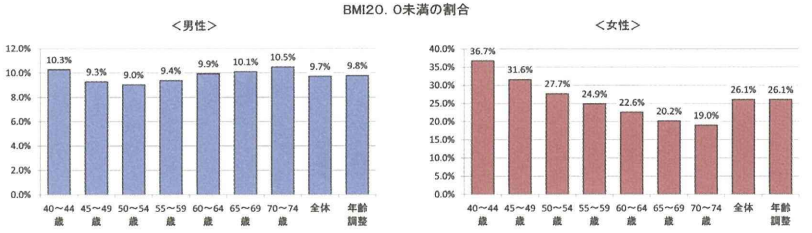
肥満者（BMI25 以上）の割合
（男女別年齢調整済み） 2010年



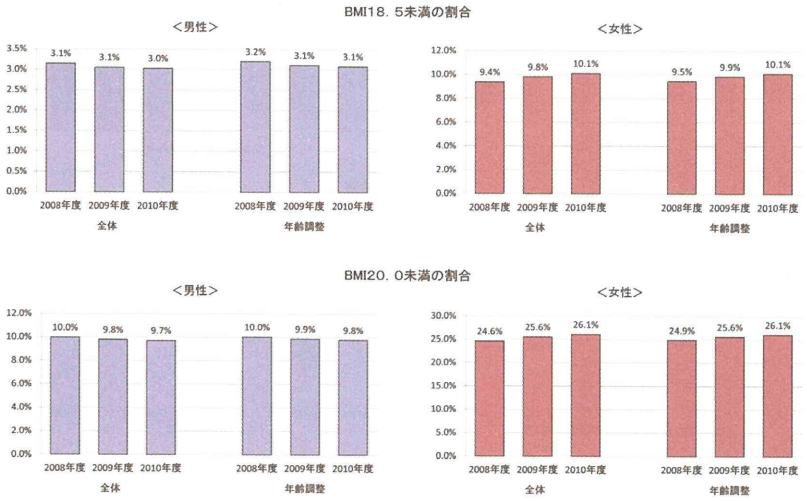


全国のBMI（やせ）の状況（2010年度）

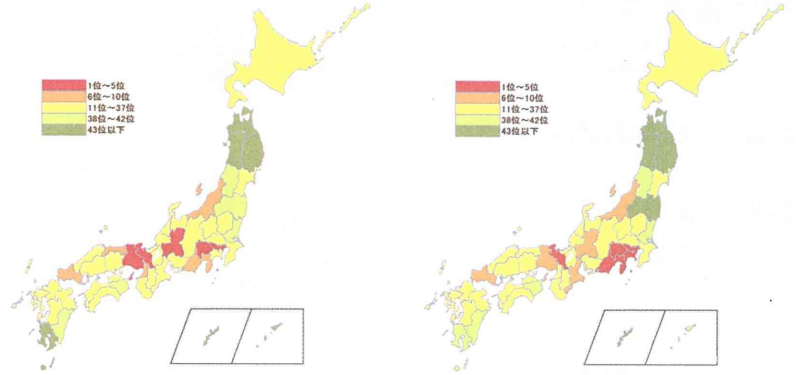




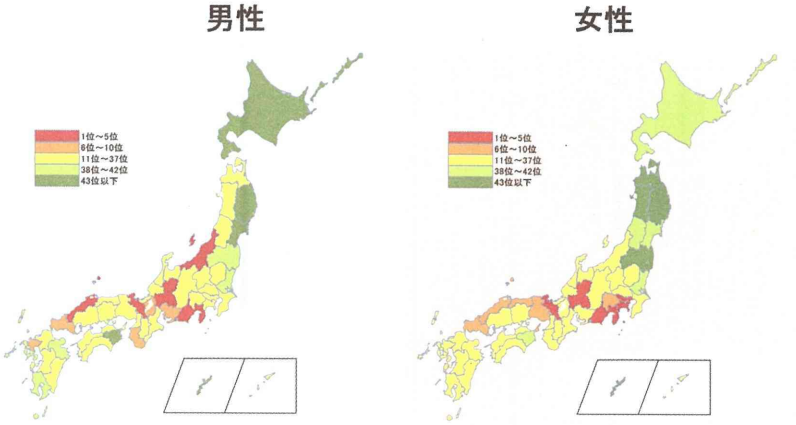
全国のBMI（やせ）の状況（年次推移）



女性のやせ（BMI 18.5 未満）の割合
（年齢調整、40～44歳） 2010年



やせ傾向（BMI20 未満）の高齢者
（70～74歳）



全国の腹囲の状況（2010年度）