Japan's obesity panic: health and risk management in contemporary Japan

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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

Japan’s obesity crisis
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

**Risk in reflexive modernity**

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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

anthropometric tradition
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

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

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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 (≥110mg/dL)
- Hypertony (≥130/85mmHg)
- Hyperlipidemia (elevated triglycerides/≥150 mg/dL or reduced HDL cholesterol/≤40mg/dL)
- step 1: body measurement (height, weight, waistline, BMI)

  - > 85 cm/m and 90 cm/f → A group (no or low risk group)
  - waist circumference ok but BMI of 25 and more → B group (moderate or high risk group)
- **step 2: physical checkup for invisible health risks**

  - **blood glucose analysis**
    - 100 mg/dl, or HbA1c of 5.2%, or persons under medical treatment

  - **adiposity ("body fat") measurement**
    - 150 mg/dl, or HDL cholesterol of < 40 mg/dl, or persons under medical treatment

  - **blood pressure**
    - >130/85, or persons under medical treatment

  - **questionnaire**
    - smoking career
    - lifestyle habits, etc.

*assessing metabo*
- 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

  assessing *metabo*
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 insurers 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

mediated risk talks

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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

Conclusion (2)